



MEDICAL SPECIALISTS OF THE PALM BEACHES, INC.

www.mspbhealth.com

DATE: _____ OFFICE: _____ PRIMARY LANGUAGE SPOKEN: _____

PATIENT NAME: _____

(Last)

(First)

(Middle)

(CHECK ONE) ASSIGNED SEX AT BIRTH: MALE _____ FEMALE _____ CHOOSE NOT TO DISCLOSE _____ UNKNOWN _____

(CHECK ONE) GENDER IDENTITY: MALE _____ FEMALE _____ TRANSGENDER MALE/ FEMALE-TO-MALE (FTM) _____

TRANSGENDER FEMALE/ MALE-TO-FEMALE (MTF) _____ GENDER NON-CONFORMING (NEITHER EXCLUSIVELY MALE NOR FEMALE) _____

ADDITIONAL GENDER CATEGORY/OTHER (PLEASE SPECIFY) _____ CHOOSE NOT TO DISCLOSE _____

(CHECK ONE) SEXUAL ORIENTATION: LESBIAN, GAY, OR HOMOSEXUAL _____ STRAIGHT OR HETEROSEXUAL _____ BISEXUAL _____

SOMETHING ELSE (PLEASE DESCRIBE) _____ DON'T KNOW _____ CHOOSE NOT TO DISCLOSE _____

CHECK ONE: MARRIED _____ SINGLE _____ WIDOWED _____ DIVORCED _____ RACE: _____ ETHNICITY: _____

ADVANCED DIRECTIVES: YES _____ NO _____ DATE OF BIRTH: _____ SOCIAL SECURITY#: _____

RESPONSIBLE PARTY: _____ RELATIONSHIP: _____ PHONE#: _____

PATIENT'S LOCAL ADDRESS: _____

(Street)

(City)

(Zip)

PERMANENT ADDRESS (IF DIFFERENT): _____

HOME TELEPHONE#: (____) _____ CELL#: (____) _____ EMAIL: _____

EMPLOYED BY: _____ OCCUPATION: _____ WORK#: (____) _____

BUSINESS ADDRESS: _____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____ PHONE#: (____) _____

ALLERGIES TO MEDICATIONS: _____

PRIMARY PHARMACY: _____ PHONE#: (____) _____

LOCATION: _____

PRIMARY CARE PHYSICIAN: _____ REFERRED BY: _____ REASON FOR VISIT: _____

CHECK ONE:

ILLNESS/INJURY RELATED TO: WORK _____ AUTO _____ OTHER _____ DATE OF INCIDENT: _____

INSURANCE INFORMATION

NAME OF PRIMARY INSURANCE COMPANY: _____ HMO _____ PPO _____ POS _____

POLICY/ID# _____ GROUP # _____

POLICY HOLDER: _____ RELATIONSHIP: _____ POLICY HOLDER'S DATE OF BIRTH: _____

SOCIAL SECURITY#: _____

SECONDARY INSURANCE COMPANY NAME: _____

POLICY/ ID# _____ GROUP # _____

**AUTHORIZATION TO RELEASE INFORMATION AND TO PAY BENEFITS TO
MEDICAL SPECIALISTS OF THE PALM BEACHES, INC.
And CONSENT FOR TREATMENT**

I hereby authorize Medical Specialists of the Palm Beaches, Inc. (MSPB) and its employees and agents to release my medical records documenting my examination and treatment, including AIDS related testing, psychiatric or substance abuse information, upon valid request.

I hereby assign payment directly to Medical Specialists of the Palm Beaches, Inc. for any medical/surgical procedures performed. I agree that this authorization shall be valid until rescinded in writing or replaced by one of a later date. I agree to be financially responsible to Medical Specialists of the Palm Beaches, Inc. for all charges in the event that I have no insurance or my insurance is rejected, and for any balance or fee not covered by my insurance and/or determined to be my responsibility. I understand and acknowledge that if Medical Specialists of the Palm Beaches, Inc. files my insurance claim, I will remain responsible for the account, and I will be expected to pay any amount due if my insurance does not pay the claim within 45 days. I acknowledge that any amounts quoted as my "out-of-pocket costs" are only an estimate and that the exact determination of my financial responsibility will be made after my insurance company processes the claim. Payment is expected at the time of service. Methods of payment accepted include check, cash and credit card.

I further agree to pay all costs of collection, including reasonable attorney's fees, at the legal rate of interest on the account until paid in full, and I agree to waive all rights of exemption under the Constitution and the laws of the State of Florida.

I hereby request and authorize all doctors, nurses, technicians or affiliated medical personnel, hospitals and health care facilities to furnish all records and reports, including x-rays, photostatic copies, and abstracts or excerpts of all records, and any other information requested relating to any hospitalizations, examinations, treatments, tests or opinions concerning any condition for which I am presently being treated, including AIDS related testing, psychiatric or substance abuse information. A copy of this authorization shall be as valid as the original of this document.

I understand that my MSPB physician has a financial interest in the MSPB Diagnostic, MSPB Laboratory, MSPB Vein Center and/or MSPB Rehabilitative Therapy facility to which I may be referred. I acknowledge that I may receive these services at an MSPB facility or other facilities whose names and addresses I have been provided.

GENERAL CONSENT TO TREATMENT

By signing below, I (or my authorized representative on my behalf) authorize MSPB physicians, practitioners and their staff to conduct any diagnostic examinations, tests and procedures and to provide any medications, treatment or therapy necessary to effectively assess and maintain my health, and to assess, diagnose and treat my illness or injuries. I understand that it is the responsibility of my individual treating healthcare providers to explain to me the reasons for any particular diagnostic examination, test or procedure, the available treatment options and the common risks and anticipated burdens and benefits associated with these options as well as alternative courses of treatment.

RIGHT TO REFUSE TREATMENT

In giving my general consent to treatment, I understand that I retain the right to refuse any particular examination, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by my individual treating health care providers. I also understand that the practice of medicine is not an exact science and that no guarantees have been made to me as to the results of my evaluation and/or treatment.

PLEASE PRINT PATIENT'S FULL NAME

PATIENT'S SIGNATURE

DATE

WITNESS SIGNATURE



**MEDICAL SPECIALISTS OF
THE PALM BEACHES, INC.**

Acknowledgment of Receipt of Notice

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices.

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate relationship:

____ parent or guardian of minor patient

____ guardian or conservator of an incompetent patient

Name of Patient: _____

For Office Use Only:

____ Signed form received by: _____

____ Acknowledgment refused:

Efforts to obtain:

Reasons for refusal:



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Confidential Channel Communication Request

As required by the Health Information Portability and Accountability Act of 1996 (HIPAA) you have a right to request that communications concerning your personal health information be made through confidential channels. This medical practice will not ask you why you are making your request and will try to accommodate all reasonable requests.

I, _____ (print name) hereby request the use of the following confidential channels for the communication of information related to my personal health, treatment or payment for treatment. This request supersedes any prior request for confidential channel communications I may have made.

Please select all that apply:

☐ Phone, I want you to contact me by telephone at: _____
☐ DO ☐ DO NOT leave messages on my answering machine

☐ Mail, I want you to contact me at the following address: _____

☐ Email, I want you to contact me at the following email address: _____

☐ Fax, I want you to contact me at the following fax number: _____

☐ Other requests for confidential communications: You may designate a representative that is permitted to discuss your medical condition with MSPB on your behalf (specify): _____

Name	Relation	Telephone
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_____	_____	_____
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☐ Check here if you agree to reimburse this office for the costs associated with this request. Any costs associated with this request will be explained to you before you are billed for them.

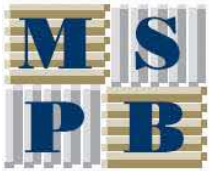
Signed _____	Print Name _____	Date _____
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If not signed by the patient, please indicate relationship:

- ☐ parent or guardian of minor patient
- ☐ guardian or conservator of an incompetent patient
- ☐ beneficiary or personal representative of deceased patient
- ☐ other (specify) _____

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For office use only:

Date Granted: _____ Date Terminated or Modified: _____



**MEDICAL SPECIALISTS OF
THE PALM BEACHES, INC.**

Guidelines for Appointments and Treatment

We value the trust you place in MSPB and strive to provide timely, high-quality care to all our patients. To maintain the best possible care and the integrity of the doctor-patient relationship, we kindly ask that patients:

- Attend scheduled appointments or provide timely notice if a cancellation or rescheduling is necessary.
- Follow the treatment plan recommended by the physician and agreed upon during your care.

Failure to provide timely notice of missed or late appointments, or consistent noncompliance with the agreed-upon treatment plan, may impact our ability to continue providing care. In some cases, repeated instances may result in the termination of the doctor-patient relationship.

We appreciate your understanding and cooperation in helping us provide the best care for all our patients.

X

Patient Signature