Hand & Wrist Specialists of the Palm Beaches

Consents, Agreements, and Acknowledgements

I hereby consent and authorize to the rendering of care and treatment, including but not limited to medical, surgical, diagnostic, or any other treatment considered necessary or advisable by the employees and authorized agents of Hand & Wrist Specialists of the Palm Beaches (HWSPB). I understand that the practice of medicine is not an exact science. I also understand the medical, surgical, and diagnosis may involve risks of injury or even death. No guarantees have been made to me with respects to the outcomes of my examinations or treatments. I understand that I may be observed and / or receive care from medical, nursing and other healthcare students in training at HWSPB. I understand that it is my responsibility to follow all instructions both written and verbalized by HWSPB, as well as make any arrangements needed for my follow-up care. I have the right to refuse care at any time.

Patient Signature (or guardian):_____Date:_____

I authorize Hand & Wrist Specialists of the Palm Beaches and its associates to leave phone messages on my home and/or cellphone. I understand that these messages may include sensitive medical information.
The following parties are authorized to discuss or obtain copies of my medical information:

Name:_____ **Patient Signature (or guardian):** **Date:**

Name:_____ _____ _____

I have been given the opportunity to review and receive a copy of Hand & Wrist Specialists of the Palm Beaches' Notice of Privacy Practices.

I understand that in order to maintain an accurate medical record and prevent medication adverse interactions, I must report any changes in medications to Hand & Wrist Specialists of the Palm Beaches as soon as reasonably possible. I also consent to the coordination of my medication record with my pharmacy and Hand & Wrist Specialists of the Palm Beaches. Once our office (HWSPB) issues medical support equipment to a patient (and/or patient's guardian), then the equipment immediately becomes non-refundable.

I agree to be enrolled in the practice portal. I may obtain my medical records and send messages to the practice via the portal. I understand that this is a high security messaging system and NOT to use it for urgent messages.

I understand that Hand & Wrist Specialists of the Palm Beaches is generally providing service to patients Monday through Friday from 8:30 AM to 5:00 PM. Same day appointments are available on an urgent basis only. For emergencies, I am to call 911 or go to the nearest Emergency Room.

I agree to arrive on time or early to my appointment. If I arrive more than 15 minutes late to my appointment, I understand that my appointment may be cancelled and I would be subject to a $25 cancellation fee per the practices' discretion.

Hand & Wrist Specialists of the Palm Beaches <u>REQUIRES 24 HOURS' NOTICE</u> to cancel or re-schedule office appointments, and 2 weeks' notice to cancel or re-schedule surgery. I understand that failure to adhere to this policy will result in a charge ($25 dollars for doctor's appointments, $50 dollars for therapy appointments), and up to $350 dollars for surgery per the practice's discretion. <u>It is the policy of this medical office that once a patient is checked-in, their related Co-Pay becomes non-refundable.</u> <u>In addition, if a patient's billed charges amount goes to collections due to lack of payment, then the amount owed by the patient will be raised by up to 35% to cover collections expenses and operational costs of the Medical Office.</u>

I understand that I am responsible for providing Hand & Wrist Specialists of the Palm Beaches with all medical records and diagnostic imaging as requested by the practice. In the event that I do not provide the office with the records requested, I understand that my appointment may be cancelled and I would be subject to a $25 cancellation free.

I understand that Hand & Wrist Specialists of the Palm Beaches accepts the determination of Medicare; however, I am still responsible for any deductible, co-insurances, and/ or non-covered services. I authorize any payments made by Medicare or secondary insurance be forwarded directly to Hand & Wrist Specialists of the Palm Beaches.

Patient Signature(or guardian):_____**Date**_____

Hand & Wrist Specialists of the Palm Beaches

Last Name	First Name	M I	Gender (at birth) ☐ Male ☐ Female
Date of Birth	SSN#	Email Address (**Required**)	
Street Address	City	State	Zip
Home Phone	Cell Phone	Alt Phone	
Preferred method of contact ☐ Home Phone ☐ Cell Phone ☐ Portal ☐ Other_____		Referred by, or how you found us	
Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Partnered ☐ Widowed	Employer ☐ Check here if retired	Occupation	
Emergency Contact Name	Phone Number	Relationship to Patient	
Pharmacy Name	Pharm Location (Address or Cross Streets	Pharmacy Phone #	

The Government REQUIRES that ALL patient's answer the following:

Preferred Language ☐ English ☐ Spanish ☐ Other_____	Race ☐ White ☐ Black ☐ Hispanic ☐ Asian ☐ Other_____
Ethnicity ☐ Hispanic ☐ Non-Hispanic	

Insurance and Financial

Name of financially responsible party	DOB (Date of birth)	Relationship to patient
Primary Insurance/Payer (Must present proof of coverage)	Secondary Insurance/Payer (Must present proof of coverage)	

I certify that I have provided current and accurate insurance and or payer information. I authorize and assign Hand & Wrist Specialists of the Palm Beaches (HWSPB) all insurance benefits including, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges accrued by services rendered by HWSPB whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. HWSPB may use my healthcare information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits of the benefits payable for related services.

Signature:_____Date:_____