Family Physicians
of Jonesboro

Authorizations & Acknowledgments

Date:_____ MRN_____

Patient Name:_____
First Middle Last

Acknowledgment of Notice of Privacy Practices

*Initial Here*_____I acknowledge that a copy of the Notice of Privacy Practices was provided to me.

General Consent to Treatment and Test

*Initial Here*_____I am voluntarily seeking medical treatment. I consent to examination by the physician, nurse or other health care professionals at this clinic. I also consent to any medical procedures, x-ray, laboratory tests or other health care services ordered by the health care team. I understand that I may refuse specific treatments or procedures by informing the health care team.

Release of Information

*Initial Here*_____I authorize Family Physicians of Jonesboro to release any medical information necessary to process payment of my claim.

Assignment of Insurance Benefits and Acceptance of Financial Responsibility

*Initial Here*_____I authorize payment directly to Family Physicians of Jonesboro for their fees. I understand and agree that if any part of my account is not paid by insurance, I am financially responsible

_____ Date:_____

SIGNATURE OF PATIENT/PARENT/GUARDIAN/PERSON AUTHORIZED TO SIGN FOR PATIENT