ROYAL PALM BEACH MEDICAL GROUP
11903 Southern Blvd, #108, Royal Palm Beach, FL 33411
*561-793-1475 * RPBmedical.com*

NEW PATIENT INFORMATION
*****PLEASE COMPLETE ENTIRELY*****

WELCOME TO OUR OFFICE!

TODAY'S DATE	DATE OF BIRTH

PATIENT'S LAST NAME (PLEASE PRINT)	PATIENT'S FIRST NAME	MARITAL STATUS	GENDER	AGE
		S M W D SEP	M F	

HOME STREET ADDRESS 1	HOME ADDRESS 2/ APT NUMBER	CITY	STATE	ZIP

CELL PHONE	HOME PHONE	BUSINESS PHONE/ EXTENSION	EMAIL ADDRESS

EMPLOYER'S NAME	EMPLOYER'S STREET ADDRESS	EMPLOYER'S CITY	EMPLOYER'S STATE	ZIP

OCCUPATION	RELIGION	HOW LONG AT CURRENT EMPLOYER	SOCIAL SECURITY# (REQUIRED)
		YEARS	

DO YOU HAVE: LIVING WILL | POWER OF ATTORNEY | HEALTHCARE SURROGATE | DO NOT RESUSCITATE (DNR) ORDER? (ASK ATTORNEY)

LIVING WILL	POWER OF ATTORNEY	HEALTHCARE SURROGATE	DNR ORDER	
Y N	Y N	Y N	Y N	*PLEASE PROVIDE US A COPY. THANK YOU!*

SIGNIFICANT OTHER NAME:		PARENT NAME:	
PHONE NUMBER:		PHONE NUMBER:	

CIRCLE ALL THAT APPLY: CAUCASIAN HISPANIC AFRICAN-AMERICAN SOUTH ASIAN EAST ASIAN NATIVE AMERICAN ASHKENAZI
OTHER:____________________

HOW WERE YOU REFERRED?	NAME/ADDRESS/CITY/STATE/ZIP OF PERSON REFERRING	ANY FAMILY TREATED HERE?
		Y N

LAST NAME OF POLICY HOLDER	HOLDER'S FIRST NAME	HOLDER'S SOCIAL SECURITY#	HOLDER'S DRIVERS LIC.#	RELATIONSHIP

HOLDER'S STREET ADDRESS/ PERSON RESPONSIBLE	HOLDER'S CITY	HOLDER'S STATE	ZIP

NAME OF PRIMARY INSURANCE	HMO	PPO	EFFECTIVE DATE	POLICY#	GROUP#
NAME OF SECONDARY INSURANCE	HMO	PPO	EFFECTIVE DATE	POLICY#	GROUP#

DO YOU HAVE MEDICARE? Y N	DO YOU HAVE MEDICAID? Y N
EFFECTIVE DATE:	EFFECTIVE DATE:

Insurance Authorization and Assignment of Benefits

ALL CHARGES ARE DUE AT THE TIME SERVICES ARE RENDERED AND THE RESPONSIBILITY OF THE PATIENT (OR GUARDIAN). REGARDLESS OF INSURANCE COVERAGE, IT IS REQUIRED PATIENT PAY COPAY, DEDUCTIBLE AND COINSURANCE PRIOR TO THE VISIT. I REQUEST THAT PAYMENT OF AUTHORIZED INSURANCE COMPANY BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF FOR ANY SERVICES FURNISHED ME BY THAT PARTY WHO ACCEPTS ASSIGNMENT. I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION AND HEALTH CARE FINANCING ADMINISTRATION OR INTERMEDIARIES OR CARRIERS OR ANY OTHER INSURANCE COMPANY ANY INFORMATION NEEDED FOR THIS OR OTHER RELATED CLAIM I UNDERSTAND THAT MY SIGNATURE REQUESTS THAT PAYMENT BE MADE AND AUTHORIZE RELEASE OF MEDICAL INFORMATION NECESSARY TO PAY THE CLAIM TO ROYAL PALM BEACH MEDICAL GROUP, LLC AND/OR DR. BRAD LIPSON, D.O. TO PROVIDE TREATMENT.

SIGNATURE:________________________________ DATE: ____________________
(OF AUTHORIZED POLICY HOLDER/ PERSON RESPONSIBLE FOR PAYMENT)

ROYAL PALM BEACH MEDICAL GROUP * 11903 Southern Blvd #108, Royal Plm Bch, FL 33411 * (561) 793-1475 * rpbmedical.co

TO BE FULLY COMPLETED BY PATIENT- PLEASE PRINT CLEARLY

HEALTH QUESTIONNAIRE

Version May 20

PATIENT'S FIRST NAME: LAST NAME: BIRTH DATE: / /

REASON FOR VISIT: TODAY'S DATE: / /

(if pain, then explain what triggers/improves it, what you have tried, other symptoms with i

CURRENT CONCERNS:

PRIMARY LANGUAGE? ☐ ENGLISH ☐ OTHER, BELOW:

PLEASE FOLLOW THE LINES ACROSS THE PAGE AND MARK THE APPROPRIATE BOXES:

FAMILY HISTORY (CIRCLE)	ALIVE & WELL	DECEASED	CAUSE OF DEATH (AGE)	HIGH BLOOD PRESSURE	HEART DISEASE OR STROKE	DIABETES	CANCER (PLEASE LIST TYPE)	ARTHRITIS OR AUTOIMMUNE DISEASE	KIDNEY DISEAS OR DIALYSIS
FATHER									
MOTHER									
BROTHER /SISTER									
BROTHER /SISTER									
BROTHER /SISTER									
BROTHER /SISTER									
MOTHERS' RELATIVES									
FATHERS' RELATIVES									

HOSPITAL or SURGERIES

Indicate the dates you were in the ER or admitted and the name of the hospital as well as the reason

e.g. TONSILS? APPENDIX? HERNIA? BIOPSY/CANCER? GALLBLADDER? SCOPES? EPIDURAL? STRESS TESTING? HEART STENT

Date	*Illness /procedure / location / doctor/surgeon name*		

LIST OF YOUR CURRENT MEDICATIONS AND VITAMINS /ANY OVER-THE-COUNTER SUPPLEMENTS (Aspirin, Advil, Tylenol, Fish Oil, Vitamin D)

NAME (and number of pills a day)	DOSE	HOW OFTEN	NAME	DOSE	HOW OFTEN

PLEASE LIST ANY ALLERGIES YOU HAVE (MEDICATIONS, POLLEN, FOODS, PENICILLIN, IODINE, SULFA, MILK, NUTS): PATIENT TO FILL OU

MEDICAL HISTORY FOR PATIENT — Mark (C) for Current problems. Check (√) the box and indicate the age when you had the following:

☐ decreased hearing ☐ runny nose
☐ ringing ear ☐ dizzy spells
☐ ear infections ☐ watery eyes
☐ glaucoma ☐ cataracts
☐ vision change: ☐ double ☐ blurry
☐ nose bleeds ☐ sinusitis
☐ eye infections ☐ itchy skin
☐ sore throats ☐ stuffy nose
☐ hay fever ☐ sneezing
☐ hoarse voice ☐ scratchy throat
☐ pneumonia ☐ pleurisy
☐ bronchitis ☐ emphysema
☐ less active due to *breathing*
☐ cough with mucus ☐ wheeze
☐ lifetime use > 100 cigarettes
☐ asthma ☐ inhaler use__#/week
Shortness of breath...:
☐ ..with activity ☐ ..lying flat
☐ ..palpitations ☐ ..always
☐ Chest pain ☐ pressure
☐ high blood pressure
☐ heart murmur ☐ valve problem
☐ LIST ALL OTHER PAST MEDICAL PROBLEMS HERE:

☐ irregular pulse
☐ fainting ☐ passing out
☐ swollen ankles/ feet
☐ leg pain with walking
☐ varicose vein ☐ blood clot
☐ appetite loss
☐ difficulty reading
☐ hard to swallow ☐ drink
☐ heartburn ☐ indigestion
☐ nausea ☐ vomiting
☐ stomach ulcers ☐ pain
☐ abdominal bloat ☐ cramp
☐ change in bowel habits
☐ diarrhea ☐ blood in stool
☐ constipated ☐ diverticulitis
☐ blood in urine ☐ burning
☐ hernia ☐ skin/eye yellow
☐ liver disease ☐ rashes
☐ change in urination
☐ kidney stones ☐ side pain
☐ childhood illness:

☐ straining or incomplete urine
☐ waking up to urinate__# times
☐ gall bladder pain ☐ gallstones
☐ hemorrhoid ☐ internal ☐ external
☐ chronic fatigue ☐ anemia
☐ cancer ☐ easy bruising
☐ thyroid ☐ spinning ☐ vertigo
☐ diabetes ☐ Insulin use
☐ balance issue ☐ hard to walk
☐ stroke ☐ seizures ☐ gout
☐ heart attack ☐ low iron
☐ numbness ☐ tingling ☐ falls
☐ headache:frequency__#/week
☐ arthritis ☐ toe/ foot pain
☐ back pain- recurrent
☐ fracture ☐ joint injury
☐ recent hair loss ☐ lupus
☐ cold or numb feet ☐ hives
☐ skin ulcer ☐ slow healing

IMMUNIZATIONS: DATE OF LAST-

____FLU	____TETANUS
____HEPATITIS B	____HEPATITIS A
____PNEUMONIA	____MENINGITIS
____SHINGLES	____MEASLES
____HPV/GARDASIL	____PERTUSSIS

☐ nervousness ☐ anxiety
☐ hard to fall/ ☐ stay asleep
☐ snoring ☐ dry mouth
☐ napping ☐ panic attacks
☐ erection problem
☐ libido /low sex drive
☐ lack of motivation
☐ moodiness ☐ depression
☐ bipolar disorder ☐ ADHD
☐ psychosis ☐ schizophrenia
☐ STDs/ sexual infections:
☐ herpes ☐ chlamydia
☐ gonorrhea ☐ warts
☐ syphilis ☐ HIV/AIDS
☐ Hepatitis ☐ HPV
☐ measles ☐ mumps
☐ rheumatic ☐ scarlet fever
☐ rheumatoid arthritis ☐ lupus
☐ psoriasis ☐ eczema
☐ polio ☐ tuberculosis
☐ Domestic Violence history
☐ Sexually Active
☐ CAFFEINE ____#cup/day
☐ ALCOHOL____#oz/day
☐ SMOKING____#pack/day
-For _____# years
☐ STREET DRUG USE –list:

DATE /RESULT OF LAST
COLONOSCOPY:______
ENDOSCOPY:________
BONE DENISTY:_______
LUNG/HEART TESTS:___
FEMALES: Age 1st period:
Date of last PAP:_______
☐ normal ☐ abnormal
Last Mammogram:______
☐ normal ☐ abnormal
MENSTRUAL HISTORY:
☐ regular ☐ irregular
☐ pain ☐ cramping
☐ discharge ☐ itching
☐ hot flash ☐ menopause
☐ loss of urine ☐ odor
☐ gestational diabetes
☐ pregnancy complications
#PREGNANCIES: ______
#MISCARRIAGES: _____
#LIVE BIRTHS: _______
☐ use glasses ☐ contacts
☐ colorblind ☐ hearing aids
☐ interested in supplemen
#vegetable/fruit a day:____
#day/week exercise:____
#min/day exercise:______

PLEASE LIST THE NAMES OF ALL PRIOR DOCTORS YOU HAVE SEEN IN THE PAST:
(include Specialty/Phone/Fax numbers)- you may continue on back:

Family History Questionnaire for Common Hereditary Cancer Syndromes

Patient Name: ______________________ Physician: ______________________

Date Completed: ______________________ Date of Birth: ______________________

Please mark below if there is a *personal or family history* of any of the following cancers. If yes, then indicate family relationship and *age at diagnosis* in the appropriate column. Consider parents, children, brothers, sisters, grandparents, aunts, uncles, and cousins.

	YOU	Age at Diagnosis	SIBLINGS/ CHILDREN	Age at Diagnosis	MOTHER'S SIDE	Age at Diagnosis	FATHER'S SIDE	Age at Diagnosis
For exaple: Colorectal cancer	*none*	—	*Brother*	*36 yrs*	*Aunt* *Cousin*	*44 yrs* *58 yrs*	*Grandfather*	*65 yrs*
BREAST AND OVARIAN CANCER								
Breast cancer								
Ovarian cancer								
Breast cancer in both breasts OR multiple primary breast cancers								
Male breast cancer								

Are you of Ashkenazi Jewish descent? ☐ Yes ☐ No

	YOU	Age at Diagnosis	SIBLINGS/ CHILDREN	Age at Diagnosis	MOTHER'S SIDE	Age at Diagnosis	FATHER'S SIDE	Age at Diagnosis
COLON AND UTERINE CANCER								
Uterine (endometrial) cancer								
Colorectal cancer								
Ovarian, stomach, kidney/urinary tract, brain, OR small bowel cancer								
10 or more cumulative colon polyps								
MELANOMA								
Melanoma								
Pancreatic cancer								
OTHER CANCER								
______________								

HAVE YOU OR ANY MEMBER OF YOUR FAMILY EVER BEEN TESTED FOR HEREDITARY RISK OF CANCER?

☐ Yes ☐ No If yes, please explain: ______________________

FOR OFFICE USE ONLY

☐ Patient appropriate for further risk assessment and/or genetic testing
- ☐ BRAC*Analysis*® – A test for Hereditary Breast and Ovarian Cancer Syndrome
- ☐ COLARIS® – A test for Lynch Syndrome (Hereditary Nonpolyposis Colorectal Cancer)
- ☐ COLARIS *AP*® – A test for Adenomatous Polyposis Syndromes
- ☐ MELARIS® – A test for Hereditary Melanoma

☐ Discussed hereditary cancer risk with patient
☐ Patient offered genetic testing
- ☐ ACCEPTED ☐ DECLINED

☐ Follow up appointment scheduled
Date: ______________

Myriad Genetic Laboratories, Inc. • 320 Wakara Way • Salt Lake City, UT 84108-1214 • 1-800-469-7423 • www.myriadtests.com
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MYRIAD

Royal Palm Beach Medical Group

PATIENT'S REQUEST FOR MEDICAL SERVICES **(PLEASE COMPLETE FULLY)**

Perhaps you have heard reports of a **"malpractice crisis."** Lawsuits can be costly, time-consuming and distracting. This form is for the patients requesting medical care by **Royal Palm Beach Medical Group** and its employees, subsidiaries, and or affiliates, including but not limited to **Brad Lipson DO, Cynthia Post PA, Laura Ballard ARNP, Nadine Clark ARNP** (jointly and severally, the "Clinic"). Feel free to decline to sign this form and see a different doctor. You may freely use your cell phone or our phone to call anyone for advice in filling out this form. **NOTE:** Patients initials and signature may be submitted by the PROVEN DOCUMENTED "Medical Power of attorney initials and signature." (Only if the patient is currently medically incapacitated to make medical or sound decisions). A copy of the official legal document proving Medical Power of Attorney must be furnished at the time this document is filled out, so as to be put on the patients chart for our records. By having the Medical Power of Attorney sign this, it is understood that the patient is unable to make any decisions medically on their behalf, now or in the future.

Are you having an emergency at this time? **(write yes or no)** _____ **Patients Initials:** ____ If the answer is "yes", then stop no and request emergency help immediately.

Have you or a spouse/family member ever been involved with a or filed a lawsuit against any entity? (Especially against a hospital, medical Clinic or physician) **(write yes or no)** _____ **Patients Initials:** ____

I agree to limit any claim relating to any diagnosis, treatment, or care by the Clinic to $250,000 for all non-economic damages, including pain and suffering or inconvenience:
Patients Initials: ____

I agree to waive my legal rights to any and all future and past claims against the Clinic/physician that are deemed to be an act of non-compliance regarding medical care documented in my chart.
Patients Initials: ____

In the event I assert a claim against the Clinic and it is denied, then I agree to pay for the reasonable attorney and expert fees of the Clinic's defense.
Patients Initials: ____

I ______________________________, request services from the Clinic in full agreement with and understanding of the above. I do not rely on any oral representations by anyone on staff in completing this form and am not under any pressure to sign. This form applies to all past and future services rendered by the physician/clinic and shall bind me and my heirs, legal representatives and assigns. Each provision shall be severable from the remainder and enforceable to the fullest extent of the law. By signing below I also acknowledge that fact that Dr. Lipson has opted NOT TO CARRY MEDICAL MALPRACTICE INSURANCE and I fully comprehend this fact.

Patient's (or Medical Power of Attorney) **SIGNATURE** ______________________________ **DATE:** ____________
Patient's (or Medical Power of Attorney) **PRINTED NAME:** ______________________________

Staff member signature ______________________ Date: ______________________
Staff member printed name: __________________________

11903 Southern Blvd. Suite 108 Royal Palm Beach, Florida 33411
Phone 561-793-1475 Fax 561-793-1478
Website: http//www.rpbmedical.com

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights- You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices- You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures- We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.
Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.
Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.
Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Other Instructions for Notice

- Effective June 16, 2015

Signed this________________________day of________________20

Print Patient Name:____

Signature:____

Relationship to Patient-CIRCLE ONE: Self or__________________________

Cancellation/No Show Policy

Royal Palm Beach Medical Group requires a 24 hour notice for cancelling an appointment. Failure to contact our office within 24 hours of your appointment or if you no-show an appointment can result in a $20.00 charge. This charge will not be covered by your insurance.

We reserve the right to cancel or reschedule an appointment if you are more than 10 minutes late.

Thank you for your cooperation. It is our belief that this policy will help us to better serve each of our patients fairly and respectfully.

____________________	____________________
Patient Signature	Date

Royal Palm Beach Medical Group

11903 Southern Blvd. Suite 108

Royal Palm Beach, FL 33411

Controlled Substances Prescription Physician-Patient Agreement

Patients Name: ______________________________

Address: ______________________________

Phone Number: ______________________________

Pharmacy Number: ______________________________

Conditions of Agreement

It is understood by the above patient that **ALL** prescriptions renewals for controlled substances must be anticipated in a timely manner by the patient, that is within 3 (three days) of prescription expiration or exhaustion in order to obtain a renewal if deemed medically appropriate by the physician Refills may be given for **no more** than a month's supply at any refill date. A patient must be seen at **least every 3 (three months)** to continue to receive medications refills.

The patient is responsible for informing the physician within this time period either in person at a follow up visit by telephone during **regular working hours (9am-5pm)**. After hours, weekend and holiday requests **will not be considered under any circumstances.** Do not even call our service with this request.

The patient **must** use or trade with only **one** pharmacy regarding the Controlled Substances so as to facilitate this agreement. Pharmacy "hopping" will not be tolerated.

Please safeguard your medication against theft. Please lock up your medication cabinet, car or checked baggage. **LOST, STOLEN OR MISPLACED NARCOTICS WILL NOT BE REPLACED.** Do not

exceed the prescription directions, do not give your medicine to friends or family. **WE WILL NOT RENEW PRESCRIPTIONS EARLY.**

At the physician's discretion, periodic patient urine and/or blood toxicology drug screens for controlled substances may be ordered to substantiate patient compliance and adherence with the above.

Should the patient receive controlled substances, such as **NARCOTICS & SEDATIVES**, from other physicians, this office **must** be informed by the patient **within 72 hours (3 days)** of having filled the prescriptions. The following information will be given to this office. The physician's name and telephone number, the pharmacy's name and telephone number, and the medical reason for the controlled substances.

Should the patient not adhere to or otherwise violate the above agreement or furnish false information then the patient will be discharged from our medical care with a 2 (two) weeks' notice being given immediately, in writing, sent to the above address. It will be the patient's responsibility to inform this office of any change in address or insurance information.

Medication	**Dose**	**Frequency**
____________	____________	____________
____________	____________	____________
____________	____________	____________
____________	____________	____________
____________	____________	____________

I have read and completely understand the above agreement.

____________	____________	____________
Patient Signature	Date	Patient's Physician

BRAD LIPSON, DO
ROYAL PALM BEACH MEDICAL GROUP

11903 Southern Blvd, Suite 108, Royal Palm Beach, Florida 33411 * (561) 793-1475 * fax (561) 793-1478

REQUEST FOR RELEASE OF MEDICAL RECORDS

DATE: ______________________

✓ I, ____(Patient's Name) hereby authorize:
(LIST **ALL PRIOR DOCTORS, ER/ HOSPITALS, & URGENT CARE)**

✓ ____
(Physician's Name)

____
(Address)

____
(State) (Zip Code)

____
(Telephone) (Fax)

to release any/all information with respect to any illness including mental illness, drug or alcohol abuse and HIV-AIDS testing or treatment and copies of all applicable records that may be requested to:

Royal Palm Beach Medical Group, LLC
Dr. Brad Lipson, DO
11903 Southern Blvd, Suite 108
Royal Palm Beach, Florida 33411
FAX# 561-793-1478

(Patient's Signature) ____

✓ ____
(Address) (City)

PLEASE FILL OUT COMPLETELY

____
(State) (Zip Code)

✓ ____
(Telephone)

✓ ______________________ ______________________
(Date of birth) (Social security number)

The information contained is confidential & privileged and is only intended for the use of the recipient listed above. Other use of this information is strictly prohibited. If you have received this in error, please call 561-793-1475 immediately and destroy the information.