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.

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 1ST 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, 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: _____

CHILDREN'S HISTORY FORM

NAME:_____
Last First Middle Initial
DOB:_____/_____/_____ AGE:_____ DATE SEEN:_____

INFORMANT:_____ Relationship To Child:_____
Who has legal guardianship of this child?_____
Do all legal guardians request this evaluation?_____
WHAT MADE YOU SEEK HELP AT THIS TIME?_____
_____

PROVIDE BRIEF DESCRIPTION OF MAJOR PROBLEMATIC BEHAVIOR
(including duration and how you have handled it)_____
_____
_____
_____
_____
_____

HAS THE PATIENT HAD ANY PREVIOUS PSYCHIATRIC/PSYCHOLOGICAL EVALUATIONS /TREATMENTS? (PLEASE ELABORATE)
Date **Treating Professional** **Reason** **Outcome/Medication:**
_____
_____
_____

SIGNS AND SYMPTOMS Has your child had any of the following**?**
(Please explain items checked in space provide)
Eating problems (poor appetite/picky eater/overeats)_____
Sleeping problems(insomnia, nightmares, sleepwalking, night terrors)_____
Sadness_____ Irritability _____ Temper Tantrums _____
Headaches _____ Stomachaches_____
Other physical complaints not readily explained_____
Hyperactivity _____ Poor Concentration _____ Drugs/Alcohol Abuse_____
Lying_____ Stealing_____ Setting Fires_____ Tics/Unusual Movements_____
Suicidal Thoughts_____ Anxiety/ Fears _____ What? _____
Other Repetitive Behaviors (rituals, mannerism, habits), or Problems/ Concern:
_____
ANY OTHER AREAS OF CONCERNS:_____
_____
_____

ABUSE/ TRAUMA: Has child ever been physically/sexually abused? YES☐ No ☐
GIVE DETAILS:_____
_____
_____
_____

PATIENT'S BIOLOGICAL FAMILY MEDICAL AND PSYCHIATRIC HISTORY: (Fill in details of diagnosis, how related, etc.)

	Maternal Relatives	Paternal Relatives
Alcoholism	_____	_____
Drug Abuse	_____	_____
Mental Illness (type)	_____	_____
Psychiatric Hospitalizations	_____	_____
Mental Retardation	_____	_____
Learning Disabilities	_____	_____
Hyperactivity	_____	_____
Suicide Attempt	_____	_____
Other Medical Illnesses (specify)	_____	_____

PATIENT'S MEDICAL HISTORY (PROBLEMS WHILE MOTHER WAS PREGNANT WITH PATIENT):
Illnesses/Complications:_____
Medications taken:_____
Tobacco/Alcohol/Other Drugs (prescription or otherwise):_____
Length of Gestation (months):_____
Delivery (type: e.g., head first, breech): _____
Birth Weight:_____ Apgar rating:_____
Problems during delivery/shortly thereafter: _____
Medications/Anesthesia during delivery: _____
Length of stay in hospital:_____

CURRENT MEDICATIONS AND DOSES:
_____
_____
_____

SERIOUS INJURIES/ ILLNESSES/ SURGERY IN PAST (high fever, seizures, head injury, etc.)_____
_____

Allergies
(specify):_____

CURRENT PHYSICIANS (name, address, date of most recent physical exam/lab work):_____

DEVELOPMENTAL MILESTONES (in months):
First Word_____ Sat alone_____ Walked _____ Talked in sentences_____
Weaned _____ Fed Self_____ Tied own shoes_____
Toilet training (ease or difficulty: any wetting or soiling afterward)_____

FAMILY HISTORY: Child lives with: mother_____
father_____ adoptive parents_____ other (specify)_____

	NAME	AGE	EDUCATION	OCCUPATION
MOTHER:				
FATHER:				
SIBLINGS:				
STEPPARENT:				

MARITAL HISTORY:

	MOTHER	FATHER
Number of Marriages		
Children from previous marriages		
Date of most recent marriages		
Date(s) of separation(s)		

If divorced:
How Long:_____
Custody arrangement:_____
Visitation schedule:_____
Child's adjustment to divorce:_____

Current School_____
Phone:_____ **Teacher:**_____
Special Classes/ SLD/Tract:_____ **Grade:**_____

Signature of person completing form **Date**

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

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. 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.

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

BOCA RATON PSYCHIATRIC GROUP, P.A.

I, _____, am the legal guardian of

_____ and give consent to the **Boca Raton**

Psychiatric Group to evaluate and treat _____.

I also give_____, permission to make decisions

regarding treatment in my behalf.

X _____Date _____

BOCA RATON PSYCHIATRIC GROUP

MINOR CHILD CONSENT FOR PSYCHIATRIC TREATMENT

In connection with the medical services I/we am/are receiving from BOCA RATION PSYCHIATRIC GROUP and its medical staff, I/we, in accordance with Florida Statute 1014.06, hereby consent to BOCA RATION PSYCHIATRIC GROUP, Roger Z. Samuel, M.D., and their respective agents to provide or arrange to provide health care services (including psychotherapy) or prescribe medicinal drugs to the below-named minor child.

Name of patient/child:
DOB of patient/child:
Name of legal guardian:
Signature of Legal Guardian:
Relationship to patient/child:
Witness:
Date Signed:

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