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

**PATIENT CONSENTS**

Completion of the following sections provides consent for representatives of Neil A. Patterson, MD.PA to perform certain actions. Please review carefully.

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**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**

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**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**

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**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.*

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**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.*

_____ _____

Signature of Patient or Legal Guardian Date

_____ _____

Print name of patient Print name of legal guardian