NEIL A. PATTERSON, M.D., P.A.

PATIENT CONSENTS

CONSENT FOR RETRIEVING PRESCRIPTION HISTORY

I give my consent to retrieve my prescription history from external sources, such as insurance company data bases, pharmacies etc. We use this information to improve accuracy of your prescription planning.

YES NO

CONSENT FOR REPORTING YOUR IMMUNIZATION HISTORY

I give my consent to report my immunization history to the Florida Shots program which I understand is the Florida State Immunization database.

YES NO

END OF LIFE PLANNING

Do you have End of Life planning completed?

YES NO

*If "**YES**" please circle those that apply*;

- **DURABLE POWER OF ATTORNEY**
- **ADVANCED DIRECTIVE**
- **LIVING WILL**

***Please provide a copy of your plan to be scanned in your chart**

*If "**NO**" please let our Staff know if you would like more information.*

PRACTICE POLICY REGARDING MISSED OR LATE CANCELLED APPOINTMENTS

*I am aware that there is a $**50.00** fee which is my responsibility to pay if I miss a scheduled appointment or if I cancel a scheduled appointment without giving the office at least 4 business hours notice.*

OUTSTANDING BALANCE POLICY

I am aware that the office policy regarding outstanding patient debts is that two statements will be sent to the patient's attention. If no resolution is made, the account may be forwarded to a collection agency resulting in possible discharge from the practice. In the event that your account is forwarded to collections, the patient or guarantor will be financially responsible for all collections costs and fees (recovery fee + 50% of balance) associated.

AFTER HOURS SERVICES

Insurances will not pay for after hours services at this time. If new services are provided to you by any means after our regular office hours there will be a $45.00 charge for services rendered. This fee is payable by the patient and is not billable to your insurance plan. This fee will not be applied to your account if we have seen you for the same problem in the past week or if you follow-up with an office visit within a week for the same problem.

____________________________________ ______________________________

Signature of Patient or Legal Guardian Date

____________________________________ ______________________________

Print name of patient Print name of legal guardian

New pt 10/2019