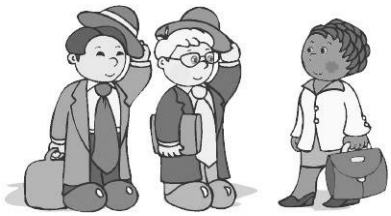


Silver Lake Pediatrics, P.A.
33017 Professional Drive
Leesburg, FL 34788
(P) 352-314-2275
(F) 352-314-2279

Date of Birth_____**HOW DID YOU HEAR ABOUT OUR OFFICE?**_____

Last Name:_____ First Name_____M or F_____SS#_____

Siblings (First Name, DOB, M/F, SS#)_____

Siblings (First Name, DOB, M/F, SS#)_____

Home Phone:_____Work Phone:_____Cell_____Email_____

Address:_____City:_____State:_____ Zip:_____

Father's Name_____SS#_____DOB:_____Occupation_____

Mother's Name_____SS#_____DOB:_____Occupation_____

Pharmacy/Location_____ Pharmacy's Phone#_____

Primary Insurance:_____ HMO / PPO/ Standard
Circle One

Primary Insured's Name:_____ Relation to Patient:_____

Member's Social Security#:_____ Member's D.O.B._____

Insurance ID#:_____ Group #:_____

Mailing Address:_____City:_____State:_____Zip:_____

Employer:_____ Work Phone/ext:_____

I hereby give authorization to Silver Lake Pediatrics, P.A., to provide medical care for the above-mentioned patient.

Insurance Assignment & Release Form: I hereby assign to Silver Lake Pediatrics, P.A. any insurance or other third-party benefits available for health care services provided to me. I understand that Silver Lake Pediatrics has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to Silver Lake Pediatrics, I agree to forward to the practice all health insurance or other third-party payments that I receive for services rendered to me immediately upon receipt I recognize that I am financially responsible for all services rendered to the above-name patient regardless of insurance coverage. By signing this form, I agree to assign all health insurance benefits to Silver Lake Pediatrics and to be financially responsible for any co-payments, deductibles and non-covered fees.

Office Policy: I realize all fees are due at the time services are rendered. I know that there is a $25 charge on all returned checks and a $25 charge for confirmed sick appointments and a $50.00 charge for physicals, consultations or extended visits cancelled without 24 hours prior notice or failure to show up for a scheduled appointment. **I understand Silver Lake Pediatrics, P.A. will file claims to the insurance company as a courtesy, and that I am responsible for any services the insurance company does not cover. Additional charges may apply for same day emergent visits.**

Acknowledgement of Receipt of Privacy Notice: I have been presented with a copy of Silver Lake Pediatrics, P.A. **NOTICE OF PRIVACY POLICIES,** detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restrictions(s) if any concerning the use of my personal medical information:

_____

Signature:_____**Print Name:**_____ Date:_____
(Parent, Guardian or Legal Representative of Patient) CIRCLE ONE PLEASE

Witness:_____ Date:_____

Initials _____ Date ___/___/____

Name:_____ **DOB:**_____/_____/_____

PAST MEDICAL HISTORY(PATIENT ONLY)

***Any chronic, ongoing or recurrent medical conditions (i.e. ADHD, Behavioral Problems, Cerebral Palsy, Down Syndrome, Diabetes, etc.)** _____

_____

- Full Term Pregnancy **NO YES IF NO HOW MANY WEEKS** _____
- Jaundice at Birth **NO/YES IF YES TREATMENT**_____
- Vision Problems: N/A NO YES - If YES, please explain: _____
- Natural Chickenpox: N/A NO YES - If YES, please give the Date: _____
- GER or Gastro Problems: N/A NO YES - - If YES, please explain: _____
- Surgeries: N/A NO YES - If YES, please explain: _____
- Hospitalizations: N/A NO YES - If YES, please explain: _____
- Problems with Ears or Hearing: N/A NO YES - If YES, please explain: _____
- Asthma, Bronchitis, Bronchiolitis, or Pneumonia: N/A NO YES - If YES, please explain: _____
- Heart Problems or Heart Murmur: N/A NO YES - If YES, please explain: _____
- Blood Transfusions: N/A NO YES - If YES, please explain: _____
- Constipation requiring Doctor Visits: N/A NO YES - If YES, please explain: _____
- Thyroid or Endocrine Problems: N/A NO YES - If YES, please explain: _____
- Use of Alcohol or Drugs: N/A NO YES - If YES, please explain: _____
- If Female have Menstrual Periods Started?: N/A NO YES - If YES, please give the Date: _____
- Any Problems with menstrual cycle? N/A NO YES - If YES, please explain: _____
- Chronic or Recurrent Skin Problems (Acne, Eczema, Etc.): N/A NO YES - If YES, please explain: _____
- Convulsions or Other Neurological Problems: N/A NO YES - If YES, please explain: _____
- Ringworm or Fungal Infections: N/A NO YES - If YES, please explain: _____
- Sore throats/Recurrent Strep: N/A NO YES - If YES, please explain: _____
- Serious Injuries or Accidents: N/A NO YES - If YES, please explain: _____
- Frequent Ear Infections: N/A NO YES - If YES, please explain: _____
- Frequent Headaches: N/A NO YES - If YES, please explain: _____
- Diabetes: N/A NO YES - If YES, please explain: _____
- Anemia or Bleeding Problems: N/A NO YES - If YES, please explain: _____
- Frequent Abdominal Pain: N/A NO YES - If YES, please explain: _____
- Bladder or Kidney Infections: N/A NO YES - If YES, please explain: _____
- Bed Wetting: (After age 5): N/A NO YES - If YES, please explain: _____

Nurse: Initials _____ Date ___/___/____

>>>>>>>> **PLEASE COMPLETE REVERSE SIDE** >>>>>>>>>

SOCIAL HISTORY

*Lives with both parents: NO YES

If NO, then has visitation with other parent: NO YES
If NO, then who has custody of child:_____

*Parents Age (DAD): _____ Height: _____ Education Level: _____ Occupation: _____
*Parents Age (MOM): _____ Height: _____ Education Level: _____ Occupation: _____

*Siblings: NO YES
If YES, then how many_____

*Pets: NO YES
If YES, then what kind, how many, & inside or outside_____

*Frequent travel outside the United States: NO YES *Missionary Work: NO YES

*Does child live on a farm: NO YES

*Does the child participate in hunting activities: NO YES

*Smokers in the home: NO YES

FAMILY HISTORY

ONLY AS FAR BACK AS PATIENT'S GRANDPARENTS.
M=Mother, F=Father, S=Siblings, MGM=Maternal (Mother's) Grandmother, MGF=Maternal (Mother's) Grandfather, PGM=Paternal (Father's) Grandmother, PGF=Paternal (Father's) Grandfather, A=Aunt, U=Uncle, C=Cousin

*Deafness or Hearing Impaired :_____ *Kidney Disease: _____

*Nasal Allergies or Hay Fever: _____ * Bed Wetting (after age 10): _____

*Drug Allergies: _____ *Epilepsy or Convulsions: _____

*Asthma/Chronic Bronchitis/COPD: _____ *Mental Illness/Retardation: _____

*Tuberculosis: _____ *Immune Problems, HIV, AIDS: _____

*Heart Disease: _____ *Cancer (What Kind): _____

*High Blood Pressure :_____ *Sudden Death <30 yars old: _____

*High Cholesterol :_____ *Blindness/Vision Problems: _____

*Anemia: _____ *Autism: _____

*Bleeding Disorders:_____ * Liver Disease: _____

*Alcohol Abuse:_____ *Drug Abuse: _____

*Endocrine: Diabetes, Thyroid, Pancreas, Parathyroid, others(please specify) :_____

*Gastrointestinal Problems: _____
Lactose, galactose, fructose, celiac disease (gluten): _____

ALLERGIES (PATIENT ONLY)

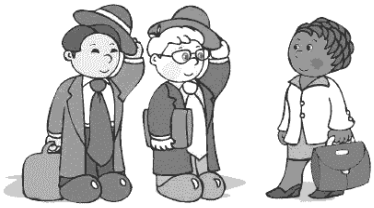
*Medication Allergies:_____

*Food Allergies :_____

*Insect Allergies (Bees, Wasps, Ants):_____

*Indoor/Outdoor Allergies: _____

If allergies what type of a reaction (Hives, facial swelling, etc..)_____



Silver Lake Pediatrics

33017 Professional Drive, Leesburg, FL
Phone: (352)314-2275 Fax: (352) 314-2279

1801 Salk Avenue, Tavares, FL 32778
Phone: (352) 742-2585 Fax: (352) 742-0724

Request for Protected Health Information/Medical Records

This is an authorization to:
Release clinical/medical information to another healthcare provider/facility for treatment purposes.

Patient Name: _____ DOB: ____/____/____
Address: _____
Phone: (____)_____-_____ Insurance:_____ ID #: _____

I _____, hereby authorize information to be released from:
(Please print name)
Practice Name: _____
Address: _____
Phone: (_____) _____-_____ Fax: (_____) _____-_____

FAXED
/ /

Send information to: (select office location)

33017 Professional Drive
Leesburg, FL 34788 Fax : (352) 314-2279_____

1801 Salk Avenue
Tavares, FL 32778 Fax: (352) 742-0724_____

The type of information to be released is as follows: (check the appropriate boxes)

- ☐ Physical Exams
- ☐ Progress Notes
- ☐ Immunization Record
- ☐ Newborn screening
- ☐ Labs
- ☐ Diagnostic Testing
- ☐ Other:_____

Purpose of release:

- ☐ My personal Records
- ☐ Use by another health care provider
- ☐ Other: _____

This authorization for the release of medical records and information including diagnosis, treatment and/or examination related to mental health (psychiatry or psychology), drug and/or alcohol abuse, HIV testing/AIDS, and sexually transmitted disease.

As required by state and federal law, your healthcare provider may not use or disclose your health information except as provided by its Notice of Privacy Practices without your authorization. Your signature on this form indicates that you are giving permission for the uses and disclosures of the protected described on this form.

I understand that state law prohibits the re-disclosure of the information disclosed to the persons/entities listed on this form without my further authorization, but that my healthcare provider cannot guarantee that the recipient of the information will not re-disclose this information contrary to such prohibition.

I understand that this authorization will remain in effect for one year or until I revoke it in writing. I understand that I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing to the healthcare provider releasing the information. I further understand that any such revocation does not apply to information already released in response to this authorization.

I understand that I am under no obligation to sign this authorization. I further understand that my ability to obtain treatment will not depend, in any way, on whether I sign this authorization. I understand that I have the right to inspect and to obtain a copy of any information disclosed.

I hereby release Silver Lake Pediatrics, P.A., and its employees from any/all liability that may arise from the release of information as I have directed.

I hereby authorize Silver Lake Pediatrics, P.A. to obtain the medical records described above.

_____ _____
Parent / Guardian / Patient (once 18 yrs of age) Signature Date

Relationship to Patient: _____

Initials _____
Date ___/___/____
Hx attached _____

Silver Lakes Pediatrics, P.A.

Rafael A. Cheas, M.D., F.A.A.P.

FINANCIAL POLICY

Thank you for choosing our practice! We are committed to the success of your medical treatment and care (in our office or via telemedicine. As part of this commitment, we provide several services as a courtesy to you, the patient, as outlined below:

If you have:	**You are responsible for:**	**Our staff will, as a courtesy to you:**
An HMO with which we are contracted	Payment of co- pays and deductibles at the time of service.	File an insurance claim on your behalf.
An HMO with which we are not contracted	**Payment in full is due at the time of service.**	
Point of Service (POS), PPO Plan, or Indemnity (commercial plans) with which we are contracted	Payment of the patient responsibility is due at the time of service.	File an insurance claim on your behalf.
Commercial Plans, PPO Plans, POS plans or any other type of plan with which we are **not** contracted such as:	Payment of the patient responsibility is due at the time of service based on out of network benefits. Many insurance companies base their payment on "usual and customary charges." The patient is responsible for any amount above "usual and customary."	File an insurance claim on your behalf.
Medicaid	No payment is due.	File an insurance claim on your behalf.
No Insurance	**Payment in full is due at the time of service.**	

As a courtesy, we will attempt to call your insurance company ahead of time to determine eligibility, deductibles, coinsurance, and obtain approval. This does not guarantee reimbursement. As the parent/guardian, you remain fully responsible for the entire amount of the bill.

Divorce

In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

I have read, understand, and agree to the above Financial Policy. I understand that charges not covered by my insurance company, as well as applicable copayments and deductibles, are my responsibility. I understand that failure to pay my account may result in my account being forwarded to a collection agency as well as restrictions to scheduling appointments.

I authorize my insurance benefits to be paid directly the provider. I also authorize the provider to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim.

_____

PATIENT NAME

_____ _____ _____

PARENT/GUARDIAN SIGNATURE PRINTED NAME DATE

ARBITRATION AGREEMENT RELATED TO MEDICAL CARE, TREATMENT & ALL DISPUTES

The patient and undersigned Medical Care Provider ("MCP") – which includes any affiliated physicians, employees, any related medical group, professional association, or any other entity or individual which has provided medical services in conjunction with the MCP – agree to submit any dispute whatsoever to binding arbitration including without limitation any claim for malpractice, personal injury, battery, breach of express or implied contract, loss of consortium, wrongful death or any payment or any other disputes relating in any way to past, present or future medical care. Any dispute will go to binding arbitration.

BY SIGNING THIS CONTRACT, YOU AGREE TO HAVE ANY ISSUE OF ALLEGED MEDICAL NEGLIGENCE OR BREACH OF CONTRACT BETWEEN YOU AND YOUR MCP DECIDED BY BINDING ARBITRATION IN WHICH BOTH PARTIES GIVE UP THEIR RIGHT TO A TRIAL BY JURY, OR TRIAL BY A JUDGE.

The patient, and/or his or her spouse, born or unborn children, parents, heirs, or anyone launching any legal or equitable action (hereinafter "the Patient") and the MCP agree that any complaint of any type which in any way relates to medical services shall without exception be submitted to binding arbitration. The governing law shall be the Federal Arbitration Act, state law notwithstanding. It is the express intention of the parties that any and all claims or complaints of any kind shall be submitted to and resolved by binding arbitration, which will be the exclusive and sole remedy. It is the specific and irrevocable intention of the parties to submit any question concerning this Agreement's arbitrability to the arbitrators only and to no other person or entity. All issues regarding the validity, enforceability and scope of this Agreement or any part of it shall also be subject to arbitration. If either party challenges the validity of this Agreement in court, the prevailing party shall be entitled to attorneys' fees and to costs as determined by the court.

The MCP and any affiliated medical service provider that chooses to join in this Agreement agree to be equally bound as the Patient is to binding arbitration in the event of any dispute. Such disputes can be brought by the MCP against the Patient, including terms of payment, services rendered, physical or emotional abuse, and other disputes. The Patient understands that any and all medical care provided is sufficient consideration, and the Patient will be fully and legally bound by this Agreement. Both parties to this Agreement are giving up their constitutional right to have any dispute decided in a court of law before a jury. All parties understand that they are giving up the right to have any dispute decided by a judge or jury through the court system. Resort to the legal system by action at law or in equity will only be permissible if necessary to enforce any decisions reached through arbitration. The parties agree that any dispute about any provisions of this Agreement will be decided through arbitration.

The parties hereby bind anyone whose claims may arise out of or relate to treatment or services provided by the MCP at the time of the occurrence giving rise to the claim. In the case of any pregnant mother, the term "patient" means both the mother and the mother's expected child or children. The parties consent to the participation in this arbitration of any person or entity that would otherwise be a proper additional party in a court action if they have been involved in any way in the care of the Patient. This may include claims of the Patient against another physician, nurse or medical professional, or a hospital or other facility. Additionally, this Agreement is intended to resolve all claims for vicarious liability of the MCP.

The signers agree that the maximum total amount of all non-economic and economic damages combined shall never exceed $250,000, applied on ***a per case*** basis, regardless of the number of claimants seeking compensation, and regardless of the number of physicians, professional associations, employees or entities named as defendants. The Patient agrees to waive any and all rights to any higher award. This limitation applies regardless of whether another healthcare provider, such as a physician, a hospital or other facility or employees of such a physician, hospital or facility are named as defendants in the binding arbitration or in any other proceeding. Non-economic means damages for pain and suffering, disfigurement, embarrassment and anything else not representing loss of past or future earnings, medical or other costs. The arbitrators may choose to award damages in excess of $250,000 only when extreme hardship is demonstrated. As consideration for the limitation on any awards, the MCP will pay up to and only the first $2,500 of attorney fees for the Patient. The parties agree that if any punitive damages are awarded, they may not exceed three times any compensatory award. Save as required by Medicare/Medicaid, the parties agree that any awards in excess of $10,000 shall be paid in equal annual payments over 10 years without being reduced to present value. The arbitrators may reduce the time period in cases of extreme hardship. They will also consider any other collateral sources of compensation (e.g., workers compensation, life insurance, disability, charitable, and governmental benefits, and other monies paid to the injured patient or any other party) which shall diminish any awards for non-economic and/or economic damages. The MCP shall be entitled to an off-set for any monies received by the Patient for claims against any other health care provider, if such claims arise out of or relate in any way to the claims of the Patient against the MCP. The parties agree to the complete disclosure of all collateral sources of compensation. Failure to promptly disclose any additional sources on request is agreed to be grounds for immediate and total dismissal of any claim.

Statute of Limitations: In no case shall the statute of limitations exceed 12 months from the date any alleged injury or problem could or should have been discovered regardless of the age of the Patient. The arbitrators and their empowerment under the FAA shall determine any question concerning the application of this provision. **Severability:** If any specific term or provision of this Agreement is determined by a court of competent jurisdiction to be illegal, invalid, or otherwise unenforceable, the entire remainder of this Agreement shall be construed to be in full force and effect, and all other provisions will still apply. The parties agree in general that any provisions so challenged will be brought to the arbitrators to decide upon, and not to a judge or jury. **Timing*:*** The parties agree to try to resolve all issues within 9 months of any complaint. **Entire Agreement/Merger Clause:** This Agreement represents the entire agreement made between the MCP and the Patient. It supersedes any other agreements between the Patient and the MCP. Except as expressly set forth herein, there are no other representations, promises, understandings, or agreements of any kind between the parties. The Patient signing this Agreement acknowledges that he or she has not relied in any way upon any oral or written statements made to them besides what is contained within

this Agreement. All parties acknowledge and understand that this Agreement cannot be changed, altered, or modified in any way except by an instrument in writing, signed by all parties. **Pronouns and Headings:** The singular shall be held to include the plural, the plural held to include the singular, and the use of any gender shall be held to include every gender. All headings, titles, subtitles, or captions are inserted for convenience only, and are to be ignored in any construction of the provisions hereof. **Governing Law and Payment and Selection of Arbitrators:** This Agreement, its substantive provisions, the scope of the Agreement, the authority granted to the arbitrators and the limitations contained in this Agreement, are to be governed by, and interpreted pursuant to the Federal Arbitration Act, any conflicting state law notwithstanding. To the extent not inconsistent with the FAA, it shall also be governed by the provisions of the Revised Uniform Arbitration Act as adopted in the principal state where the MCP practices. The parties agree that any dispute between them shall be determined by a panel of three arbitrators. Each party shall select one arbitrator from lists of qualified legal/medical experts provided by the MCP. All arbitrators will hold either medical or both medical and juris doctor degrees. The two arbitrators selected shall then select a third arbitrator from the same list. Each party may remove the other's chosen arbitrator only once. The three arbitrators shall resolve any and all disputes between the parties generally pursuant to the National Arbitration Forum Code of Procedure or such procedures as they may jointly decide. All arbitration hearings shall be conducted by videoconference; the MCP will provide equipment and pay all costs of videoconference bridging and of the arbitrators. The parties shall adopt rules of evidence such as the arbitrators may see fit. The MCP shall pay the full costs of the arbitration, but shall not be responsible for paying any fees or costs charged to the Patient by their attorney save the first $2,500 as indicated above. Reasonable discovery will be permitted by both sides. The parties agree that the arbitrators are to render a written decision with reasons stated for the decision. **Right of Counsel & Rescission:** The Patient understands that this Agreement is a legal document, and the Patient has the right to consult with an attorney before signing it if desired. Your MCP encourages you to consult an attorney prior to signing or during a 15-day rescission period. You may rescind this Agreement for 15 days after signing it; you agree that it will be in full force and effect until the date received at the MCP's office. To rescind it, return a copy to the MCP by certified mail-return receipt only with "CANCELED" written on the first page, and signed by you underneath that word. The Agreement will then be rescinded for all future care, but you agree it will be valid for any and all care provided by the MCP to the Patient for the entire period of all medical services up to rescission. **Authority to Sign:** The Patient represents that he or she does in fact have the authority to sign and execute this document on his/her own behalf (if signed by the Patient), or on behalf of the Patient (if signed by a person or persons other than the Patient.) **No Undue Influence:** The individual signing this Agreement hereby acknowledges that he or she has not been pressured, induced, coerced, or intimidated in any way into signing this Agreement, and has signed it of his or her own free will and accord and not under duress of any kind. The parties agree that they have been given every opportunity to ask questions and receive answers concerning the specifics and intent of this Agreement. **Frivolous Legal Actions:** The Patient agrees that under no circumstances will a frivolous action or claim be brought against the MCP, and the MCP agrees to not bring any frivolous action or claim against the Patient. If two or more Arbitrators rule that any action or claim brought against either party is frivolous in nature, the prevailing party shall be entitled to economic and non-economic damages, including loss of wages or other compensation, damage to reputation, full attorneys' fees and punitive damages. **Mediation:** At the MCP's sole expense, upon any complaint or alleged injury, the parties agree to promptly mediate in good faith with a qualified mediator prior to any Arbitration hearing. A qualified professional mediator with medico-legal background shall be mutually agreed upon.

BY SIGNING THIS CONTRACT, YOU AGREE TO HAVE ANY ISSUE OF ALLEGED MEDICAL NEGLIGENCE OR BREACH OF CONTRACT BETWEEN YOU AND YOUR MCP DECIDED BY BINDING ARBITRATION IN WHICH BOTH PARTIES GIVE UP THEIR RIGHT TO A TRIAL BY JURY, OR TRIAL BY A JUDGE.

I hereby agree that all provisions of this Agreement are in full effect, and no word, sentence, paragraph or provision may be crossed out, excised or removed.

To be completed by the Patient, Parent, or Authorized Representative

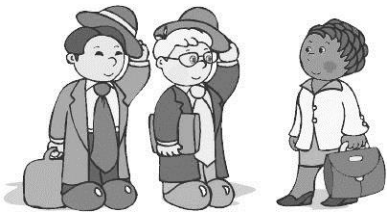
Name of Patient: _____

Your relationship to Patient (check one): □ Mother
□ Father
□ Other (please specify) _____

_____ Date: _____
SIGNATURE of Patient, Parent, or Authorized Representative of Patient

MEDICAL CARE PROVIDER'S CONSENT TO ARBITRATION: In consideration of the execution of this Binding Arbitration Agreement, the undersigned, as the legal representative of the Medical Care Provider, hereby agrees to be bound by all the terms set forth above.

Rafael B. Cheas MD _____ Date: _____
SIGNATURE of Medical Care Provider – **Rafael Cheas, M.D., individually and on behalf of Silver Lake Pediatrics, P.A.**



Release Form for individuals involved in the care of the patient

I, _____, give Silver Lake Pediatrics, P.A.**,** permission to speak with the following individuals regarding my child(ren) health status, including diagnosis, treatment options/plans and payment for health services my child(ren) receive from Silver Lake Pediatrics, P.A.

This consent is valid until such time as I provide Silver Lake Pediatrics, P.A. written revocation.

Silver Lake Pediatrics, P.A. may speak with:

Name:_____
Relationship _____

Name:_____
Relationship _____

Name:_____
Relationship _____

Name:_____
Relationship _____

Name:_____
Relationship _____

Name:_____
Relationship _____

Name:_____
Relationship _____

Parent/Guardian Signature:_____
Date:_____

CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS

The Patient hereby consents to the use or disclosure of his/her individually identifiable health information ("protected health information") and patient medical record information by **Silver Lake Pediatrics, P.A.** (the "Practice") to carry out treatment, payment, or health care operations. The Patient should review the Practice's Notice of Privacy Practices for a more complete description of the potential uses and disclosures of such information, and the Patient has the right to review such Notice prior to signing this Consent Form.

The Practice reserves for itself the right to change the terms of its Notice of Privacy Practices at any time. If the Practice does change the terms of its Notice of Privacy Practices, Patient may obtain a copy of the revised Notice.

Patient retains the right to request that the Practice further restrict how his/her protected health information is used or disclosed to carry out treatment, payment, or health care operations. The Practice is not required to agree to such requested restrictions; however, if the Practice does agree to Patient's requested restriction(s), such restrictions are then binding on the Practice.

The Patient agrees that the Practice may disclose the following types of information contained in the Patient's medical records. **IF THE PATIENT DOES NOT WISH TO HAVE ANY OF THE FOLLOWING INFORMATION RELEASED, PLEASE INDICATE BY INITIALING THE APPROPRIATE SPACES BELOW:**

_____ Mental Health Issues _____ Sexually Transmitted Disease Information _____ HIV/AIDS

_____ Substance Abuse _____ If patient is 18 years or younger (pregnancy testing info)

Patient/parent or guardian agrees and consents to the Practice releasing information, appointment reminders and general office information/feedback to the Patient in the following alternative manners (please initial the appropriate spaces below:

_____ **Via e-mail AND/OR text**

Email_____

Cell number _____

_____ Via Regular Mail

_____ Via telephone, if Patient contacts the Practice and provides the appropriate information (including the Patient's name, social security number and unique personal identifier)

At all times, Patient retains the right to revoke this Consent. Such revocation must be submitted to the Practice in writing. The revocation shall be effective *except* to the extent that the Practice has already acted in reliance on the Consent.

The Practice may refuse to treat Patient if he/she (or an authorized representative) does not sign this Consent Form. If Patient (or authorized representative) signs this Consent and then revokes it, the Practice has the right to refuse to provide further treatment to Patient as of the time of revocation (except to the extent that the Practice is required by law to treat individuals).

I HAVE READ AND UNDERSTAND THE INFORMATION IN THIS CONSENT. I HAVE BEEN OFFERED A COPY OF THIS CONSENT, AND I AM THE PATIENT OR AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS DOCUMENT VERIFYING CONSENT TO THE ABOVE STATED TERMS. Date:_____ Time _____ AM/PM

_____ _____

Print patient's name DOB Signature of Patient (or Authorized Representative*)

_____

Please Print Name

*Please explain Representative's Relationship to Patient and include a description of Representative's Authority to act on behalf of the Patient: _____