MINOR INFORMATION

In order to comply with the level of confidentiality you desire, we need the following information:

Patient Name ____ Date of Birth ___________

Address __________________________ City _______________ State _______ Zip ________

Home Phone # ____________________________ Cell Phone # ______________________________

Is a Parent or Guardian With You Today? ☐ Yes ☐ No

If yes, Who is With You and What is Their Relationship to You? ______________________________________

As parent or legal guardian of (Patient's Name) ______________________________, I am responsible for all payments made to her account and give Murray Woman's Clinic, PLLC consent to treat her. I understand that Murray Woman's Clinic, PLLC will not release private healthcare information on any patient unless there is a signed authorization on file. That authorization will remain in effect until revoked in writing or until expiration date.

______________________________________ ______________

Parent / Legal Guardian's Signature Date

TO MINORS: IF YOUR PARENT OR GUARDIAN IS NOT WITH YOU TODAY, PLEASE READ AND COMPLETE THE FOLLOWING

Is your parent or legal guardian aware of your visit today and understand they are financially responsible for your account? ☐ Yes ☐ No

Do you object to your parent or legal guardian knowing of your visit? ☐ Yes ☐ No

Important Notice

If you do not pay in full or make other arrangements today, monthly statements will be sent to your house. If we bill your parent's or legal guardian's insurance, the insurance company will send your parents an explanation of benefits itemizing the services you received. Murray Woman's Clinic's policy is to call and remind patients of upcoming appointments and a message may be left on an answering machine, voice mail or given to a family member. It is your responsibility to advise your doctor or nurse of any special request for confidentiality now or in the future. Please sign below indicating you have read and understand the above information.

______________________________________ ______________

Signature of Minor Patient Date