BOCA RATON PSYCHIATRIC GROUP, P.A.

PLEASE PRINT **DATE _____**

[ ] Dr. [ ] Mr. [ ] Mrs. [ ] Miss [ ] Ms. [ ] Male [ ] Female [ ] Other

AGE _____

MARITAL STATUS: []SINGLE []MARRIED []WIDOWED [] DIVORCED[]SEPARATED

PATIENT'S LAST NAME _____ FIRST _____MIDDLE _____

STREET ADDRESS _____ APT_____

CITY _____ STATE_____ ZIP _____REFERRED BY_____

EMPLOYER _____ EMPLOYER ADDRESS _____

HOME PHONE # _____ CELL# _____EMAIL _____

DATE OF BIRTH _____ DRIVER LICENSE # _____

PHARMACY NAME/ADDRESS_____

PHARMACY PHONE #_____

SECONDARY ADDRESS:

_____

_____

PERSON TO CONTACT IN CASE OF EMERGENCY _____ PHONE _____

FINANCIAL RESPONSIBILITY

GUARANTOR'S LAST NAME _____ FIRST _____ M_____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

DOB _____ SS# _____ DRIVER LIC #_____

EMPLOYER _____ PHONE _____

IS THIS CASE RELATED TO ANY LITIGATION? []YES []NO
DOES A LAWYER REPRESENT YOU? []YES [] NO

INSURANCE INFORMATION
NAME OF INSURANCE COMPANY _____
PLEASE INCLUDE A COPY OF YOUR INSURANCE CARD (FRONT AND BACK)

PLEASE INCLUDE A COPY OF YOUR ID

A PHYSICIAN/CLINICIAN – PATIENT TREATMENT RELATIONSHIP WILL BE ESTABLISHED IF MUTUALLY AGREED TO UPON COMPLETION OF THE INITIAL CONSULTATION PROCESS. WE DO NOT ACCEPT ASSIGNMENT FOR MEDICARE IN THIS OFFICE. WE DO REQUIRE PAYMENT AT THE TIME SERVICE ARE RENDERED.

AUTHORIZATION

I AUTHORIZE BOCA RATON PSYCHIATRIC GROUP, P.A.(BRPG) TO RELEASE ANY MEDICAL OR PSYCHIATRIC INFORMATION (INCLUDING PSYCHOTHERAPY AND SUBSTANCE ABUSE RECORDS) TO THE HEALTH CARE ADMINISTRATION, MY INSURANCE COMPANY, MEDICARE AND THEIR AGENTS AS NEEDED TO AUTHORIZE THESE BENEFITS OR THE BENEFITS PAYABLE FOR THESE SERVICES. I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE AND INSURANCE BENEFITS BE MADE ON MY BEHALF TO BOCA RATON PSYCHIATRIC GROUP, P.A. FOR SERVICES FURNISHED BY ITS AGENTS OR PROVIDERS. I ALSO AGREE THAT ANY AND ALL BALANCES WILL BE PAID BY ME, AND THAT PHOTOCOPIES OF THIS FORM WILL BE VALID. I REQUEST THAT THIS INFORMATION ALSO APPLIES TO ALL OTHER INSURANCE COMPANIES.

GOOD FAITH ESTIMATE – FOR PATIENTS WHO PAY PRIVATELY, OUR PSYCHIATRIC FEE PER EVALUATION AND/OR CONSULTATION IS $495.00 FOR THE 1ST HOUR & $750 FOR 1.5 HOURS. THE TYPICAL FOLLOW-UP VISIT IS $268.00 BUT MAY RANGE AS HIGH AS $584.00. PSYCHOTHERAPISTS BILL AT A LOWER RATE. YOU MAY REQUEST A WRITTEN GOOD FAITH ESTIMATE FOR EXPECTED SERVICES.

I UNDERSTAND I WILL *NOT* RECEIVE A CONFIRMATION CALL FROM BRPG, PA REMINDING ME OF MY SCHEDULED VISIT. I UNDERSTAND THAT IF I FAIL TO KEEP A SCHEDULED APPOINTMENT OR CANCEL WITHOUT 1 FULL *BUSINESS* DAYS TO KEEP A SCHEDULED APPOINTMENT OR CANCEL WITHOUT 1 FULL BUSINESS DAY (24 HOURS) NOTICE, I WILL BE RESPONSIBLE FOR THE FULL NORMAL FEE OF BRPG.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES, WHETHER OR NOT PAID BY THE INSURANCE CARRIER. **I UNDERSTAND I WILL NOT RECEIVE A CONFIRMATION CALL REMINDING ME OF MY VISIT.** I UNDERSTAND THAT IF THE CHARGES FOR SERVICES RENDERED BY BOCA RATON PSYCHIATRIC GROUP, P.A. ARE NOT PAID WITHIN 60 DAYS OF THE DATES OF SERVICE, I AM OBLIGATED TO REIMBURSE BRPG THE FEES CHARGED BY ANY COLLECTION AGENCY, WHICH WILL BE ADDED TO THE ACCOUNT AT THE TIME ITS PLACED WITH THE AGENCY FOR COLLECTION: THIS MAY BE BASED ON A PERCENTAGE AT A MAXIMUM OF 30% OF THE DEBT PLUS ALL REASONABLE COSTS AND EXPENSES, INCLUDING REASONABLE ATTORNEY FEES INCURRED IN SUCH COLLECTION EFFORTS. FURTHERMORE, I UNDERSTAND I WILL BE CHARGED INTEREST ON A MONTHLY BASIS AT A RATE OF 18% ANNUALY, UNTIL SUCH DEBT IS PAID IN FULL.

WE DO NOT CHARGE FOR PHONE CALLS REGARDING A QUICK QUESTION OR SIMPLE ISSUE, BUT CALLS LASTING OVER 3-5 MINUTES MAY INCUR A CHARGE SIMILAR TO AN OFFICE VISIT CHARGE.

I HAVE INFORMED BOCA RATON PSYCHIATRIC GROUP, P.A. AND ITS AGENTS OF MY INSURANCE COVERAGE OR LACK THEREOF. I UNDERSTAND THAT IF MY INSURANCE STATUS CHANGES (INCLUDING MEDICARE), IT IS MY RESPONSIBILITY TO INFORM BOCA RATON PSYCHIATRIC GROUP, P.A. AND THERE WILL BE NO REFUND, NULLIFICATION, OR REIMBURSEMENT OF THE FULL, NORMAL FEE PAID OR OWED TO BOCA RATON PSYCHIATRIC GROUP, PA. FOR SERVICES PROVIDED UP TO THE DATE OF NOTIFICATION.
I AM AWARE THAT ALL PSYCHIATRIC MEDICATIONS HAVE SOME ABILITY TO IMPAIR COORDINATION OR ALERTNESS AND I NEED TO CONSIDER THIS BEFORE I DRIVE OR OPERATE MACHINERY, THIS IS ESPECIALLY TRUE WHEN STARTING A NEW MEDICATION OR INCREASING A DOSE.

MUST FILL AREAS BELOW

SIGNED: _____
(IF GUARDIAN OR LEGAL REPRESENTATIVE, ALSO PRINT NAME)

PATIENT'S NAME: _____
DATED: _____

NAME _____ BIRTHDATE_____AGE _____ TODAY'S DATE _____

REASON FOR VISIT TODAY? _____

MEDICAL HISTORY

ALLERGIES OR DRUG REACTIONS: _____

MEDICATIONS (PLEASE LIST ALL MEDICATIONS INCLUDING ALL PRESCRIPTION AND NON-PRESCRIPTION MEDICATIONS & SUPPLEMENTS TAKEN IN THE PAST 3 MONTHS):

NOW? _____

IN THE PAST THREE MONTHS? _____

HABITS:

	CURRENT USE	PAST USE
TOBACCO	_____	_____
ALCOHOL	_____	_____
"RECREATIONAL DRUGS"	_____	_____
CAFFEINE	_____	_____

ILLNESS: (PAST AND PRESENT)

CARDIAC? Y ____ N ____ THYROID? Y ____ N ____GLAUCOMA? Y ____ N ____
SEIZURES? Y ____ N ____ DIABETES? Y ____ N ____CHOLESTEROL PROBLEMS? Y____N_____
SURGERIES? _____
ACCIDENTS/HEAD INJURIES? _____
OTHER MEDICAL PROBLEMS? _____

FEMALES ONLY: ARE YOU PREGNANT? Y ____ N ____ PLANNING TO GET PREGNANT? Y ____ N _____

NUMBER OF PREGNANCIES _____ MISCARRIAGES _____ ABORTIONS _____

PSYCHIATRIC HISTORY

PREVIOUS PSYCHIATRISTS/THERAPISTS: WHEN? _____

MEDICATIONS PRESCRIBED IN THE PAST? _____

PSYCHIATRIC HOSPITALIZATIONS: WHEN? _____ WHY? _____

WHEN? _____ WHY? _____

FAMILY HISTORY

PSYCHIATRIC PROBLEMS (IN YOUR FAMILY): _____

SUICIDE ATTEMPTS IN YOUR FAMILY? _____

SEIZURES _____THYROID DISEASE _____

DRUG PROBLEMS? _____ ALCOHOL ABUSE PROBLEMS? _____

Please be aware all medicines may have the potential to cause problems in pregnancy or with the developing fetus.

NAME:_____

SYMPTOM CHECKLIST

(PLEASE X THOSE THAT APPLY)

☒

___Sadness/Depressed mood
___Appetite change
___Loss of energy
___Difficulty concentrating
___Loss of interest/pleasure in activities
___Guilt
___Worthlessness
___Hopelessness
___Work Issues
___Trouble falling asleep
___Waking during the night
___Early morning awakening (too early)
___Declining school grades or work performance
___Elevated mood
___Suicidal thoughts
___Passive thoughts
___Do you possess a gun: Yes / No / Choose not to answer
___Suicidal Intent
___Suicidal plan

___Anxiety
___Excessive worry
___Excessive Energy
___Hypersexuality
___Panic attacks
___Fears/Phobias
___Obsessions
___Compulsions
___Worry
___Rituals/things needed to be “just so”
___Flashbacks

___Thoughts of hurting others
___Decreased need for sleep
___Speeded up thoughts
___Grandiosity
___Excessive speech/Pressured speech
___Flight of Ideas
___Excessive activity
___Irritability

NAME:_____

(PLEASE X THOSE THAT APPLY)
☒
___Feeling others are against you
___Belief that thoughts are being controlled
___Hallucinations
___False Beliefs

___Overactivity
___Short attention spam
___Distractibility
___Impulsivity
___Lying
___Stealing
___Oppositional or defiant
___Temper problems

___Legal problems
___Aggression/Violence
___Misuse of prescription drugs
___Skipping school

___Fear of becoming fat
___Binge eating
___Vomiting or using laxatives to lose weight

___Problems with family relationships
___Problems with money
___Low Sex Drive
___Memory problems

NAME_____ DATE_____ HEIGHT_____WEIGHT_____

Checklist: Review of Systems (Please check boxes that apply)

Constitutional ☐ weight loss ☐ weight gain ☐ fatigue ☐ general weakness ☐ fever

Eye ☐ visual changes ☐ eye pain ☐ double vision ☐ blurry vision ☐ flashing lights

Ears, nose, throat ☐ runny nose ☐ stuffy nose ☐ frequent nose bleeds ☐ stuffy ears ☐ ear pain ☐ ringing in ears ☐ hearing loss

Cardiovascular ☐ chest pain ☐ exercise intolerance ☐ palpitations ☐ faintness, ☐ Lightheadedness upon standing

Respiratory ☐ cough ☐ sputum ☐ wheeze ☐ shortness of breath

Gastrointestinal ☐ abdominal pain ☐ difficulty swallowing ☐ nausea ☐ vomiting ☐ bloody stools ☐ black tarry stools ☐ heartburn ☐ yellow eyes or skin ☐ diarrhea ☐ constipation

Genitourinary Urinary: ☐ incontinence ☐ pain ☐ night urination ☐ hesitancy ☐ bloody
Female: ☐ menopause ☐ low sex drive ☐ vaginal-discharge ☐ heavy menses ☐ hot flashes ☐ trouble reaching orgasm
Male: ☐ low sex drive ☐ erectile dysfunction ☐ pain with sex ☐ trouble reaching orgasm

Musculoskeletal ☐ falls ☐ muscle pain ☐ stiffness ☐ joint swelling ☐ joint pain ☐ arthritis ☐ back pain

Skin/Breast ☐ itching ☐ rashes ☐ excessive dryness ☐ hair loss ☐ breast pain or discharge

Neurological ☐ limb weakness ☐ seizures ☐ fainting ☐ headache ☐ pins and needles ☐ numbness ☐ poor balance ☐ speech problems ☐ dizziness ☐ tremor

Endocrine ☐ sweaty ☐ excessive thirst ☐ excessive amounts of urine ☐ heat or cold intolerance, **Female**: ☐ irregular periods

Blood System ☐ anemia ☐ excessive bleeding ☐ easy bruising

Immunologic ☐ recurrent infections ☐ allergic reactions ☐ swelling of lymph nodes

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY | SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name. First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES | NO

a. INSURED'S DATE OF BIRTH MM DD YY | SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES | NO | PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES | NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | NO *If yes,* complete items 9, 9a and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to

A. _____ B. _____ C

E. _____ F. _____ G

I. _____ J. _____ K

PLEASE JUST SIGN HERE AND HERE

(TO VIEW A COPY OF THE INFORMATION ON THE BACK OF THE ORIGINAL VERSION OF THIS FORM, PLEASE SEE THE RECEPTIONIST.)

THANK YOU

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PI CPT/	H. PSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1							NPI
2							NPI
3							NPI
4							NPI
5							NPI
6							NPI

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES | NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH. # ( )

a. b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB 0938-1197 FORM 1500 (02-12)

WCMS-1500-2W-12

SECOND FOLD — FIRST FOLD WHCF-10-ENV / WHCF-10-ENV-SS

CARRIER — PATIENT AND INSURED INFORMATION

TEXT REMINDER

I request that Boca Raton Psychiatric Group (BRPG) send me appointment reminder texts to the following cell phone number:_____

I understand that the text will say the name of the clinician I am seeing as well as the office phone number. The text messages are informational only and cannot be responded to.

I understand that text messages are unable to be sent in an encrypted format.

I understand that this is just an added assistance and that if for some reason I do not get the text, I am still responsible for keeping the appointment and for informing BRPG of any changes in my phone number.

_____ _____

Signature Print

Date_____

HIPAA PRIVACY PRACTICES

PLEASE LET THE FRONT OFFICE KNOW IF YOU WOULD LIKE A COPY OF OUR HIPAA PRIVACY PRACTICES.

PLEASE PRINT AND SIGN YOUR NAME

I,_____ (print name) have been offered/read a copy of Boca Raton Psychiatric Group's Privacy Practices.

_____ _____

Signature Date

_____ _____

Witness Date

(Our Notice of Privacy Practices is subject to change. If you would like to check on an update in the future, please contact us.)

A NOTE TO OUR PATIENTS

We would like to take the opportunity to highlight some of our routine office practices so that we can avoid misunderstandings in the future.

1. **PRESCRIPTIONS:**

If you are on medication, we generally prescribe ample medication to last until your next appointment. If you return for appointments as recommended, you should not run out of medicine. Please remember that our office does not "call in"routine prescriptions to your pharmacy. There should be enough medication on the previous prescription until the next scheduled appointment. Please note: if your physician does feel it is appropriate to call in prescriptions, we can only do so during routine office hours. As we do not have access to our patients' charts outside office hours, we do not feel the best medical care can be provided under these circumstances. Anytime you need to have a refill on medication it is important to check if you are due for an appointment by calling our staff. You can check the status of any refills prior to the end of the working day. There will be a fee for any services extra to writing prescriptions, eg: faxing or mailing prescriptions, getting authorizations, etc.

2. **CANCELLING APPOINTMENTS:**

It is important that you call to cancel existing appointments at least a full business day in advance. A specific time is allotted for appointments. Without advance notice, we are unable to utilize this time for other patients who might need to see us. Therefore, you will be charged for the time that was held for your appointment. We would rather not charge you and would rather utilize the time for other patients. You would need to cancel a Monday appointment on the prior Friday morning in order for us to try to utilize that time.

3. EMERGENCIES:

Please call between appointments if any urgent clinical matters arise. If a clinical emergency or urgent situation arises outside routine office hours, you can reach us through our answering service. However, please utilize this only for true emergencies and not for routine matters. If we are unavailable due to vacation etc., there will always be a covering psychiatrist to assist you.

PATIENTS: PLEASE KEEP THIS PAPER FOR YOUR INFORMATION.

OVER

PROCEDURES FOR PATIENTS RECEIVING PRESCRIPTIONS FOR MEDICATIONS

1. Your Psychiatrist is placing you on medication(s) for purposes of assisting in the relief of your current symptoms. It is expected that you will share in the responsibility for your treatment by taking your medication(s) as directed. If you have symptoms, which you think may be medication side effects, you should contact your Psychiatrist.

2. It is important that you keep all your appointments with your Psychiatrist in order for him/her to monitor your progress and make any necessary changes or adjustments.

3. Medication renewal will occur during the medication follow-up sessions with the prescribing Psychiatrist. You have an obligation to present yourself in person for medication monitoring. Medications will not be prescribed over the telephone routinely.

4. You are strongly urged to keep your regularly scheduled appointment to avoid running out of your medication prescribed by your doctor. You are encouraged to monitor your supply closely and check with your pharmacy for refills when your supply is low.

5. If your are not able to keep your scheduled appointment with your Psychiatrist due to an emergency and you are about to run out of medication, please call your Psychiatrist as soon as possible. Please note that we do not respond to faxes for refills from pharmacies. We only respond to calls directly from patients.

6. Please be aware that all requests for medications due to your absence are subject to your doctor's discretion and **may not be granted without an office visit.** The amount of medication authorized upon a telephone request may only be equal to the number of days until the rescheduled face-to-face monitoring session.

7. **Do not wait until you are out of medication to call the office.** Please allow two (2) business days for your doctor to contact the pharmacy. The office staff cannot guarantee that your doctor will be able to reach the pharmacy to order medication the same day you call.

8. If a second monitoring session is missed, no medication authorization shall occur until you attend an in person medication monitoring appointment with your Psychiatrist.

OVER

Notifier: Boca Raton Psychiatric Group, P.A. 7100 W Camino Real, Ste. 401, Boca Raton, FL 33433

Telephone: 561 368- 8998 561-392-9170

Patient Name: **Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for Service below, you may have to pay.
Medicare does not pay for everything; even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **Service** below.

Item or Service:	Reason Medicare May Not Pay:	Estimated Cost
99205 Evaluation & Management Official New Patient Consult	Because Medicare May Determine That This Procedure Is Not Medically Necessary Or Documentation Does Not Meet Criteria For Billing Code.	

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **Service** listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **Service** listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **Service** listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

☐ **OPTION 3.** I don't want the **Service** listed above. I understand with this choice I am not responsible for payment, and **I cannot appeal to see if Medicare would pay.**

Additional Information: **Additional Valid Date: Please Choose One Option:**

Option 1._____ Option 2._____ Option 3._____ Date:_____ Initials_____

Option 1._____ Option 2._____ Option 3._____ Date:_____ Initials_____

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call 1-800-MEDICARE (1-800-633-4227/TTY: 1-877-486-2048).
Signing below means that you have received and understand this notice. You also receive a copy.

Patient Signature or Representative:	Date:

BOCA RATON PSYCHIATRIC GROUP, P.A.
7100 W. CAMINO REAL STE 401, BOCA RATON, FL 33433
OFFICE (561) 368-8998 FAX (561) 392-9170

EXCHANGE / RELEASE OF INFORMATION

PATIENT NAME_____
D.O.B._____

I AUTHORIZE THE RELEASE OF INFORMATION

____ **FROM** BOCA RATON PSYCHIATRIC GROUP TO THE ENTITY LISTED BELOW (RELEASE OF INFORMATION)

____ **TO** BOCA RATON PSYCHIATRIC GROUP FROM THE ENTITY LISTED BELOW (REQUEST OF INFORMATION)

NAME: _____

ADDRESS: _____

_____

PHONE: _____ FAX: _____

I UNDERSTAND THAT THIS AUTHORIZATION RELEASES MY GENERAL, MEDICAL, INFORMATION AS WELL AS INFORMATION CONCERNING MY PSYCHIATRIC TREATMENT. I ALSO UNDERSTAND THAT IF MY MEDICAL INFORMATION CONTAINS TREATMENT NOTES, PSYCHOTHERAPY NOTES, DIAGNOSIS AND/OR TEST RESULTS OF **ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS),** *HIV* AND/OR RELATED CONDITIONS, AND/OR SUBSTANCE ABUSE, THESE MEDICAL RECORDS SHALL ALSO BE RELEASED, AND THAT RELEASE MAY INCLUDE TRANSMISSION VIA FAX.

I ALSO UNDERSTAND THAT I HAVE THE RIGHT TO REVOKE MY CONSENT AT ANY TIME BY DELIVERY OF WRITTEN NOTICE TO THE PROVIDER RELEASING THE INFORMATION. CANCELLATION WILL BE EFFECTIVE UPON THE DATE THE NOTICE IS RECEIVED BY PROVIDER BUT WILL EXCLUDE INFORMATION ALREADY FURNISHED TO THE RECIPIENT BEFORE THE DATE. IN THE ABSENCE OF MY WRITTEN NOTICE, THIS CONSENT SHALL BE REVOKED AUTOMATICALLY ONE YEAR AFTER THE DATE OF CONSENT AS IT APPEARS BELOW.

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE DATE

RELATIONSHIP TO PATIENT (IF LEGAL REPRESENTATIVE) DATE

SIGNATURE OF WITNESS DATE

TO RECIPIENT OF INFORMATION: THIS INFORMATION IS DISCLOSED TO YOU FROM RECORDS WHOSE CONFIDENTIALITY IS PROTECTED BY FEDERAL LAW. FEDERAL REGULATIONS, CRF PART 2 AND FLORIDA STATUTES PROHIBIT YOU FROM MAKING ANY FURTHER DISCLOSURE OF IT WITHOUT THE SPECIFIC WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS, OR AS OTHERWISE PERMITTED BY SUCH REGULATIONS. BOCA RATON PSYCHIATRIC GROUP IS NOT LIABLE FOR FURTHER DISCLOSURE.

MAIL RECORDS_____
DATE / INITIALS

FILE IN CHART ONLY_____
DATE / INITIALS

FAX RECORDS_____
DATE / INITIALS

FAX OR MAIL REQUEST_____
DATE / INITIALS