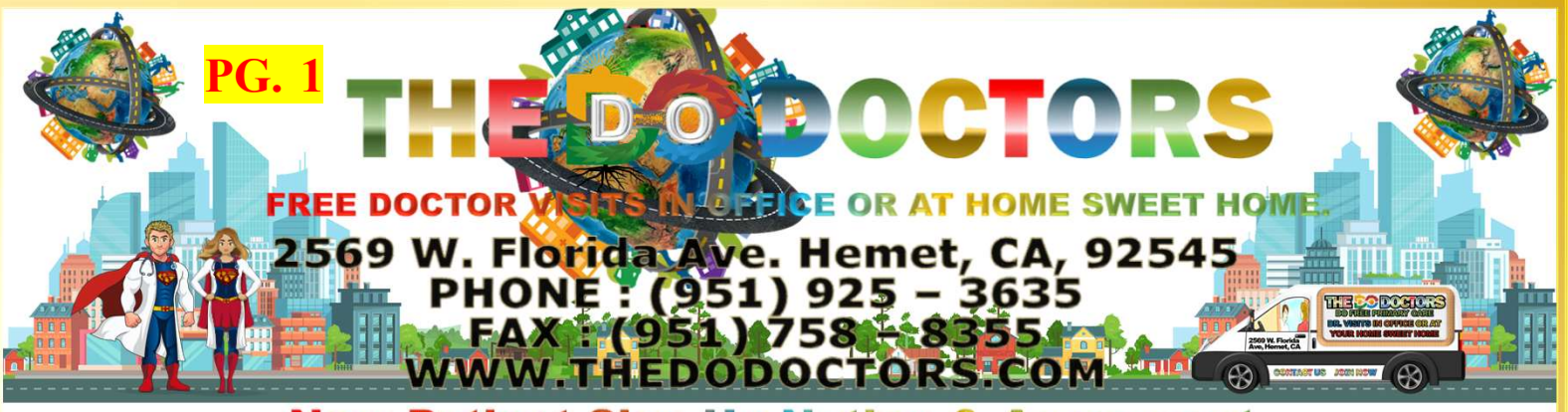

New Patient Sign-Up Notice & Agreement

Facility :_(If You Live In a Care Facility)_. Building # _____. R#_____. **Height/Weight** ____/____.
Last Name: _____. **First Name**: _____.
D.O.B: _____. **Address:** _____. **City:** _____.
Phone: _____. **Email**: _____.

MEDICATION ALLERGIES: (Section Required If None Write NKDA or check the Box) : **NO Allergies?** ☐

EMERGENCY CONTACT : YES ☐ **OR NO** ☐ **POWER OF ATTORNEY : YES** ☐ **OR NO** ☐

NAME: _____. **Relation:**_____. **Phone:**_____.

TREATMENT AND CONSULTATION AGREEMENT

• I consent and authorize all diagnostic testing and treatment according to the judgment of the Offices of David Perz, D.O. INC., The DO Doctors & their authorized representatives. I acknowledge no guarantees are, can, or will be made regarding insurance coverage, third-party service costs, or treatment outcomes. I accept full financial responsibility regardless of medical necessity, outcome, or insurance coverage determinations. I waive my right to dispute any financial obligations & I agree not to pursue legal action against David Perz, D.O. INC, The DO Doctors or their authorized representatives for costs related to all health services.

• I agree if being a mobile patient starting January or every alternate month, routine doctor visits can occur every 2-3 months. If the first visit doesn't align with this schedule a tele visit will be done to set the correct schedule. As needed visits will be either tele or in person based on the doctor's assesment of the patients needs. I understand that changing my treatment or healthcare plan without consulting with my doctor can pose risks. Therefore, I agree to discuss ***ANY & ALL HEALTHCARE SERVICES, PRODUCTS OR DECISIONS,*** such as ***HOSPICE, ALTERNATIVE TREATMENT, OR ANY OTHER TREATMENT CHANGES*** with the assigned primary care provider from The Offices of The DO Doctors or Dr. David Perz, D.O., before agreeing to make any changes or accept any treatment.

PATIENT ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

• I understand The Offices of Dr. David Perz, D.O. & The DO Doctors has certain legal duties to protect my Protected Health Information (PHI), and I have certain rights regarding my PHI.

AUTHORIZATION TO RELEASE INFORMATION

I Give permission to release medical information to (Person you want given Health updates) , Dr. David Perz, D.O. & The DO Doctors. By signing, I also give The Offices of Dr. David Perz, D.O. & The DO Doctors, permission to send & receive any information purposed to provide my care.
Specifically, please request medical records from: Previous Facility name/ Dr. Name.

Patient/Guardian Name: _____. **Date:** _____.

Patient/Guardian Sig.: _____.

PLEASE EMAIL OR FAX THIS FORM WITH YOUR MEDICATION LIST, INSURANCE & ID!