Preferred Orthopedics of the Palm Beaches
6056 Boynton Beach Blvd. Suite 215
Boynton Beach, FL 33437

***Authorization for Release of Medical Records/Payment Authorization***

**Name: _____ Date of Birth: _____/____/_____**

***Release of Information***

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____

[ ] Child(ren)_____

[ ] Not to be released to anyone

[ ] Physician Name/Office: _____

**Check information requested and how to be sent. X-rays incur a cost of $10.00**

_____ Entire Record _____ X-Ray _____ Email _____Fax _____US Mail

This ***Release of Information*** will remain in effect until terminated by me in writing.

***Messages***

Please call [ ] my home [ ] my work [ ] my cell Number
If unable to reach me: [ ] you may leave a detailed message [ ] please leave a message asking me to return your call

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing. I understand that the revocation will not apply to information that has already been released by this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the authorization. This authorization is valid for one year from date of signature if not specified.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for subsequent unauthorized disclosure and the information may not be protected by federal confidentiality rules. I also understand that although the practice makes its best efforts, the transmission of information via email or text between the practice and myself may not be encrypted and secure. If I have any questions about disclosure of my health information, I can contact the Medical Records Department at (561) 733-5888.

*Assignment of Insurance Benefits*: I hereby authorize payment directly to Preferred Orthopedics of the Palm Beaches, PA ("POPB") and assign to them any and all rights and benefits that I or the patient may have under and policy of insurance including medical, automobile, personal injury protection, workers compensation, or any other coverage and further direct

any such insurance company to make payment of benefits directly to POPB. I understand that I am financially responsible to POPB for charges not covered by this assignment.

*Consent to Medical and Surgical Treatment*: The undersigned hereby consents to all medical care and services, surgical treatments. Examinations, tests and procedures, including but not limited to x-ray examination, laboratory and diagnostics procedures and tests, anesthesia, which a physician, their employees, nurses, associates, assistants, or designees may deem advisable to the undersigned patient during this treatment.

*Payment Guarantee*: The undersigned patient and guarantor, if any, hereby agree to POPB charges to POPB in accordance with the regular rates and terms of POPB and agree to pay for any charges not covered by any third party payer. The medical practice files insurance as a courtesy to the patient, but the patient is ultimately responsible for the payment of the total incurred charges. The undersigned agrees that if the account is turned over to a collection agency or attorney, that the undersigned patient shall be obligated to pay the outstanding balance plus all court, collection, and attorney costs. The undersigned agrees that any overpayment collected on this account may be applied to any delinquent account for which the undersigned patient is legally responsible.

Signed: _____ Date: ____/____/_____

Witness:_____ Date: ___/___/_____