FORMULARIO DE SOLICITUD DEL PACIENTE

BIENVENIDO A NUESTRA CLÍNICA.

Nos especializamos en ayudar a nuestrospacientes a alcanzar su más alto nivel de salud a través de nuestros programascorrectivas posturales y espinales. Nuestro enfoque es muy avanzadas de otrosp rogramas de rehabilitación. Esto permite a nuestros pacientes a lograrresultados superiores en comparación con la mayoría de los otros sistemas.

Por favor llene la siguiente información cuidadosamente por lo que el médicopuede saber si usted es un caso que podemos aceptar. No dude en hacernoscualquier pregunta s i necesita ayuda. Esperamos poder servirle.

_____

Firma del paciente:

_____

Fecha actual:

_____

 # De archivos:

ENCUESTA DE APLICACIÓN PACIENTE

Fecha: _____

Nombre: _____ Edad: _____ Género: H M

Domicilio: _____ Teléfono de casa: ( ) _____

Ciudad, Estado, Código Postal: _____ Teléfono del trabajo: ( ) _____

Dirección de correo electrónico: _____ Teléfono celular: ( ) _____

Fecha de nacimiento: _____ / _____ / _____ Número de seguro social: _____ - _____ - _____ Estado civil: S M D W

Nombres de niños: _____ Edades: _____

Ocupación: _____ Nombre del empleador: _____

Nombre de cónyuge: _____ Teléfono del trabajo del cónyuge: ( ) _____

Celular del cónyuge: ( ) _____

Empleador del cónyuge: _____ Ocupación: _____

¿Cómo refirieron a esta oficina? _____

PROPÓSITO DE ESTA VISITA

Motivo de esta visita – principal queja:_____

¿Se relaciona este propósito con un accidente de auto / lesiones de trabajo? □ Si □ No Si, cuando: _____

¿Cuándo empezó esta afección? ___ / ___ / ___ Lo hizo comenzar: Gradual Súbito Progresivo con el tiempo

¿Las actividades que agravan sus síntomas? _____

¿Hay algo, que ha aliviado los síntomas? □ Si □ No Explique:_____

Tipo de dolor: Quemadura Aguda Dolor Sordo Palpitar Espasmo Entumecimiento Hormigueo Disparos

Hace que el dolor que irradie en tu: ___Brazo ___ Pierna ___ No irradia ¿Esta condición empeora? □ Si □ No

¿Con qué frecuencia experimenta estos síntomas durante todo el día?: 100% 75% 50% 25% 10% Sólo con la actividad

Dolencias interfiere con: __ Trabajo __ Dormir __ Pasatiempos __ Rutina Diaria Explicar: _____

¿Ha experimentado esta enfermedad antes?□ Si □ No Si es asi, por favor explique: _____

¿Que has visto esto? _____ ¿Qué hicieron?_____

¿Cómo respondió usted?_____

EXPERIENCIA CON LA QUIROPRÁCTICA

¿Has visto un quiropráctico antes de? □ Si □ No ¿Quién? _____ ¿Cuando? _____

Razón de visitas: _____

¿Cómo respondió usted? _____

¿Tomó su quiropráctico anterior antes y después de radiografías? □ Si □ No

¿Sabías que postura determina su salud? □ Si □ No

¿Sabes de alguno de sus hábitos de mala postura? □ Si □ No

Explicar: _____

¿Es usted consciente de cualquier hábito de mala postura en su cónyuge ohijos? □ Si □ No

Explicar: _____

La debilidad postural más común es el síndrome de cabeza hacia adelante (cabeza y cuello empezando a doblar hacia adelante y progresivamente moviéndose hacia abajo debilita su cuerpo entero). Las formas menos severas de esta posture pueden causar muchos efectos adversis en su salud en general. ¿Has alguna vez dicho o sentía como llevas tu cabeza hacia adelante, notó unredondeo de los hombros o en vías de desarrollo "joroba" en la base del cuello? Si No

ESTILO DE VIDA SALUD

¿Ejercitas? Si No ¿Con qué frecuencia? 1X 2X 3X 4X 5X por semana otros: _____

¿Qué actividades? Correr Trotar Peso Entrenamiento Ciclismo Yoga Pilates Piscina _____

¿Usted fuma? Si No ¿Cuánto? _____

¿Bebe alcohol? Si No ¿Cantidad / semana? _____

¿Toma café? Si No ¿Cuántas tazas / día? _____

¿Tomar cualquier suplementos (vitaminas, minerales, hierbas)?_____

CONDICIONES DE SALUD

Hábitos posturales anormales o distorsiones son el resultado de trauma o estrésal cuerpo que mal alineadas las vértebras en la columna vertebral. Cuando estas vértebras se tuercen desde su posición normal, causan estrés a lamédula espinal y los nervios delicados que pasan entre las vértebras. Estos desajustes se denominan subluxaciones (sub-lux-un-huye). Se ha documentatdo ampliamente que subluxaciones, causando estrés a losnervios, debilitará y distorsionar la estructura total de la columna vertebral. Estoresulta en una postura débil y distorsionada. Las distorsiones posturales tienenmuchos efectos adversos y graves sobre su salud en general. La mas común y prejudicial distorsión postural se llama síndrome de cabeza hacia adelante (un"encorvada hacia adelante" postura comenzando en el cuello y banjando progresivamente su columna debilitando todo el cuerpo).

Por favor indique cualquier condición de salud no mencionadas: _____

Por favor una lista de medicamentos está tomando y su propósito:_____

Por favor una lista de todos más allá de cirugías:_____

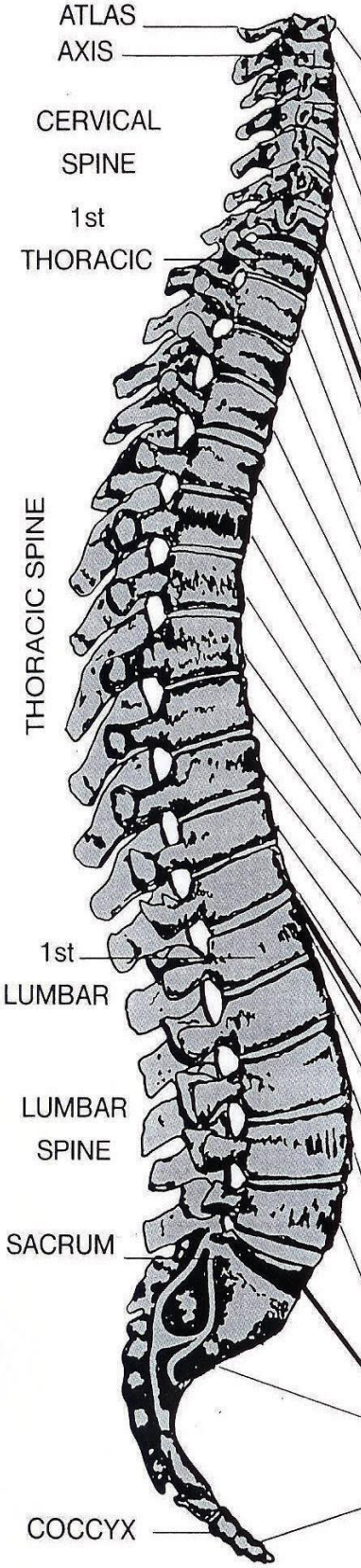
Por favor una lista de todos los anteriores accidentes y caídas: _____

Por favor comprueba alguna condición de salud que pueda estarexperimentando, ahora o en el pasado en la página siguiente.

SYMPTOMS OF SPINAL MISALIGNMENT QUESTIONNAIRE

"The nervous system controls and coordinates all organs and structures of the human body." (*Gray's Anatomy,* 29th Ed., page 4). Misalignments of spinal vertebrae and discs may cause irritation to the nerves which could affect the areas listed. Please help us help you by placing a check mark in the appropriate box under the "Possible Effects" column to indicate your symptoms.

Please Check Below



Vertebrae	Areas Controlled by Nerves*	Possible Effects of a Malfunction	
1C	Blood supply to the head, pituitary gland, scalp, bones of the face, brain, inner and middle ear, sympathetic nervous system.	☐ headaches, ☐ nervousness, ☐ insomnia, ☐ head colds, ☐ high blood pressure, ☐ migraine headaches, ☐ nervous breakdowns, ☐ amnesia, ☐ chronic tiredness, ☐ dizziness.	NECK REGION
2C	Eyes, optic nerves, auditory nerves, sinuses, mastoid bones, tongue, forehead.	☐ sinus trouble, ☐ allergies, ☐ pain around the eyes, ☐ earache, ☐ fainting spells, ☐ certain cases of blindness, ☐ crossed eyes, ☐ deafness.	
3C	Cheeks, outer ear, face bones, teeth, tri-facial nerve.	☐ neuralgia, ☐ neuritis, ☐ acne or pimples, ☐ eczema.	
4C	Nose, lips, mouth, eustachian tube.	☐hay fever,☐runny nose,☐hearing loss,☐adenoids.	
5C	Vocal cords, neck glands, pharynx.	☐ laryngitis, ☐ hoarseness, ☐ throat conditions such as sore throat or quinsy.	
6C	Neck muscles, shoulders, tonsils.	☐ stiff neck, ☐ pain in upper arm, ☐ tonsillitis, ☐ chronic cough, ☐ croup.	
7C	Thyroid gland, bursae in the shoulders, elbows.	☐ bursitis, ☐ colds, ☐ thyroid conditions.	
1T	Arms from the elbows down, including hands, wrists, and fingers; esophagus and trachea.	☐ asthma, ☐ cough, ☐ difficult breathing or shortness of breath, ☐ pain in lower arms and hands.	MID-BACK
2T	Heart, including its valves and covering; coronary arteries.	☐ functional heart conditions and certain chest conditions.	
3T	Lungs, bronchial tubes, pleura, chest, breast.	☐ bronchitis, ☐ pleurisy, ☐ pneumonia, ☐ congestion, ☐ influenza.	
4T	Gall bladder, common duct.	☐ gall bladder conditions, ☐ jaundice, ☐ shingles.	
5T	Liver, solar plexus, circulation (general).	☐ liver conditions, ☐ fevers, ☐ blood pressure problems, ☐ poor circulation, ☐ arthritis.	
6T	Stomach.	☐ stomach troubles or nervous stomach, ☐ indigestion, ☐ heartburn, ☐ dyspepsia.	
7T	Pancreas, duodenum.	☐ ulcers, ☐ gastritis.	
8T	Spleen.	☐ lowered resistance.	
9T	Adrenal and supra-renal glands.	☐ allergies, ☐ hives.	
10T	Kidneys.	☐ kidney troubles, ☐ hardening of the arteries, ☐ chronic tiredness, ☐ nephritis, ☐ pyelitis.	
11T	Kidneys, ureters.	☐ skin conditions such as acne, ☐ pimples, ☐ eczema, ☐ or boils.	
12T	Small intestines, lymph circulation.	☐rheumatism,☐gas pains, ☐certain types of sterility.	
1L	Large intestines, inguinal rings.	☐ constipation, ☐ colitis, ☐ dysentery, ☐ diarrhea, ☐ some ruptures or hernias.	LOW BACK
2L	Appendix, abdomen, upper leg.	☐ cramps, ☐ difficult breathing, ☐ minor varicose veins.	
3L	Sex organs, uterus, bladder, knees.	☐ bladder troubles, ☐ menstrual troubles such as painful or irregular periods, ☐ miscarriages, ☐ bed wetting, ☐ impotency, ☐ change of life symptoms, ☐ many knee pains.	
4L	Prostate gland, muscles of the lower back, sciatic nerve.	☐ sciatica, ☐ lumbago, ☐ difficult, painful, or too frequent urination, ☐ backaches.	
5L	Lower legs, ankles, feet.	☐ poor circulation in the legs, ☐ swollen ankles, weak ankles and arches, ☐ cold feet, ☐ weakness in the legs, ☐ leg cramps.	
SACRUM	Hip bones, buttocks.	☐ sacro-iliac conditions, ☐ spinal curvatures.	PELVIS
COCCYX	Rectum, anus.	☐ hemorrhoids (piles), ☐ pruritis (itching), ☐ pain at end of spine on sitting.	

*Directly or indirectly controlled

For further explanation of the conditions shown above, and information about those not shown, ask your Doctor of Chiropractic.

TERMS OF ACCEPTANCE

When a person seeks chiropractic and rehabilitation health care and is accepted for such care, it is essential for both parties to be working towards the same objective. As a Chiropractic facility we have one main goal, to detect and correct/reduce the vertebral subluxation complex. It is important that each person understand both the objective and the method that will be used to attain this goal. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express it's maximum health potential.

We do not offer to diagnose or treat a disease or condition other than vertebral subluxation. Regardless of what a disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **Our Only Practice Objective** is to eliminate a major interference to the expression of the body's innate wisdom and ability to heal. Our only method is specific adjusting to correct vertebral subluxations combined with rehabilitation procedures. NOTE: It is understood and agreed the amount paid to Hill Country Family Chiropractic for x-ray, is for examination only and the x-rays will remain the property of this office, being on file where they may be seen at any time while a patient of this office.

CONSENT TO CARE

You are the decision maker for your health care. Part of our role is to provide you with the information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use4 our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: Muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissection have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: Self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is no possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

I also clearly understand that if I do not follow the Doctors specific recommendations at this clinic that I will not receive the full benefit from the programs offered, and that if I terminate my care prematurely that all fees incurred will be due and payable at that time. I authorize the assignment of all insurance benefits be directed to the Doctor for all services rendered. I also understand any sum of money paid under assignment by any insurance company shall be credited to my account, and I shall be personally liable for any and all of the unpaid balance to the doctor.

I, _____, have read or have had read to me, the above consent. I have also had the opportunity to ask questions about this consent, and by signing below I agree to the above-above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions(s) for which I seek treatment.

Signature_____ Date _____ *(If under age 18) Parent's signature*

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.
Date of last menstrual cycle:_____

_____ _____
Signature Date

Consent to x-ray:

I hereby grant Hill Country Family Chiropractic permission to perform an x-ray evaluation if needed of _____. I understand that x-rays are being performed to locate vertebral subluxation, and not to diagnose or treat any other disease or condition.

_____ _____
Signature (parent if minor) Date

Consent to evaluate and adjust a minor child

I, _____ being the parent of legal guardian of _____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

_____ _____
Signature Date

Consent to Use Video Testimony Usage:

I, _____, hereby grant Hill Country Family Chiropractic permission to record and show my video testimony at their discretion.

_____ _____
Signature Date

INSURANCE INFORMATION

I clearly understand that all insurance coverage is an arrangement between my insurance carrier and me. If this office chooses to bill any services to my insurance carrier that they are performing these services strictly as a convenience for me. The Doctors office will provide any necessary report or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny any claim and that I am ultimately held responsible for any unpaid balances. Any monies received will be credited to my account. I certify that this office visit is not related to any personal injury or worker's compensation case that is active or that has not been closed and finalized.

Signature_____ Date _____
(If under age 18) Parent's signature

Electronic Health Records Intake Form

This form complies with CMS EHR incentive program requirements

First Name:_____ **Last Name**:_____

Email address: _____@_____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:** _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

Smoking Start Date (Optional): _____

Family Medical History ***(Record one diagnosis in your family history and the affected***				
Diagnosis (Write in below)	Father	Mother	Sibling: (_____)	Offspring: (_____)
Example: Heart Disease		*X*		

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) Native Hawaiian or Pacific Islander / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? *(Include regularly used over the counter medications)*	
Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?			
Medication Name	Reaction	Onset Date	Additional Comments

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature: _____ Date: _____

For office use only

Height: _____ Weight:_____ Blood Pressure:_____/_____

Acknowledgement of Receipt of Notice of Privacy Practices

1742 FM 2673
Canyon Lake, Texas 78133
Phone: (830) 964-3032
Fax: (830) 964-4460

I understand and have been provided with the opportunity to review a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- ❑ The right to review the notice prior to signing this consent,
- ❑ The right to object to the use of my health information for directory purposes, and
- ❑ The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations.

Texas Chiropractic Association Authorization

Your chiropractor and members of the practice staff may need to disclose your name, address, phone number, billing information and your clinical records to the Texas Chiropractic Association (TCA). This disclosure will be made if we need the TCA's assistance to receive reimbursement for your services or, we need the TCA's assistance because the party responsible for reimbursing your services has improperly processed your claim.

By signing this form you are giving us authorization to send the TCA this information. You are also giving the TCA authorization to re-disclose your information to the party responsible for the payment of your services, the TCA's legal counsel, and state or federal agencies that may be asked to intercede on your behalf.

Appointment Reminders and Health Care Information Authorization

Your chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not at home, a message will be left on our answering machine. By signing this form, you are giving us authorization to contact you with these reminders and information.

Patient Signature: Date:

If not signed by the patient, please indicate relationship.

- ❑ Parent or guardian of minor patient
- ❑ Guardian or conservator of an incompetent patient
- ❑ Beneficiary or personal representative of deceased patient

Name of Patient: _____

For Office Use Only:

Signed form received by: _____

Acknowledgement refused: (Efforts to obtain reasons for refusal)

_____
_____
_____

PATIENT NAME: _____

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process, except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. Further, he parties will not have the right to participate as a member of any class of claimants, and there shall be no authority for any dispute to be decided on a class action basis. An arbitration can only decide a dispute between the parties and may not consolidate or join the claims of other persons who have similar claims.
Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, as to whether this agreement is unconscionable, and any procedural disputes, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement binds all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider, including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and health care provider and/or other licensed health care providers, preceptors, or interns who now or in the future treat the patient while employed by, working or associated with or serving as back-up for the health care provider, including those working at the health care provider's clinic or office in any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdiction limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages. This agreement is intended to create an open book account unless and until revoked.
Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days, and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit. Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder, any existing court action against such additional person or entity shall be stayed pending arbitration. The parties agree that provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.
Article 4: General Provision: All claims based on the same incident, transaction, or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred but the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.
Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and, if not revoked, will govern all professional services received by the patient and all other disputes between the parties.
Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before that it is signed (for example, emergency treatment), patient should initial here _____. Effective as of the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

PATIENT SIGNATURE X _____ DATE _____

(Or Patient Representative) Indicate Relationship if Signing for Patient: _____

OFFICE SIGNATURE X _____ DATE _____