# PHYSICIAN ASSOCIATES

**6000 Executive Blvd #300**
**Rockville, MD 20852**

**5530 Wisconsin Ave #645**
**Chevy Chase, MD 20815**

The following signatures reflect that you have read the new patient packet and have agreed to the policies that are applicable to this practice. This signature page will be saved as a part of your medical record. You may have a copy of the packet upon request.

**FINANCIAL POLICY**

| Print Name | Signature | Date |
|---|---|---|
| _____ | _____ | _____ |

**HMO MEMBER** (if applicable)

| Print Name | Signature | Date |
|---|---|---|
| _____ | _____ | _____ |

**HIPAA**
(Please check one)

- o I do not want Physician Associates (Provider) to disclose any information concerning my care or treatment by Provider to individuals without my express written consent or legal authorization.

- o I authorize Provider to disclose information related to my care and treatment to the following named individuals:

  _____ _____

  _____ _____

  _____ _____

| Print Name | Signature | Date |
|---|---|---|
| _____ | _____ | _____ |