

Authorization to Release Information, Pay Benefits to MSPB, 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I agree that this authorization shall be valid until rescinded in writing or replaced by one of a later date.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.

PRINT PATIENT’S FULL NAME

PATIENT’S SIGNATURE

DATE

WITNESS SIGNATURE