ALLSPINECARE
Your Spine Surgery Specialist

# PATIENT / PHYSICIAN AGREEMENT

## PRESCRIPTION REFILLS

Our prescription refill policy requires that you allow 24-48 hours for any refill request to be completed. Every prescription is monitored by the State of Florida. No refills except in person Monday – Friday. Please don't wait until you run out of medicine to call for a refill. In order to protect you, your doctor must review your medical file before renewing a prescription. Please do not call for medications after hours or on weekends when records are unavailable. **It could take up to 48 hours after you call before your doctor can review your file and call in any prescription.** The files are reviewed and prescriptions are called to pharmacies at the end of office hours after all patients have been seen. A written prescription is required for narcotic refills. I have read, understand, and agree with the above.

Patient/Guardian Signature:_____ Date:_____

## MEDICAL RECORDS

Your records are kept in strict confidence as part of our permanent file. We will release copies only if we have your written permission. We prefer to mail copies of records, but we will give them to you in person to hand-carry if time is critical. **Please give us at least 48 hours notice prior to coming in and picking up records as it does take some time to get things together for you.** I have read, understand, and agree with the above.

Patient/Guardian Signature:_____ Date:_____

## STATEMENT OF FINANCIAL RESPONSIBILITY

I the undersigned realize that all medical and surgical charges incurred by me or my dependent/s are my financial responsibility. All court fees, attorney fees, and other fees necessary to collect this amount are payable by me. I grant consent to All SPINE Care to use and disclose my protected health information for the purposes of diagnosing or providing treatment and conducting surgical operations. My protected health information includes demographic information which is collected from me, created or received by my physician or another health care provider, and my employer. This protected information relates to my past, present, and future physical and mental health condition/s. I can receive from All SPINE Care a copy of the Notice of Privacy Practices prior to signing this document and understand it is subject to change. I understand that diagnosis and treatment of me All SPINE Care may be conditioned upon my consent as evidenced by my signature on this document. I have read, understand, and agree with the above.

Patient/Guardian Signature:_____ Date:_____

## CONFIDENTIALITY

The physician will diagnose your illness according to your complaints, symptoms, test results, and medical history. In order to treat the patient appropriately, the patient understands and authorizes treating physician and/or facility to obtain any and all medical records relating to the patient and to communicate with previous physicians by any method that can assist with the care of the patient. I have read, understand, and agree with the above.

Patient/Guardian Signature:_____ Date:_____

## INDIVIDUAL PATIENT AUTHORIZATION

Name the people and/or organization and their relationship to you that are authorizing to use and/or disclose your personal health information.

**I CERTIFY THAT, TO THE BEST OF MY KNOWLEDGE, THE INFORMATION IN THE PATIENT INTAKE FORMS ARE ACCURATE.**

**Patient/Guardian Signature:**_____ **Date:**_____