ALLCARE MEDICAL CENTERS, P.C.
PATIENT INFORMATION/AUTHORIZATION TO TREAT

PATIENTS NAME_____ DATE OF BIRTH_____ AGE ____

MAILING ADDRESS_____ CITY_____ ZIP_____

HOME PHONE (____)_____CELL PHONE (____)_____ SEX: M OR F

PATIENT SSN_____-_____-_____ DRIVER'S LICENSE#_____

MARITAL STATUS: SINGLE __ PARTNERED __MARRIED __ SEPARATED __ DIVORCED __ WIDOWED __

PATIENT EMPLOYER_____

WORK PHONE (____) _____ EMAIL ADDRESS _____

HOW DID YOU HEAR ABOUT US?_____ PRIMARY PHYSICIAN_____

PERSON TO CONTACT IN CASE OF EMERGENCY RELATIONSHIP_____

FIRST AND LAST NAME_____ PHONE(____)_____

****IF PATIENT IS A MINOR PLEASE PROVIDE US WITH THE FOLLOWING INFORMATION:**

PARENT/GUARDIAN NAME_____

DO YOU PLAN TO VACCINATE/IMMUNIZE YOUR CHILD? _____

INSURANCE _____ ***please present card @ time of service***

POLICY #_____ GROUP# _____PHONE (____)_____

NAME OF PERSON INSURED_____ RELATIONSHIP _____

DATE OF BIRTH _____EMPLOYER _____

WAS THIS A MOTOR VEHICLE ACCIDENT_____A WORKMEN'S COMPENSATION CLAIM _____

****PLEASE INITIAL THE FOLLOWING:**

_____ **I HEREBY AUTHORIZE ALLCARE MEDICAL CENTERS, P.C. TO PROVIDE TREATMENT AS PRESCRIBED BY MY PHYSICIAN.**

_____ **I HEREBY ASSIGN ALL INSURANCE BENEFITS FOR SERVICES RENDERED TO BE PAID DIRECTLY TO ALLCARE MEDICAL CENTERS, P.C..**

_____ **I UNDERSTAND THAT IF MY INSURANCE CO/THIRD PARTY PAYER DENIES PAYMENT OR MAKES PARTIAL PAYMENT I AM RESPONSIBLE FOR THE BALANCE DUE.**

_____ **I HEREBY AUTHORIZE THE RELEASE OF MEDICAL RECORDS TO ALLCARE MEDICAL CENTERS, P.C. AND ANY PERTINENT INFORMATION CONCERNING THE PATIENT FOR THE PROVISION OF CARE AND FOR OBTAINING INSURANCE REIMBURSEMENT.**

_____ **I UNDERSTAND THAT I AM LEGALLY RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED BY ALLCARE MEDICAL CENTERS, P.C. INSURANCE IS BEING BILLED AS A COURTESY. I AM RESPONSIBLE FOR PAYING ANY DEDUCTIBLE OR CO-INSURANCE AMOUNTS. I UNDERSTAND THAT CO-PAYMENTS ARE DUE AT THE TIME OF SERVICE.**

SIGNATURE OF PATIENT/PARENT/GUARDIAN_____ **DATE**_____

AllCare Medical Centers, P.C.

Health History Information for Adults

PERSONAL DATA:

Name: _____ Date: _____

Address: _____ Age: _____ DOB ____/____/____

_____ Sex: M F

Phone: (H) (_____) _____ Email: _____

(C) (_____) _____

(W) (_____) _____

Marital Status: S M D W Sep

Currently Living With: _____

Number of Children: _____ Ages: _____

Years of Education: _____ Degree: _____ Occupation: _____

Military Service: No Yes → Past Current

Spirituality/Religious Affiliation: _____

PREFERRED PHARMACY:

Name: _____ Phone: (_____) _____

Address: _____

EMERGENCY CONTACT:

Name: _____ Phone: (_____) _____

Contact Address: _____

MEDICAL HISTORY:

Have you been diagnosed with any major medical conditions? Y N

If yes please describe:

_____

_____

Current Medication(s):

Medication	Dose	Frequency	Reason for Medication
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List any known allergies – include side-effects:

_____

How would you rate your overall health? Good Fair Poor

Rate your level of exercise: Sedentary (no exercise) Mild (climb stairs, golf) Occasional vigorous exercise

What is your typical diet: Normal High Fiber/Veggie High Salt High Fat High Cholesterol Herbal diet

Name of Primary Care Physician (PCP): _____ Physician Phone (_____) _____

Vaccine	Year of Last	Test/Exam	Year of Last
Tetnus/TD		Physical	
Influenza (Flu)		Cholesterol	
Pneumonia		Eye	
Hepatitis B		PAP	
Tuberculosis Skin Test		Mammogram	
Zoster		Prostate/PSA	
Gardasil		Colonoscopy	

Hospital Admissions (not including pregnancies) Use back of sheet if you need to add more:
Month/Year Reason for hospitalization

_____ _____
_____ _____
_____ _____

Prior Mental Health Treatment:
Prior outpatient psychotherapy? Yes No Prior inpatient mental health treatment? Yes No
Prior psychiatry? Yes No Current psychiatry? Yes No
Prior Psychiatric Provider(s) (Use back of sheet if you need to add more):
Name(s) City State Phone Diagnosis Beneficial?

_____
_____
_____

SUBSTANCE USE HISTORY:
Please answer the following by checking (V) the line and filling in the blanks.

_____ Drink Alcohol _____ oz per week ____/____ # drinks per day/week
_____ Smoke _____ # Cig/day _____ Years Years quit _____
_____Other Tobacco Type: _____ Amount/Frequency:_____
_____Drink Caffeine _____ Coffee/tea _____ Cups per day
_____ Soda _____ oz per day
_____ Energy Drinks _____ oz per day

_____ Drug Use	Drug Used	Amount/Frequency	Current/Past/Both
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Have you ever felt you ought to cut down on your alcohol use or drug use? Yes No
Have people annoyed you by criticizing your drinking or drug use? Yes No
Have you ever felt bad or guilty about your drinking or drug use? Yes No
Have you ever had a drink or used drugs first thing in the morning
(as an eye opener, to steady your nerves or to get rid of a hangover?) Yes No

Prior substance use/abuse counseling? Yes No
If yes: Prior substance treatment provider(s)/facility (Use back of sheet if you need to add more):
Name(s) City State Phone Substance(s) Treated
Beneficial?

_____
_____
_____

WOMEN HEALTH QUESTIONS:

Check (V) problems you have or have had in the past:

___ Abnormal PAP smear
___ Bleeding between period
___ Bleeding with intercourse
___ Breast Lump
___ Extreme menstrual pain
___ Hot flashes
___ Irregular periods
___ Nipple discharge
___ Painful Intercourse
___ Urinary problems
___ Vaginal discharge
___ Vaginal infections

At what age did your menstrual period begin? _____ Date of last menstrual period? _____
How often do your periods occur? _____ How long do they last? _____ How many days of heavy flow? _____

Are you sexually active? ___ Yes ___ No More than one partner? ___ Yes ___ No
Are you using condoms? ___ Yes ___ No Are you using contraception, if so what kind? _____

If you have breast implants, do you have ___Silicon ___Saline?
Did you have the implant insert in the US? ___Yes ___ No

Have you had ___ a cone (cutting) ___ Cryo (freezing) ___ LEEP (burning) on your cervix in the past?
Results of your last PAP? _____
Date of your last bone density? _____

PREGNANCIES

MM/DD/YY	Hospital/Doctor	Vaginal/C-Section	Complication	Sex of Child	Weight of Child

# of children now living _____ # of miscarriages/stillbirths _____ # elective terminations _____

MEN HEALTH QUESTIONS:

Do you usually get up to urinate during the night? ___ Yes ___ No If yes, # of times _____

Do you feel pain or burning with urination? ___ Yes ___ No Any testicle pain/swelling? ___ Yes ___ No

Do you have discharge from your penis? ___ Yes ___ No Date of last prostate and rectal exam? ____

Has the force of your urine decreased? ___ Yes ___ No

Any difficulty with erection or ejaculation? ___ Yes ___ No

Have you thought of a vasectomy? ___ Yes ___ No ___ Had it

Have you had any kidney, bladder, or prostate infections within the last year? ___ Yes ___ No

SOCIAL/RELATIONSHIP HISTORY:

Current stressful events (Check (V) those that apply:
___ Legal ___Financial ___ Family Problems ___Family Illness ___School ___ Occupational
___ Loss/Grief Other: _____

What do you typically to reduce stress? _____

Marital Status:
[ ] Single, never married
[ ] Long-term relationship ___ years
[ ] Engaged
[ ] Married for ___ years
[ ] Separated
[ ] Divorce in process
[ ] Divorced for ___ years
[ ] ___ Prior marriages (self)
[ ] ___ Prior marriages (partner)

Intimate Relationships:
[ ] Never been in a serious relationship
[ ] Not currently in a relationship
[ ] Currently in a serious relationship

Relationship Satisfaction:
[ ] Very Satisfied with relationship
[ ] Satisfied with relationship
[ ] Somewhat satisfied with relationship
[ ] Dissatisfied with relationship

Describe any past or current significant issues in intimate relationships: _____

_____

History of abusive relationships? Yes Somewhat No

Currently in an abusive relationship? Yes No

History of:	Physical Abuse?	Y N		Current physical abuse?	Y N
	Emotional Abuse?	Y N		Current emotional Abuse?	Y N
	Sexual abuse?	Y N		Current sexual abuse?	Y N

FAMILY OF ORIGIN HISTORY:

Present During Childhood:

	Entire	Part of childhood	Not at all
Mother	[ ]	[ ]	[ ]
Father	[ ]	[ ]	[ ]
Stepmother	[ ]	[ ]	[ ]
Stepfather	[ ]	[ ]	[ ]
Brother(s)	[ ]	[ ]	[ ]
Sister(s)	[ ]	[ ]	[ ]
Other (specify) _____	[ ]	[ ]	[ ]

Parents' Current Medical Status:
[ ] Married to each other
[ ] Separated for ____ years
[ ] Divorced for ____years
[ ] Mother remarried ____ times
[ ] Father remarried ____ times
[ ] Mother deceased for ____ years
age of patient at mother's death ____
[ ] Father deceased for ____ years
age of patient at father's death ____

Describe Childhood Family Experience:
[ ] Outstanding home environment
[ ] Normal home environment
[ ] Chaotic home environment
[ ] Witnessed abuse/violence
[ ] Experienced abuse/violence

By whom were you raised? _____

Were you adopted? ____yes ____no If so, at what age? _____

Place an **X** by any of the following medical problems experienced by you or any member of your immediate family in the past or present. In the column marked "Person?" please write in who experienced the medical condition (e.g., self, mom, dad, sibling, grandparent) for each condition you mark.

Medical Condition	X	Person?	Medical Condition	X	Person?
Cardiovascular/Circulatory			**Urinary**		
Heart Disease			Bladder or kidney infections		
Heart Attack			Kidney disease/stones		
High Blood Pressure			Urinary stress incontinence		
High Blood Cholesterol			Nighttime wetting		
Rheumatic fever			Daytime wetting		
Swelling of feet			Painful urination		
			Frequent urination		
Endocrine					
Diabetes			**Respiratory**		
If yes, at what age			Asthma or emphysema		
Gallstones/Gallbladder disease			Lung Disease/pneumonia		
Thyroid disease/goiter			COPD		
			Tuberculosis		
Gastrointestinal/Digestive			Shortness of breath		
Acid Reflux (heartburn)			Sleep apnea/on c-pap		
Diverticulosis					
Ulcers (stomach/intestine)			**Musculoskeletal**		
Pancreatitis			Arthritis		
Liver disease/hepatitis			Joint pain		
Frequent diarrhea			Back pain		
Frequent constipation			Hip pain		
Blood in stools			Knee pain		
Irritable colon/bowel			Ankle and foot pain		
			Broken bones		
Hematological					
Anemia			**Sleep Related**		
Blood clots			Snoring		
Bleeding disorder			Restless sleep		
			Trouble falling asleep		
			Trouble waking up		
			Morning headache		
			Daytime drowsiness		

HISTORY OF CANCER:

Personal History

Type	Age Diagnosed

Family History

Person	Type	Age Diagnosed

Place an **X** by any of the following psychological/neurological problems experienced by you or any member of your immediate family in the past or present. In the column marked "Person?" please write in who experienced the psychological/neurological condition (e.g., self, mom, dad, sibling, grandparent) for each condition you mark.

Psychological	X	Person?	Psychological Cont.	X	Person?
ADHD			Autism Spectrum Disorder		
Anxiety			Reading Disorder		
Obsessive-compulsive disorder			Math Disorder		
Panic Disorder			Writing Disorder		
Bipolar Disorder					
Depression			**Neurological**		
Anorexia			Epilepsy or seizures		
Bulimia			Stroke		
Binge Eating			Dizziness		
Dementia			Headaches/Migraines		
Alzheimers			Numbness or tingling		
Parkinsons			Muscle weakness		
Schizophrenia			Shakiness/Tremors		
Suicidal thoughts, plans, behaviors			Loss of Consciousness		
Alcoholism			Loss of vision		
Addiction			Ringing in ears		

Continued on next page

Complete this section ONLY if you are here for an ***initial psychological appointment***:

MAIN CONCERNS:

Please list the main concerns you would like help with in therapy and/or testing and rate the severity of each using this scale:

1----------2----------3----------4----------5----------6----------7----------8----------9----------10
Not a Problem Mild Moderate Severe Couldn't be Worse

	Rating
1. _____	_____
2. _____	_____
3. _____	_____

Briefly describe what motivated you to seek therapy/testing at this time (rather than some time earlier or later):

_____
_____
_____

What do you hope to be able to do or achieve as a result of participating in therapy/testing?

_____
_____
_____

Allcare Medical Centers, P.C.
5860 Ranch Lake Blvd. Suite 200
Bradenton, Florida 34202

Telephone (941) 388-8997
Fax (941) 306-5876
www.allcaremedicalcenters.com

Authorization For Release of Protected Health Information

I, _____, born, _____ request and authorize AllCare Medical Centers, P.C. to:
(Patient Name) (Date of Birth)

_____ Exchange with _____ Receive From _____ Provide to

_____
(Name of Agency and/or Person to Provide or Receive Information)

Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____

I authorize release of information (in written and/or oral from) regarding:

- ❑ Initial Evaluation and Recommendations
- ❑ Psychological Evaluation
- ❑ Social History
- ❑ Progress Notes
- ❑ Duration of Treatment or Program
- ❑ Medical Information (e.g., Labs, X-ray data, etc)
- ❑ Summary of Treatment Participation/Progress
- ❑ Coordination of Care
- ❑ All Available Information
- ❑ Treatment Summary
- ❑ Diagnosis and Assessment
- ❑ Hospital Discharge Summary
- ❑ Academic Performance
- ❑ Social Skills and Behavior at School
- ❑ Physician Notification
- ❑ Appointment Times/Attendance
- ❑ Financial/Insurance Information
- ❑ Other: _____

The above information is being disclosed for the purpose of:

- ❑ Evaluation, diagnosis, and treatment
- ❑ Coordination of services
- ❑ Arranging financing/payment for services
- ❑ Transferring information regarding previous treatment
- ❑ Other: _____

I give permission for information to be disclosed via ___phone, ___fax, ___mail, ___in-person, ___email

I understand I may revoke this authorization at any time by providing written notice to my physician/clinician and to the named recipient of the disclosed health information. However, my revocation will not be effective to the extent that action has been taken in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. **For *PSYCHOLOGICAL* information, this consent automatically expires one year following completion/termination of care. For *MEDICAL* information, this consent will NOT expire.**

I understand AllCare Medical Centers will not condition services upon my signing an authorization unless the services are provided to me for the purpose of creating health information for a third party.

I acknowledge the information may include material that is protected by state and/or federal law applicable to mental health, and/or drug/alcohol abuse, and/or HIV/AIDS or all three. My signature authorizes release of all such information as specified above. AllCare Medical Centers notifies you of the potential that this information, once forwarded to the other party, could be redisclosed and no longer protected by this rule.

Signature of Patient: _____

Signature of Responsible Party: _____
Relationship to the Patient: _____

Date Signed: _____

Note: A photocopy or fax of this release is as good as the original

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ **DATE:**_____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
	add columns	+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

A2663B 10-04-2005

AllCare Medical Centers, P. C.
5860 Ranch Lake Blvd. Suite 200
Bradenton, Florida 34202-3708
941-388-8997 Fax 941-306-5876

OFFICE POLICY

We consider it a privileged responsibility to be chosen as your health care providers. This is a trust that does not come easily, and we will make every effort to ensure that your trust is well placed and your confidentiality be protected. To that end, we agree:

- To provide you with the best care we can, in a timely and cost effective manner with every effort to minimize waiting time.
- To return your calls as quickly as possible, and to take adequate time to understand your specific problems and when necessary, arrange for all referrals to specialists and testing facilities.
- To bill your insurance company in a timely manner, to be as accurate as possible with our billing procedures, and to efficiently answer any billing questions you may have.
- To be responsive to your constructive criticism in an attempt to continuously improve our services.

In return, and to help us meet the above goals, we ask of our patients the following:

- Co-pays must be paid at every visit. We do not bill for co-pays.
- Your Account balance past 30 days must be paid prior to the next visit and the payment arrangement must be signed and in effect prior to being seen.
- Self-Pay patients are required to pay for their visit in full at the time of service.
- Please inform the front office of any change of personal information. For example: phone number, address, marital status, and insurance information, etc.
- Please keep all appointments. Any No Show or Late Cancel appointments may be charged as follows:
    - First Time – No Charge
    - Second Time – Half price of the Visit scheduled at cash pay rates.
    - Third Time – Full Price of the Visit scheduled at cash pay rates.
- If your account balance remains past due after 90 days, we will notify you that without a response from you; we may use a collection agency or our attorneys to obtain payment in full.

IF YOU ARE SEEN OUTSIDE OF OUR NORMAL BUSINESS HOURS THERE WILL BE A AN EXTRA CHARGE OF $30.00 TO BE PAID BY THE PATIENT – INSURANCE WILL NOT COVER THIS

I agree to abide by the policies and procedures of the AllCare Medical Centers office.

Date:_____ Patient's Signature:_____

Patient's Name:_____ DOB:_____

Witness Signature:_____

A. Notifier: AllCare Medical Centers, P C

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.** Services below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.** below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
Urinalysis 81003, 81002, 81001	Not Medically Necessary	$10.00
Venipuncture 36415, 36416	Not Medically Necessary	$10.00
Various Lab Tests	Not Medically Necessary	Varies
Drug Tox Urine Screens	Not Medically Necessary	$20.00 (each)
TDAP and Zostervax Vaccines	Not Medically Necessary	Varies
Chronic Care Management	Not Medically Necessary	Varies

WHAT YOU NEED TO DO NOW:

Read this notice, so you can make an informed decision about your care.
Ask us any questions that you may have after you finish reading.
Choose an option below about whether to receive the services listed above.
Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.** listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.** listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

☐ **OPTION 3.** I don't want the **D.** listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

PATIENT – PHYSICIAN ARBITRATION AGREEMENT

ARTICLE 1: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by Florida law, and not by lawsuit or resort to court process except as Florida law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have such dispute in a court of law before a jury, and instead are accepting the use of arbitration.

ARTICLE 2: I understand and agree that this arbitration Agreement binds me and anyone else who may have a claim arising out of or related to all treatment or services provided by the physician, including any spouse or heirs of the patient and any children, whether born or unborn at the time of the occurrence giving rise to any claim. This includes, but is not limited to, all claims for monetary damages exceeding the jurisdictional limit of the small claims court, including without limitation, suits for loss of consortium, wrongful death, emotional distress or punitive damages. I further understand and agree that if I sign this agreement on behalf of some other person for whom I have responsibility, then, in addition to myself, such person(s) will also be bound, along with anyone else who may have a claim arising out of the treatment or services rendered to that person. I also understand and agree that this agreement relates to claims against the physician and any consenting substitute physician, as well as the physician's partners, associates, association, corporation, or partnership, and the employees, agents, and estates of any of them. I also hereby consent to the intervention or joinder in the arbitration proceeding of all parties relevant to a full and complete settlement of any dispute arbitrated under this Agreement, as set forth in the FMA/FHA Medical Arbitration Rules.

ARTICLE 3: I agree that the arbitrators have the same immunity from civil liability as that of a judicial officer when acting in the capacity of arbitrator under this Agreement. This immunity shall supplement, not supplant, any other applicable statutory or common law.

ARTICLE 4: I UNDERSTAND THAT I DO NOT HAVE TO SIGN THIS AGREEMENT TO RECEIVE THE PHYSICIAN'S SERVICES, AND THAT IF I DO SIGN THE AGREEMENT AND CHANGE MY MIND WITHIN 30 DAYS OF TODAY THEN I MAY CANCEL THIS AGREEMENT BY GIVING WRITTEN NOTIVE TO THE UNDERSIGNED PHYSICIAN WITHIN THAT TIME STATING THAT I WANT TO WITHRAW FROM THIS ARBITRATION AGREEMENT.

ARTICLE 5: On Behalf of myself and all others bound by this Agreement as set forth in ARTICLE 2, agreement is hereby given to be bound by the Medical Arbitration Rules of the Florida Healthcare Association (FHA) and the Florida Medical Association (FMA), as they may be amended from time to time, which are hereby incorporated into this Agreement. A copy of these Rules is included in the pamphlet in which this agreement is found. Additional copies of the Rules are available from the Florida Medical Association 1430 Piedmont Drive East Tallahassee, FL 32308. Attention: Arbitration Rules. I understand that disputes covered by this Agreement will be covered by Florida law applicable to actions against health care providers, including the Medical Injury Compensation Reform Act of 1975 (including any amendments thereto).

ARTICLE 6: OPTIONAL RETROACTIVE EFFECT

If I intend this Agreement to cover services rendered before the date it is signed (for example, emergency treatment), I have indicated the earlier date I intend this Agreement to be effective from and

ARTICLE 7: I have read and understood all the information in this pamphlet, including the explanation of the Patient-Physician Arbitration Agreement, this Agreement, and the Rues, I understand that in the case of any pregnant woman, the term "patient" as used herein means both the mother an the mother;s expected child or children.

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

NOTICE BY SIGNING THS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

_____ Dated: _____

(Patient, Parent, Guardian, or Legally Authorized Representative of Patient)

If signed by other than patient, indicate relationship: _____

PHYSICIAN'S AGREEMENT TO ARBITRATE:

In consideration of the foregoing execution of this Patient-Physician Arbitration Agreement, I likewise agree to be bound by the terms set forth in this Agreement and in the rules specified in ARTICLE above.

_____ Dated: _____

(Physician or Duly Authorized Representative)

_____ _____

Administrator, Manager, Physician Print Name of Physician, Medical Group, Partnership or Association

AllCare Medical Centers P C
Payment Agreement

In accordance with AllCare Medical Centers Office Policy I authorize AllCare Medical Centers P. C. to automatically withdraw or charge to the below card number my total current balance on the 25th of each month.

PATIENT NAME: _____

PATIENT SIGNATURE: _____

PATIENT ACCOUNT NUMBER: _____

Card Type VISA MASTERCARD DISCOVER AMEX

Name on Card: _____

Card Number: _____

Expiration Date: _____

Security Code: _____

Please be aware that the amount charged will only be the amount owed to AllCare Medical Center for services performed.

THIS WILL BE KEPT PRIVATE AND CONFIDENTIAL

Allcare Medical Center, P. C.

Our Family Taking Care Of Yours

5860 Ranch Lake Blvd, Bradenton, Florida 34202
Phone (941)388-8997 FAX (941)306-5876
www.allcaremedicalcenters.com

Dear Valued Patient,

September 21, 2016

Allcare Medical Centers values you and your health. It is important to us that we build a lasting relationship with our patients as well as our community.

Effectively immediately all patients receiving scheduled medications from Providers at Allcare Medical will need to submit to a urine drug screening at their appointments. This is in no part a punishment to our patients. We believe that being a responsible member or our community means holding every medical professional as well as patients accountable for their health and prescribing practices.

We understand that some insurance companies may not reimburse for this screen. We will work with every insurance company in efforts to make sure they are reimbursed. Should the effort be ineffective, you as the patient, will be responsible for the fee associated with this test. The fee for a urine drug screen without insurance payment is $48.00.

You have the right to refuse this test but we will not be able to prescribe controlled medications if you do. We appreciate your understanding and welcome any questions you may have.

I Accept this policy and will proceed with testing:_____ Date:_____

I decline this testing:_____ Date:_____

Patient Name:_____ DOB:_____