## BOCA RATON PSYCHIATRIC GROUP, P.A.

[] Dr. [] Mr. [] Mr	s. [] Miss	[] Ms. [] Male	[] Female [] Other	
AGE				
MARITAL STATUS: []S	SINGLE []MA	RRIED []WIDOWE	D [] DIVORCED[]SEPARATED	
PATIENT'S LAST NAM	1E	FIRST	MIDDLE	
STREET ADDRESS			APT	
CITY	STATE	ZIP	REFERRED BY	
EMPLOYER		EMPLOYE	R ADDRESS	
HOME PHONE #		CELL#	EMAIL	
DATE OF BIRTH	DR	IVER LICENSE#_		
PHARMACY NAME/A	DDRESS			
PHARMACY PHONE #				
SECONDARY ADDRES	SS:			
			PHONE	
FINANCIAL RESPO	NSIBILITY			
GUARANTOR'S LAST	NAME	FIRS	T M	
ADDRESS		CITY	STATE ZIP _	
DOB	SS#		_ DRIVER LIC #	
EMPLOYER		P	HONE	
IS THIS CASE RELATE DOES A LAWYER REF			S []NO	
INSURANCE INFORM NAME OF INSURANCE PLEASE INCLUDE A	E COMPANY		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

MUST FILL AREAS BELOW

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.

THERE IS AN ADMINISTRATIVE FEE FOR PAYMENTS MADE BY METHODS OTHER THAN CASH OR CHECK. CHARGES LESS THAN \$100.00 = \$3.00. CHARGES \$100.00 OR MORE = \$6.00.

GOOD FAITH ESTIMATE – FOR PATIENTS WHO PAY PRIVATELY, OUR PSYCHIATRIC FEE PER EVALUATION AND/OR CONSULTATION IS \$495.00 FOR THE  $1^{\rm ST}$  HOUR & \$750 FOR 1.5 HOURS. THE TYPICAL FOLLOW-UP VISIT IS \$277 BUT MAY RANGE AS HIGH AS 602.00. 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, P.A. 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.

# 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 REAC	ΓΙΟΝS:		
MEDICATIONS (PLEASE LIST PRESCRIPTION MEDICATION			
NOW?			
IN THE PAST THREE MONTH	S?		
DOU YOU CONSUME GRAPE	FRUIT/GRAPEFRUIT JUICE	E Y/ N	(INTEREACTS WITH MEDS)
HABITS:			
TOBACCO	CURRENT US		PAST USE
ALCOHOL			
"RECREATIONAL DRUGS"			
CAFFEINE	<u></u>		
ILLNESS: (PAST AND PRESI	ENT)		
SURGERIES?ACCIDENTS/HEAD INJURIES	?		Y N DL PROBLEMS? YN
<b>FEMALES ONLY:</b> ARE YOU	PREGNANT? Y N	PLANNING	TO GET PREGNANT? Y N
NUMBER OF PREGNANCIES	MISCARR	IAGES	ABORTIONS
PSYCHIATRIC HISTORY			
PREVIOUS PSYCHIATRISTS/	ΓHERAPISTS: WHEN?		
MEDICATIONS PRESCRIBED	IN THE PAST?		
PSYCHIATRIC HOSPITALIZA	TIONS: WHEN?	WHY?	
FAMILY HISTORY	WHEN?	WHY?	
PSYCHIATRIC PROBLEMS (IN Y	OUR FAMILY):		
SUICIDE ATTEMPTS IN YOUR F	AMILY?		
SEIZURES	THYRO	OID DISEASE	
DDUG DDODI EMS9	Λ.	I COUOL APLIC	E DDODI EMS?

NAME:
CURRENT SYMPTOM CHECKLIST
(PLEASE X THOSE THAT APPLY CURRENTLY)
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
Anvioty
Anxiety
Excessive Energy
Excessive Energy
Hypersexuality Panic attacks
Fears/Phobias
Obsessions
Compulsions
Worry
Rituals/things needed to be "just so"
Flashbacks
I Id3IIDdCR3
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 CURRENTLY) ⊠
Feeling others are against youBelief that thoughts are being controlledHallucinationsFalse Beliefs
<ul> <li>Overactivity</li> <li>Short attention spam</li> <li>Distractibility</li> <li>Impulsivity</li> <li>Lying</li> <li>Stealing</li> <li>Oppositional or defiant</li> <li>Temper problems</li> </ul>
Legal problemsAggression/ViolenceMisuse of prescription drugsSkipping school
Fear of becoming fatBinge eatingVomiting or using laxatives to lose weight
Problems with family relationshipsProblems with moneyLow Sex DriveMemory problems

NAME	DATE	HEIGHT	WEIGHT	

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

Constitutional	weight loss weight gain fatigue general weakness fever
Еуе	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, <b>Female</b> : irregular periods
Blood System	anemia excessive bleeding easy bruising
Immunologic	recurrent infections allergic reactions swelling of lymph nodes



### HEALTH INSURANCE CLAIM FORM

ALTH INSURANCE CLAIM FORM	· ·			
PROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12		3		PICA T
PICA	OTUCD	1a. INSURED'S I.D. NUMBER	(For Program in	Item 1)
MEDICARE MEDICAID TRICARE CHAMPY	HEALTH PLAN BLK LUNG	Ta. INSURED S T.D. NOMBER		
(Medicare #) (Medicaid #) (ID#/DoD#) (Member I	3. PATIENT'S BIRTH DATE SEX	4. INSURED'S NAME (Last Nar	ne, First Name, Middle Initial)	
PATIENT'S NAME (Last Name, First Name, Middle Initial)	MM   DD   YY M F			
PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No.,	Street)	
	Self Spouse Child Other	CITY	S	TATE
STATE	8. RESERVED FOR NUCC USE	Citi		
CODE TELEPHONE (Include Area Code)	4	ZIP CODE	TELEPHONE (Include Area Co	de)
CODE TELEPHONE (Include Area Code)			( )	
OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROU	JP OR FECA NUMBER	
4 7 7		a. INSURED'S DATE OF BIRTH	H SEX	
OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous)	MM   DD   YY	м F	
SECTION FOR SHIPP LIPE	b. AUTO ACCIDENT? PLACE (State)	b. OTHER CLAIM ID (Designate	ed by NUCC)	
RESERVED FOR NUCC USE	YES NO L	1		
RESERVED FOR NUCC USE	c. OTHER ACCIDENT?	c. INSURANCE PLAN NAME C	PROGRAM NAME	
	YES NO	d. IS THERE ANOTHER HEAL	TH BENEFIT PLAN?	
INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	YES NO	If yes, complete items 9, 9a and	9d.
READ BACK OF FORM BEFORE COMPLETIN	NG & SIGNING THIS FORM.	13. INSURED'S OR AUTHORIZ	ED PERSON'S SIGNATURE I aut to the undersigned physician or s	horize
<ol> <li>PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the to process this claim. I also request payment of government benefits eit</li> </ol>		services described below.	, to the shipping and	
below.				
SIGNED	DATE	SIGNED	TO WORK IN CURRENT OCCUP	ATION
		127 WILLIAM LINES	THE WORK IN CORNER TO COOCH	ALION VV
4. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP)			TO MM   DD	1.1
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#### **TEXT REMINDER**

I request that Boca Raton Psychiatric Group (I reminder texts to the following cell phone number:	BRPG) send me appointment			
I understand that the text will say the name of the office phone number. The text messages 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 assistant not get the text, I am still responsible for informing BRPG of any changes in my phone	keeping the appointment and for			
Signature Pr	int			
Date				
HIPAA PRIVACY P	RACTICES			
PLEASE LET THE FRONT OFFICE KNOW I OUR HIPAA PRIVACY PRACTICES.	F YOU WOULD LIKE A COPY OF			
PLEASE PRINT AND SIGN	N YOUR NAME			
I,been offered/read a copy of Boca Raton Psycl	(print name) have hiatric 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. Our policy is to provide written prescriptions. 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 for 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.

#### 4. PHONE CALLS FROM OUR OFFICE:

Please pay attention to incoming calls and voicemails from our office because they usually contain important information about your health and/or appointments.

## PATIENTS: PLEASE KEEP THIS PAPER FOR YOUR INFORMATION.

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

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 <u>Service</u> 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 <u>Service</u> listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if <u>Medicare</u> would pay.
Additional Information: Additional Valid Date: Please Choose One Option:
Option 1Option 2Option 3Date:Initials
Option 1Option 2Option 3Date:Initials
his notice gives our opinion, not an official Medicare decision. If you have other questions of
nis notice or Medicare billing, call 1-800-MEDICARE (1-800-633-4227/TTY: 1-877-486-2048).
igning below means that you have received and understand this notice. You also receive a copy.
Patient Signature or Representative: Date:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection: If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn. PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850. Form CMS-R-131 (03/11)

Form Approved OMB No. 0938-0566

## 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 IN	VFORMATION
FROM BOCA RATON PSYCHIATRIC GR	OUP TO THE ENTITY LISTED BELOW (RELEASE OF INFORMATION)
TO BOCA RATON PSYCHIATRIC GROU	P FROM THE ENTITY LISTED BELOW (REQUEST OF INFORMATION)
NAME:	
ADDRESS:	
PHONE:	FAX:
INFORMATION CONCERNING MY PSYCHI INFORMATION CONTAINS TREATMENT NO ACQUIRED IMMUNE DEFICIENCY SYNDR	ION RELEASES MY GENERAL, MEDICAL, INFORMATION AS WELL AS ATRIC TREATMENT. I ALSO UNDERSTAND THAT IF MY MEDICAL OTES, PSYCHOTHERAPY NOTES, DIAGNOSIS AND/OR TEST RESULTS OF COME (AIDS), HIV AND/OR RELATED CONDITIONS, AND/OR SUBSTANCE FALL ALSO BE RELEASED, AND THAT RELEASE MAY INCLUDE
DELIVERY OF WRITTEN NOTICE TO THE EFFECTIVE UPON THE DATE THE NOTIC ALREADY FURNISHED TO THE RECIPIENT	E THE RIGHT TO REVOKE MY CONSENT AT ANY TIME BY PROVIDER RELEASING THE INFORMATION. CANCELLATION WILL BE IS RECEIVED BY PROVIDER BUT WILL EXCLUDE INFORMATION BEFORE THE DATE. IN THE ABSENCE OF MY WRITTEN NOTICE, THIS FICALLY ONE YEAR AFTER THE DATE OF CONSENT AS IT APPEARS
SIGNATURE OF PATIENT OR LEGAL REPRES	SENTATIVE DATE
RELATIONSHIP TO PATIENT (IF LEGAL REP.	RESENTATIVE) DATE
SIGNATURE OF WITNESS	DATE
WHOSE CONFIDENTIALITY IS PROTECT AND FLORIDA STATUTES PROHIBIT WITHOUT THE SPECIFIC WRITTEN OF	THIS INFORMATION IS DISCLOSED TO YOU FROM RECORDS TED BY FEDERAL LAW. FEDERAL REGULATIONS, CRF PART 2 YOU FROM MAKING ANY FURTHER DISCLOSURE OF IT CONSENT OF THE PERSON TO WHOM IT PERTAINS, OR AS REGULATIONS. BOCA RATON PSYCHIATRIC GROUP IS NOT
MAIL RECORDS DATE / INITIALS	FILE IN CHART ONLY DATE / INITIALS
FAX RECORDSDATE / INITIALS	FAX OR MAIL REQUEST DATE / INITIALS