ADULT MEDICINE CLINIC OF BLYTHEVILLE, P.C.
519 North 6th Street, Blytheville, AR 72315
Phone : (870) 762-5800, Fax : (870) 762-5801

Authorization and Acknowledgments

Patient Name:______________________________ Date of Birth: ____________________

Address: __________________________________

City: _________________State: ____ Zip:______

Telephone No.:____________________________

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1. **Privacy Practices** - I acknowledge that I have received and reviewed the Notice of Privacy Practices Policy. I understand that I may revoke this consent at any time, except where information has already been released.
2. **Contact Policy** - I **DO / DONOT** (Circle One) authorize Adult Medicine Clinic of Blytheville to leave messages on my home answering machine regarding appointments, billing, availability of lab results and prescription management. I realize I will personally have to call the office to get my lab results.
3. **Contact Policy** - I **DO / DONOT** (Circle One) authorize Adult Medicine Clinic of Blytheville to contact me or leave messages for me at work.
4. **Payment, Assignment and Release** – I understand that Adult Medicine Clinic of Blytheville may bill my insurance carrier/government programs as a courtesy to me but I am financially responsible for all fees incurred and I agree to pay them in full. I understand that it is my responsibility to understand what treatment options are and are not covered by my insurance policy and what I am required to secure those benefits.
5. **Prescription History Consent** - I agree to allow Adult Medicine Clinic of Blytheville to review any prescription history available to my Electronic Health Record
6. A copy of this authorization shall be as effective and valid as the original.

_______________________________________ ____________________________

Signature: (Parent or Legal Guardian if Minor Child) Date