MEDICAL SPECIALISTS OF THE PALM BEACHES, INC.

www.mspbhealth.com

DATE: _____ OFFICE: _____ PRIMARY LANGUAGE SPOKEN: _____

PATIENT NAME:_____
(Last) (First) (Middle)

CHECK WHICH APPLIES: SEX/GENDER: M _____ F_____ INTERSEX_____ TRANSGENDERED _____ PRONOUNS_____

CHECK ONE: MARRIED_____SINGLE_____ SEPARATED_____DIVORCED_____WIDOWED_____PARTNER_____

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 _____
(If applies, check)

POLICY/ID#_____ GROUP #_____

POLICY HOLDER:_____ RELATIONSHIP:_____

POLICY HOLDER'S DATE OF BIRTH: _____ SOCIAL SECURITY #: _____

SECONDARY INSURANCE COMPANY NAME: _____

POLICY/ ID#_____ GROUP #_____

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

Revised 4/15/19

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 I agree that this authorization shall be valid until rescinded in writing or replaced by one of a later date.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 if 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.

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 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 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** Revised 4/15/19