**PATIENT / CLIENT INFORMATION**

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Full Name:

Patient Email:

Date of Birth:

Phone Number Cell:

Address:

City, State, Zip:

Gate Code/Parking info:

**MEDICAL INFORMATION**

Current Medications:

Allergies:

Pharmacy Name:

Pharmacy Address:

Pharmacy Phone Number:

Support Network / Emergency Contact Information:

How did you hear about us:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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*Please include your pharmacy information OR a pharmacy of choice and we will look up the one with closest proximity to your home*

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**CONFIDENTIAL PATIENT SERVICE AGREEMENT**

THIS AGREEMENT (the “Agreement”) is made and entered into as of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (the “Effective Date”) between Palm Beach Wellness Institute (“PBWI”) and \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (the “Client”).

This document is filled out and signed by: Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**BACKGROUND INFORMATION**

This document has been prepared for the benefit of **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.** PBWI is a provider of addiction medicine, recovery, and wellness services, and the Client seeks such services from PBWI. This agreement details the services, fees, and mutual acknowledgments associated with the Client’s engagement of PBWI to provide those addiction medicines, recovery, and wellness services determined by PBWI to be in the Client’s best interest. This Agreement constitutes the arrangements upon which PBWI has agreed to undertake care of the Client for the provision of addiction medicine, recovery, and wellness services. Please review it carefully. PBWI shall commence providing addiction medicine, recovery, and wellness services set forth below upon the Client’s intake to PBWI. The Effective Date set forth above aligns with the client’s intake to PBWI, and commencement of PBWI’s addiction medicine, recovery, and wellness services for the benefit of **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.**

**THE AGREEMENT**

In consideration of the mutual promises contained herein, PBWI and Client each agree as follows:

1. **Managing Physician:** Karen Flannery, M.D., will be the Client’s “Managing Physician” on behalf of PBWI. Although other recovery and wellness professionals may be involved in handling the Client’s care, Dr. Flannery shall be the Client’s main point of contact regarding the Client’s relationship with PBWI.
2. **Fees:** PBWI’s hourly rate for concierge physician services is $650. For the physician in-person visit, travel time, communication via phone call, text, video conferencing, or email it is billed at the same hourly rate. This may also include calls with other collaborating physicians, patients’ family members, referents, therapists, treatment centers, or others as appropriate. PBWI’s hourly rate for ancillary recovery and wellness services varies depending on the service and provider. For recovery and wellness services, travel time is billed at the current federal rate per mile. Communication via phone call, text, video conferencing, or email is billed at the same hourly rate

PBWI represents and warrants to the Client that all professionals providing services on behalf of PBWI shall be appropriately licensed by the State of Florida to provide such services.

1. **Scheduling:** PBWI requires twenty-four (24) hours advance notice by the Client for rescheduling or cancellation of any appointment unless otherwise noted on a prepaid invoice. Any appointment that is canceled by the Client without such notice will be charged at the full rate.
2. **Billing:** All such services set forth herein shall be billed in fifteen (15) minute increments. Invoices for services are the product of the hours worked multiplied by the hourly rates of the person providing services at the time the work is performed. PBWI’s invoices generally will be prepared and charged to card on file on a weekly basis. If you prefer an alternate form of payment, please make prior arrangements. The Client will be responsible for all fees and costs, including reasonable attorney's fees for any collection efforts undertaken by PBWI to collect any amounts owed under this Agreement which are past due.

**Please note that PBWI does not bill or accept any form of health insurance for the forementioned services.** Additionally, Dr. Flannery has opted out of CMS’ Medicare program. This means that neither the physician/ practice nor the beneficiary submits a bill to Medicare for services rendered. Instead, the beneficiary pays the practice out-of-pocket, and neither party is reimbursed by Medicare. By signing this agreement, the Client agrees to these terms as stated.

5. **Applicable Law and Venue:** The laws of the State of Florida shall govern the construction and interpretation of this agreement and each of PBWI and the Client agree that the venue of any lawsuit between them shall be in West Palm Beach, Palm Beach County, Florida.

6. **Binding Effect:** All the terms, covenants, warranties, and representation contained herein shall be binding upon and shall inure to the benefit of the successors, assigns, legal representatives, and heirs of each of PBWI and the Client. This Agreement is not effective upon PBWI unless and until it is fully executed by the Client.

7. EACH OF PBWI AND THE CLIENT HEREBY WAIVES TRIAL BY JURY and consents to all relief ordered by the court, after the time for appeal has expired.

By the Client’s signature below, the Client acknowledges that PBWI has addressed all questions and concerns the Client may have regarding PBWI’s provision of services on the Client’s behalf as of the Effective Date. In the event that the Client has questions regarding PBWI’s provision of addiction medicine, recovery, and wellness services on behalf of the Client at any time during the course of the Client’s treatment, PBWI will address those questions in a timely manner. For any billing questions, please contact:

**Telephone Number: 561-802-0929, Email: Info@pbwellnessmd.com**

The Client further acknowledges that the practice of addiction medicine, recovery, and wellness services is not an exact science and that no guarantees have been made about PBWI’s provision of services on behalf of the Client.

If this Agreement meets with the Client’s approval, kindly sign a copy of this letter, and return to us, at which time this Agreement will constitute the arrangement between the Client and PBWI with respect to the matters set forth herein.

Thank you for engaging PBWI, and we look forward to partnering with you on your path to recovery.

Sincerely,

Palm Beach Wellness Institute, PA

By: Karen Flannery, M.D.

IF THE CLIENT LACKS THE CAPACITY TO MAKE HIS/HER OWN HEALTHCARE DECISION: I HAVE BEEN DESIGNATED AS THE CLIENT’S HEALTHCARE SURROGATE PURSUANT TO FLORIDA STATUTES § 765.202. THE CLIENT HAS AUTHORIZED ME TO MAKE ALL HEALTHCARE DECISIONS ON HIS/HER BEHALF AND TO HAVE REASONABLE ACCESS TO HIS/HER HEALTH INFORMATION IN ORDER TO MAKE DECISIONS INVOLVING HIS/HER HEALTHCARE. I REPRESENT TO PBWI THAT THE CLIENT HAS NOT REVOKED HIS/HER DESIGNATION OF ME AS HIS/HER HEALTHCARE SURROGATE AND THAT I HAVE FULL POWER AND AUTHORITY TO ENTER INTO THIS AGREEMENT ON THE CLIENT’S BEHALF.

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Witness Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Cell Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Surrogate Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Surrogate Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Surrogate Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INSURANCE**

Even though we do not accept insurance, we recommend that you add a copy of your insurance to this form.

* In the event that labs, imaging or other testing is ordered, your insurance provider may cover it.
* In the event that Palm Beach Wellness Institute schedules an appointment with another practice, with your approval, we will provide your insurance information.

Please attach a copy of your insurance card here or email it to [Info@PBWellnessMD.com](mailto:Info@PBWellnessMD.com).

Should you have any questions, please feel free to reach out to us via phone at 561-802-0929 or via email at Info@PBWellnessMD.com

I do not have a medical insurance card

I do have a medical insurance card

Please attach a photo of your card here (front and back)

**CREDIT CARD INFORMATION**

Patients Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Card Holders Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CELL #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Card Type: MC Visa Discover American Express

Card Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Expiration Date: \_\_\_\_\_\_\_\_ CVV # \_\_\_\_\_\_ Billing Zip: \_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Card Holder Signature Todays Date

**CONSENT TO TREAT**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby request and consent to Palm Beach Wellness Institute to perform all clinical services and wellness services deemed necessary in the evaluation of program/client appropriateness. I acknowledge and understand that no promises or guarantees have been made to me regarding the outcome of my treatment plan by Palm Beach Wellness Institute and I do hereby release Palm Beach Wellness Institute from any liability in the event my treatment is unsuccessful, either in the short or long term.

I have been advised and understand that I will be under the care of the managing physician, or the physician assigned by Palm Beach Wellness Institute, and I give consent to all examinations, laboratory procedures, psychological testing, and other such similar procedures. Medical treatment shall be rendered under the order of the managing physician, or her designee.

In case of severe medical emergency, I have listed an emergency medical contact on a release form and do authorize Palm Beach Wellness Institute to contact that party should such an emergency occur. Further, I understand that, while under the care of Palm Beach Wellness Institute, the need for emergency treatment and/or transfer to a hospital may become necessary and appropriate. Should the need for such treatment and/or transfer be deemed necessary and appropriate by my managing physician, their providers, and designees, I consent to such emergency treatment and/or transfer to a hospital and indemnify, and hold harmless, Palm Beach Wellness Institute, its staff, or any physician who may be in attendance from any loss resulting from such emergency treatment and/or transfer.

I understand that Palm Beach Wellness Institute will not be responsible for any unknown medical conditions that may arise during treatment, even if they lead to sudden death, coma, or serious medical complications, and for which Palm Beach Wellness Institute shall be released from any liability thereon. I represent that I have fully discussed all of my medical conditions and all medications that I am taking with Palm Beach Wellness Institute and/or its contractors.

**CONSENT TO TELEMEDICINE**

I understand that telemedicine is the use of electronic technology for communication for the purpose of providing healthcare services wherever the doctor and the patient are located.

I understand that the institution is based in Florida and likewise uses telemedicine to conduct consultation with their patients.

I understand that with the use of telemedicine, the interaction shall be done through real-time audio-video communication.

I understand that the laws that protect privacy and confidentiality, as well as the confidentiality of medical information through the Health Insurance Portability and Accountability Act (HIPPA) also apply to telemedicine.

I understand that I will be responsible for any payments that apply to my telemedicine visit.

I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment; I have the right to privacy where it shall be necessary to seek my consent in order to disclose my information unless those that are permitted by law to disclose without the need of my consent.

I understand any lawsuit arising out of this agreement or service shall be brought to the courts of the state of Florida, to the exclusion of other states.

**With the pronouncements above:**

I authorize Palm Beach Wellness Institute to provide me their diagnosis, observations, recommendations regarding my condition through telemedicine.

Whenever necessary, I authorize Palm Beach Wellness Institute to consult with other physicians or specialists whom they believe to have full knowledge and skills that can address my case.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment. I have read and understood the information provided above, my rights, and obligations regarding telemedicine. I have had the opportunity to ask questions and all of which were answered to my satisfaction. Therefore, I hereby give my consent to the use of telemedicine for medical care.

**Approved and agreed to** this (Date) \_\_\_\_\_\_\_\_\_ by the undersigned:

Print \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If signer is not the Patient,

Print \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_