MONTESOL MEDICAL CENTERS

PATIENT ACKNOWLEDGEMENT AND CONSENT
FOR MEDICAL TREATMENT AND COVERAGE

Please initial and sign to complete the acknowledgement and consent for Medical Treatment, Release of Information, Notice of Privacy Practices and Payment Policy

☐ Consent for Treatment

I voluntarily consent to care, and treatment performed by my physician and all other health care providers at MonteSol Medical Centers. Such care may include but is not limited to, diagnostic procedures, X-Rays, blood draws, laboratory tests, medication administration, and other procedures deemed necessary by the health care providers treating me. I understand that the practice of medicine and surgery is not an exact science and that diagnosis and treatment may cause injury or even death. I understand that I have a right to consent or to refuse to consent to any proposed treatment or procedure, and to discuss it with my health care provider. I also understand that in the course of my medical treatment I may have one or more photographs of my skin or wound(s) taken, to use in monitoring my treatment and guiding healthcare provider interventions. I understand that individuals who want to learn about the roles of healthcare providers may observe the treatment I receive, and I consent to this, but I have the right at any time to object to letting such an individual observe and my objection will be honored.

☐ Authorization, for Release of Information

I authorize MonteSol Medical Centers to utilize confidential medical or other information contained in my medical record as necessary for claims payment, medical management, or quality of care review purposes. I further authorize the release and discharge of such confidential, information to my insurance company or other health coverage plan, including government payers, as necessary for claims payment, medical management and quality review activities conducted by such company or plan, or its designees. This authorization includes the release of any AIDS diagnosis or positive HIV antibody test results, alcohol and/or drug abuse information, genetic testing, medication history, congenital disorders, and mental health information. I understand this authorization for release of information can be revoked by me in writing at any time, but only with respect to the proposed treatment and not with respect to care and treatment that has already been rendered to me.

☐ Notice of Privacy Practices

By signing this document, I acknowledge review of MonteSol MedicalCenter's Notice of Privacy Practices, with a copy available upon request, as required by the Health Insurance Portability and Accountability Act (HIPAA) to ensure that I have been made aware or my privacy rights.

Payment Policy

☐ Payment Agreement (Health Insured)

I request that payment of authorized insurance benefits, including Medicare and Medicaid, be made on my behalf for any services provided to me by MonteSol Medical Centers. I acknowledge that I have provided my insurance information and authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related services by MonteSol Medical Centers to my insurance company or other entity upon request to secure payment of my benefits. I understand that I am financially responsible to MonteSol Medical Centers for any charges not covered by health care benefits. It is my responsibility of notify MonteSol Medical Centers of any changes in my healthcare coverage.

MONTESOL MEDICAL CENTERS

☐ **Self-Pay**

By signing this document, I acknowledge I am fully responsible for all service(s) provided by MonteSol Medical Centers. Payment is due in total at the time of services are rendered. I acknowledge and fully understand that they service(s) requested today will not be billed to any insurance carrier(s) at my request.

_____ _____/_____/_____

Signature of Patient or Legal Representative Date

_____ _____

Printed Name Relationship if not Patient

MONTESOL MEDICAL CENTERS

HIPAA PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change out Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do. We shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, singed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- The Practice has Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the uses of their information, but the Practice does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition receipt of treatment upon the execution of this Consent.

_____ _____/_____/_____

Signature of Patient or Legal Representative Date

_____ _____

Printed Name Relationship if not Patient

MONTESOL MEDICAL CENTERS

CONSENT TO RELEASE PROTECTED HEALTH INFORMATION

Please check all that apply and list name(s) of spouse, child(ren) and other involved in care as applicable.

- ☐ You have permission to leave information on my answering machine regarding my medical care and test results.
- ☐ You have my permission to speak with my spouse/partner about my medical care.
- ☐ You have my permission to talk with my children or other family members involved with my medical care.
- ☐ Other, please describe _____
  _____

Name:	**Relationship:**	**Contact #:**
Name:	**Relationship:**	**Contact #:**
Name:	**Relationship:**	**Contact #:**
Name:	**Relationship:**	**Contact #:**
Name:	**Relationship:**	**Contact #:**
Name:	**Relationship:**	**Contact #:**

Upon request, I may limit the amount of time that this consent for release of information is valid. I may revoke this authorization, in writing, at any time. I understand that the revocation will not apply to information that has already been released. I understand that authorizing the disclosure of this information is voluntary.

_____ _____/_____/_____
Signature of Patient or Legal Representative Date

_____ _____
Printed Name Relationship if not Patient

MONTESOL MEDICAL CENTERS

AUTHORIZATION TO RELEASE HEALTH INFORMATION

Patient Name:		**Date of Birth:**
Address:		
City:	**State:**	**Zip Code:**

I hereby authorize: **MonteSol Medical Centers AND**
(organization/provider/person)

Name: _____

Phone Number: _____ **Fax Number:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

PLEASE SUBMIT RECORDS VIA ONE OF THE FOLLOWING METHODS:

Address: _____

Fax/Email: _____ **Attention To:** _____

To DISCLOSE AND COMMUNICATE TO ONE ANOTHER healthcare information indicated below that is contained in my patient records to the recipient indicated above. I understand and acknowledge that this may include treatment for physical and mental illness, alcohol/drug abuse, and/or HIV/AIDS test results or diagnoses. **This authorization includes permission to request and for the release of Psychiatric, Psychological, Therapy, and/or Mental Health Notes.**

INFORMATION TO BE DISCLOSED

☐ Hospital Admission/Discharge Letters & Summaries **Treatment Dates:** _____ to _____	☐ History & Physical Examinations ☐ Lab & X-Ray Results ☐ Progress Reports ☐ Physical/Occupational Therapy Reports ☐ Pathology and Radiology Reports ☐ All the Above ☐ Other _____

I have the right to revoke this authorization at any time unless an organization/provider/person has already released information in reliance upon having it. This authorization and consent will expire upon written notice.
I understand that the organization/provider/person names in this authorization cannot refuse to treat me if I do not sign.

_____ _____/_____/_____
Signature of Patient or Legal Representative Date

_____ _____
Printed Name Relationship if not Patient

☐ If other than the patient's signature, a copy of legal documentation is attached, if applicable.
☐ For deceased patient: a death certificate along with executor or administrator of estate paperwork is attached, if applicable.

MONTESOL MEDICAL CENTERS

PHOTOGRAPH/VIDEO RELEASE CONSENT FORM

I hereby grant MonteSol Medical Centers permission to the rights to use photographs and/or video recordings of me for educational and/or advertising purposes by MonteSol Medical Centers and may be displayed within our office and/or on the office's webpage, www.montesolmedicalcenters.com. The doctors and office staff will protest patient's personal data such as name, age and date of birth from being displayed.

I understand that my image may be edited, copied, exhibited, published or distributed and waive the right to inspect or approve the finished product wherein my likeness appears. Additionally, I waive any right to royalties or other compensation arising or related to the use of my image or recording. I also understand that this material may be used in diverse educational settings within an unrestricted geographic area.

I will be consulted about the use of the photographs or video recording for any purposes other than those listed above. There is no time validity of this release nor is there any geographic limitation on where these materials may be distributed.

By signing this form, I acknowledge that I have completely read and fully understand the above release and agree to be bound thereby. I hereby release, acquit and forever discharge MonteSol Medical Centers, its current and former physicians and employees of the above-named entities from any and all claims, demands, rights, promises, damages and liabilities arising out of or in connection with the use of distribution of said photographs and/or video recordings, including but not limited to any claims for invasion of privacy, appropriate of likeness or defamation.

CONSENT TO EMAIL OR TEXT USAGE FOR APPOINTMENT REMINDERS AND OTHER HEALTHCARE COMMUNICATIONS

Patients of MonteSol Medical Centers may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information.

☐ *(Patient Initials)* If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/ information at that email or text address from the Practice.

☐ *(Patient Initials)* I consent to receive text messages from MonteSol Medical Centers at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminder/feedback/health information unless I request a change in writing.

_____ _____/_____/_____
Signature of Patient or Legal Representative Date

_____ _____
Printed Name Relationship if not Patient

_____ _____/_____/_____
Signature of Witness Date

_____
Witness Printed Name

MONTESOL MEDICAL CENTERS

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: The undersigned patient agrees that any dispute regarding the care and treatment or medical services provided by MonteSol Medical Centers, LLC and its physicians and employees (collectively "MonteSol Medical Centers"), including any claim that services rendered were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to binding arbitration as provided by Florida law, and not by a lawsuit or resort to court process except as Florida law provides for judicial review of arbitration proceedings.

Article 2: All Disputes Must be Arbitrated: It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to the care and treatment or medical services provided by MonteSol Medical Centers including claims brought by 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. In the case of any pregnant mother, the term "patient" herein shall mean the mother and the mother's expected child or children. This agreement includes all claims against MonteSol Medical Centers, its employees and physicians, and all affiliated group practice physicians, partners, associates, clinicians, association, corporation or partnership, and the employees, agents and estates of any of them. All such claims and disputes must be arbitrated including, without limitation, all claims for damages, loss of consortium, wrongful death, emotional distress and consequential or punitive damages.

Article 3: Notice and Demand for Arbitration: Patient must provide not less than a sixty (60) day advance written notice and demand for arbitration. Such notice and demand for arbitration must be submitted in writing by certified or registered mail to the following address:
2669 Forest Hill Blvd, Suite 100, West Palm Beach, FL 33406
Attention: Corporate Manager

Article 4: Arbitration Procedure: Arbitration shall be conducted by a single arbitrator in accordance of the Rules of the American Arbitration Association. The parties consent to venue exclusively in Palm Beach County Florida and the parties agree that any dispute regarding the arbitrability of such claim or dispute shall be determined by such arbitration proceeding. Each party to the arbitration shall share equally in the expenses and fees of the arbitration, not including attorney's fees, witness fees, or other expenses incurred by a party for such party 's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract and the determination of the arbitrator shall be binding and enforceable by any state court of competent jurisdiction.

Article 5: General Provisions: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable Florida statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the Florida Code of Civil Procedure provisions relating to arbitration. If any provision if this arbitration agreement is held invalid of unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.
I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.
NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY DISPUTE REGARDING YOUR HEALTHCARE TO BE DECIDED BY BINDING ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL.

_____ _____/_____/_____
Signature of Patient or Legal Representative Date

_____ _____
Printed Name Relationship if not Patient

A signed copy of this document is to be given to the patient. Original is to be filed in the patient's medical records.