

**Palm Beach Women's Care
Daniel N. Sacks, MD, P.A.
3199 Lake Worth Road B-1
Boynton Beach, Florida 33461**

Acknowledgement And Authorization Form

Before signing any of the following, please make sure you read all the forms. By signing below you acknowledge that you have received this form. You are entitled to a copy of any of the forms, but in an effort to save the environment, we only require you to take a copy of our arbitration agreement.

I have received and read a copy of the financial policy:

_____ Initial

I have received and read a copy of the privacy policy:

_____ Initial

I have received and read a copy of the arbitration agreement:

_____ Initial

I have an advance directive or I have been given the opportunity to execute one today:

_____ Initial

I, _____, hereby authorize Palm Beach Women's Care to furnish any and all information as required by insurance companies to collect payment for medical services rendered to me. I direct the insurer to pay, without equivocation, directly to the physician, all benefits due for medical care rendered to me. I am aware that I am personally responsible for all charges. A photocopy of this authorization will be as valid as the original.

Signature of Patient/Legal Guardian

Date



“Under Florida law, physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. YOUR DOCTOR MEETS THESE REQUIREMENTS AND HAS DECIDED NOT TO CARRY MALPRACTICE INSURANCE. This is permitted under Florida law subject to certain conditions. Florida law imposes penalties against non-insured physicians who fall to satisfy adverse judgments arising from claims of medical malpractice. This notice is provided pursuant to Florida law.”

Signature of Patient/Legal Guardian

Date

Print Name