GORMAN MEDICAL, P.C.

8540 Scarborough Dr, Suite 370
Colorado Springs, Co 80920
Phone: 719-358-8270 Fax: 719-358-8299

NEW PRIMARY PATIENT REGISTRATION

Patient Printed Name: ____________________

Date of Birth: ____/____/____ Age: ______ Sex: Male ☐ Female ☐ SSN: ____________________

Address: ____________________ City: ____________________ State: ______ Zip: ________

Phone: Home: ________________ Cell/Text: ________________ Message: ________________

May we leave a message: Yes ☐ No ☐ Email: ____________________ Marital Status: __________

Employer: ________________ Occupation: ________________ Phone: ________________

Address: ____________________ City: ____________________ State: ______ Zip: ________

Emergency Contact Name: ____________________ Relationship: ________________

Phone: Home: ________________ Cell: ________________ Work: ________________

How did you hear about us: Family/Friend ☐ Internet ☐ Ad in Newspaper ☐ Physician Referral (If checked, see below) ☐

Physician Name: ____________________ Phone: ________________

Previous Primary Care Facility: ____________________

Previous Primary Care Physician: ____________________ Phone: ________________

Address: ____________________ City: ____________________ State: ______ Zip: ________

PRIMARY INSURANCE: ____________________

Identification Number: ________________ Group Number: ________________ Co-pay: s________

Please fill in the following information if the subscriber is NOT the patient:

Subscriber DOB: ____/____/____ Subscriber SSN: ____________________

SECONDARY INSURANCE: ____________________

Identification Number: ________________ Group Number: ________________ Co-pay: s________

Please fill in the following information if the subscriber is NOT the patient:

Subscriber DOB: ____/____/____ Subscriber SSN: ____________________

Signature of Patient or Authorized Individual: I authorize the release of medical or other information necessary to process all Government and/or commercial insurances. I authorize the payment of medical benefits to the attending physician or supplier for services rendered. I understand that I am financially responsible for all charges not paid by my insurance and/or worker's compensation carrier.

Abusive, unprofessional, uncontrolled behavior results in AUTOMATIC DISMISSAL from the practice

Patient Signature: ____________________ Date: ________________

SOCIAL HISTORY

Ever smoke? Yes ☐ No ☐ Currently smoking? Yes ☐ No ☐ Packs per day/week: ___ How many years: ___

Current smokers, are you ready to quit? Yes ☐ No ☐ **Former** smokers, what was your quit date? ___________

Drink alcohol? Yes ☐ No ☐ Per day: _________ Per week: __________ How many years: _________

Recreational Drug use? Yes ☐ No ☐ If yes, Explain: ____

____

Have you been or are currently being sexually abused, threatened, or hurt by anyone? Yes ☐ No ☐

PERSONAL HISTORY OF ILLNESSES

MAJOR ILLNESSES	YES (DATE)	NO
ASTHMA		
PNEUMONIA/LUNG DISEASE		
TUBERCULOSIS		
HEART ATTACK/PROBLEMS		
HIGH BLOOD PRESSURE		
STROKE		
BLOOD CLOTS IN THE LUNGS OR LEGS		
KIDNEY INFECTIONS/STONES		
SEXUALLY TRANSMITTED DISEASE		
HIV/AIDS		
THYROID DISEASE		
DIABETES		
EATING DISORDERS		
DEPRESSION/ANXIETY		
ARTHRITIS/JOINT PAIN/BACK PROBLEMS		
COLLAGEN VASCULAR DISEASE (LUPUS)		
CANCER		
REFLUX/HIATAL HERNIA/ULCERS		
HEPATITIS/JAUNDICE/LIVER DISEASE		
GALLBLADDER DISEASE		
COLITIS/CROHN'S DISEASE		
ANEMIA		
BLOOD TRANSFUSIONS		
MIGRAINE HEADACHES		
SEIZURES/CONVULSIONS/EPILEPSY		
OTHER		

INJURIES/ILLNESSES

CHECK HERE IF NONE- ☐

REASON	DATE OR YEAR	HOSPITAL

OPERATIONS/HOSPITALIZATIONS

CHECK HERE IF NONE- ☐

SURGERY/REASON	DATE OR YEAR	HOSPITAL

CURRENT MEDICATIONS

CHECK HERE IF NONE - ☐

(INCLUDING HORMONES, VITAMINS, HERBS, AND NON-PRESCRIPTION MEDICATION)

CURRENT MEDICATIONS	DOSAGE (mg) & TIMES PER DAY	DATE OF LAST FILL	PRESCRIBER

MEDICATION ALLERGIES OR OTHER ALLERGIES

CHECK HERE IF NONE- ☐

ALLERGY	TYPE OF REACTION

OBSTETRIC HISTORY

(FEMALES ONLY/MALES GO TO PAGE 6)

CHECK HERE IF NO PREGNANCIES- ☐

	NUMBER		NUMBER		NUMBER
PREGNANCIES		ABORTIONS		MISCARRIAGES	
PREMATURE BIRTHS		LIVE BIRTHS		LIVING CHILDREN	

#	BIRTHDATE	BIRTH WEIGHT	SEX	WEEKS PREGNANT	TYPE OF DELIVERY	COMPLICATIONS
1.						
2.						
3.						
4.						

GYNECOLOGIC HISTORY

DATE OF LAST MENSTRUAL PERIOD (FIRST DAY)		
AGE MENSTRUAL PERIODS BEGAN		
HOW OFTEN DO YOU GET YOUR MENSTRUAL PERIOD		
LENGTH OF YOUR MENSTRUAL PERIOD (NUMBER OF DAYS BLEEDING)		
	YES	NO
ANY RECENT CHANGES IN YOUR PERIODS?		
ARE YOUR MENSTRUAL PERIODS HEAVY?		
DO YOU BLEED BETWEEN MENSTRUAL PERIODS?		
DO YOU BLEED AFTER INTERCOURSE?		
DO YOU HAVE PAINFUL MENSTRUAL PERIODS?		
HAVE YOU HAD A SEXUALLY TRANSMITTED DISEASE (STD)		
HAVE YOU HAD PELVIC INFLAMMATORY DISEASE(PID)		
DATE OF LAST PAP TEST:		
WAS IT NORMAL?		
HAVE YOU EVER HAD AN ABNORMAL PAP TEST		
DO YOU HAVE PELVIC PAIN?		
DO YOU HAVE ENDOMETRIOSIS?		
DO YOU HAVE FIBROIDS?		
DO HAVE PAIN WITH INTERCOURSE?		
CURRENT METHOD(S) OF BIRTH CONTROL: ☐ BIRTH CONTROL PILLS ☐ DEPO PROVERA ☐IUD ☐NUVARING ☐TUBAL LIGATION ☐VASECTOMY ☐CONDOMS ☐ OTHER: __________		

REVIEW OF SYSTEMS

PLEASE MARK (X) IF ANY OF THE FOLLOWING SYMPTOMS APPLY TO YOU NOW OR SINCE ADULTHOOD. IF YOU ARE NOT SURE, PLEASE PUT A (?) NEXT TO THE SYMPTOM

	NO	NOW	PAST	NOTES
CONSTITUTIONAL				
FEVER	☐	☐	☐	
EYES				
DOUBLE VISION	☐	☐	☐	
VISION CHANGES	☐	☐	☐	
GLASSES/CONTACTS	☐	☐	☐	
SPOTS BEFORE EYES	☐	☐	☐	
EAR, NOSE, AND THROAT				
MOUTH SORES	☐	☐	☐	
HEARING LOSS	☐	☐	☐	
STREP THROAT	☐	☐	☐	
CARDIOVASCULAR				
CHEST PAIN	☐	☐	☐	
DIFFICULTY BREATHING ON EXERTION	☐	☐	☐	
SWELLING OF LEGS	☐	☐	☐	
RAPID OR IRREGULAR HEARTBEAT	☐	☐	☐	
RESPIRATORY				
WHEEZING/ASTHMA	☐	☐	☐	
SPITTING UP BLOOD	☐	☐	☐	
SHORTNESS OF BREATH	☐	☐	☐	
CHRONIC COUGH	☐	☐	☐	
GASTROINTESTINAL				
FREQUENT DIARRHEA	☐	☐	☐	
BLOODY STOOL	☐	☐	☐	
NAUSEA/VOMITING/INDIGESTION	☐	☐	☐	
CONSTIPATION	☐	☐	☐	
INVOLUNTARY LOSS OF GAS OR STOOL	☐	☐	☐	
GENITOURINARY				
BLOOD IN URINE	☐	☐	☐	
PAIN WITH URINATION	☐	☐	☐	
FREQUENT URINATION	☐	☐	☐	
MUSCULOSKELETAL				
MUSCLE WEAKNESS	☐	☐	☐	
MUSCLE PAIN/JOINT PAIN	☐	☐	☐	

	NO	NOW	PAST	NOTES
SKIN				
RASH	☐	☐	☐	
SORES	☐	☐	☐	
MOLES	☐	☐	☐	
ACNE	☐	☐	☐	
BREASTS				
LUMPS	☐	☐	☐	
NIPPLE DISCHARGE	☐	☐	☐	
NEUROLOGIC				
DIZZINESS	☐	☐	☐	
SEIZURES	☐	☐	☐	
SEVERE MEMORY PROBLEMS	☐	☐	☐	
FREQUENT OR SEVERE HEADACHES	☐	☐	☐	
SEVERE ANXIETY	☐	☐	☐	
WOULD YOU LIKE A REFERRAL TO A COUNSELOR? ☐ YES ☐ NO				
ENDOCRINE				
DRAMATIC WEIGHT CHANGE	☐	☐	☐	
EXCESS HAIR GROWTH OR LOSS	☐	☐	☐	
HOT FLASHES	☐	☐	☐	
DES EXPOSURE	☐	☐	☐	
DIABETES	☐	☐	☐	
HEAT OR COLD INTOLERANCE	☐	☐	☐	
ABNORMAL THIRST	☐	☐	☐	
HEMATOLOGIC/LYMPHATIC				
FREQUENT BRUISES	☐	☐	☐	
CUTS THAT DO NOT STOP BLEEDING	☐	☐	☐	
ENLARGED LYMPH NODES (GLANDS)	☐	☐	☐	
OTHER				
	☐	☐	☐	
	☐	☐	☐	
	☐	☐	☐	
	☐	☐	☐	
	☐	☐	☐	
	☐	☐	☐	
	☐	☐	☐	
	☐	☐	☐	

FAMILY HISTORY

RELATION	LIVING	DECEASED	AGE	CAUSE
MOTHER				
FATHER				
SIBLINGS				
CHILDREN				

ILLNESS	YES	WHICH RELATIVE(S)	AGE OF ONSET
DIABETES			
STROKE			
BLOOD CLOTS IN THE LUNGS OR LEGS			
HEART DISEASE			
HIGH BLOOD PRESSURE			
HIGH CHOLESTEROL			
OSTEOPOROSIS (WEAK BONES)			
RECURRENT MISCARRIAGE			
INFERTILITY			
BIRTH DEFECTS			
BREAST CANCER			
COLON CANCER			
OVARIAN CANCER			
UTERINE CANCER			
OTHER			

RADIOLOGY POLICY

To ensure you receive the best possible care here at Gorman Medical, **all** imaging/radiology orders sent by our providers, will be sent to **(CSI) Colorado Springs Imaging Center**. CSI is an independent, locally-owned diagnostic center that our practice prefers to work directly with due to their facility providing us with accurate results in a prompt, timely manner. If for any reason, you are unable to establish care with CSI, please discuss this matter with the provider. Imaging performed at any other facility is your (the patient's) responsibility to obtain the results and provide them to your provider. ______

Initials ↑

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

ACKNOWLEDGE OF RECEIPT OF PRIVACY NOTICE

Providers:

Charles H. Ripp, MD
Fran J. Gorman, DNP, MSN-NP, RN
Elise Musolf, DC, FNP-C
Sandra Ziegler, AGNP-BC
Sharon Mitchell, FNP-C

Privacy regulations require us to have releases signed by our patients for us to speak with family members, friends, and other relations regarding medical treatment. Each person must be listed individually by name, relation, and phone number.

By signing this consent, you are authorizing the permission to leave information concerning your health in both emergent and non-emergent situations.

Times our office may contact below person(s):

-As a reminder that you have an appointment.
-After you had a procedure to follow up.
-For questions regarding the payment of your care.
-For any test results.

Please print the name and relationship of each person to whom you are authorizing the release of private healthcare/medical information. Gorman Medical P.C. endorses, supports, and participates in electronic Health Information Exchange (HIE) as a means to improve the quality of your health and healthcare experience. HIE provides us with a way to securely and efficiently share patients' clinical information electronically with other physicians and health care providers that participate in the HIE network. Using HIE helps your health care providers to more effectively share information and provide you with better care. The HIE also enables emergency medical personnel and other providers who are treating you to have immediate access to your medical data that may be critical for your care. Making your health information available to your health care providers through the HIE can also help reduce your costs by eliminating unnecessary duplication of tests and procedures. However, you may choose to opt out of participation in the CORHIO HIE, or cancel an opt-out choice, at any time. **If you are not wanting to name anyone, please leave the slots blank and then print and sign below.**

________________________________ ___________________________
Name Relation

________________________________ ___________________________
Name Relation

________________________________ ___________________________
Name Relation

Patient Printed Name: ____ Date: ___________________

Patient Signature: ____

To review HIPAA rights, visit: www.hhs.gov/ocr/privacy/hipaa/understanding

FINANCIAL AND ATTENDANCE POLICY

Welcome to Gorman Medical! We are pleased that you have chosen us to provide your care and services. We would like to inform you of our payment policies. We accept cash and credit cards for payment (**no personal checks**).

No Insurance/Non-Contracted Insurance: If you have no insurance, we expect you to pay for your visit at the time of service. Non-contracted insurance will be billed if appropriate insurance information is given, however, payment will be expected at the time of service. *$150 for new patients and $75 for established patients.*

Medicare: We are a participating provider for the Medicare program. We will submit your claim/ services to Medicare. If you have a secondary or supplemental, we will submit it after payment from Medicare, however, we must have a copy of your card and the appropriate information.

Medicaid and Medicaid HMO: We do participate in the Medicaid program. You must provide us with a copy of your Medicaid card indicating that you are eligible for Medicaid at the time of service. Should services be rendered, and you are no longer eligible for Medicaid coverage, you will be responsible for payment based on our normal fee schedule.

Contracted Insurance (HMO, PPO, EPO, POS): If you have insurance we are contracted with, we submit your insurance claims for you, if you supply us with the necessary information. This includes a copy of your card, the address to submit claims to, and a telephone number to allow us to verify coverage. You are still responsible for payment of your co-payment at the time of service and any amounts not covered by your insurance, including the deductible. If your coverage is denied for any reason, you are responsible for payment of the entire balance due, based on our normal fee schedule.

Worker's Compensation: We do not accept Worker's Compensation insurance. You will need to find another provider.

Auto Accidents: We do not accept Auto Accident insurance. You will need to find another provider.

Ancillary Services: We try to arrange for labs, radiology, and any other testing to be provided at a facility that participates with your insurance. However, with the constantly changing insurance contracts and plans, we are not always aware of any changes made to these participation lists. As the patient, please notify us of any concerns as it is your insurance and your responsibility to know what facilities your insurance participates with to lower your costs.

Referrals and Authorizations: We attempt to assist with referrals and authorizations; however, it is ultimately **your responsibility** to obtain any referrals or authorizations for visits, procedures, testing, or any other service provided. Should your insurance deny payment for no referral, no authorization, or not medically necessary you will be deemed financially responsible for all services rendered at Gorman Medical PC.

All co-pays are to be paid on the day of the service.

No Show Fees and Missed Appointments: When we schedule your appointment, this is your time that has been reserved with the doctor. We cannot fill that space if you do not notify us in advance of your inability to make the appointment. Please note that **reminder calls are strictly a courtesy**. Ultimately you are responsible for all appointments made. To avoid any fees, we request a 24-hour notice. We do accept a late cancellation within the 24hr time frame before or after the appointment time. Fees do depend on the type of appointment that was missed:

Appointment Type	Late Cancel Fee	No Show Fee
Follow-Ups	$25.00	$50.00
Injection Procedures	$75.00	$150.00
Other Procedures	$35.00	$85.00

These fees will not be billed to your insurance, and you are responsible to pay within 30 days of the missed appointment. Frequent attendance violations can lead to dismissal from practice.

ASSIGNMENT OF BENEFITS AND AUTHORIZATION TO RELEASE INFORMATION

I hereby assign my Medicare and/or any other insurance benefits to which I am entitled. I authorize and direct my insurance carriers(s) including private insurance, and other health /medical plans to issue payment check(s) directly to Gorman Medical PC for services rendered to me or my dependents regardless of my insurance benefits if any.

I authorize Gorman Medical, P.C. to furnish and/or release any information necessary to insurance carriers concerning my illness or treatment to process my insurance claims. A photocopy of my signature can be used to process my insurance claim for the period of a lifetime. This order will remain in effect until revoked in writing.
I have requested medical services from Gorman Medical PC on behalf of my dependents or myself and I understand that by making this request I become fully responsible for all charges incurred during authorized treatment. I further understand that fees are due and payable on the date that services are rendered and agree to pay all charges incurred immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

I will be responsible not only for the charges incurred but also for any costs involved in the collection of my account. These include but are not to be limited to interest charges, re-billing fees, court costs, attorney fees, and collection costs. In the event, my account becomes delinquent and turned to a collection agency or attorney due to non-payment, that I will pay an additional 33.3 % of the balance as reasonable collection fees (to be added to the balance at the time the account is placed for collections) plus any court costs and attorney's fees incurred relating to the collection account.

Insurance coverage is a matter between my insurance company and myself; **I am ultimately responsible for the payment of my account.**

I have had the opportunity to read and understand the payment policies set forth and have been allowed to ask questions about these policies. I understand my responsibility for payment to Gorman Medical PC and/or providers representing Gorman Medical, P.C.

*****IMPORTANT PLEASE READ THOROUGHLY*****

Legal Litigations: If you have an active, planned, or possible impending litigation regarding/involving other medical providers or concerning your pain/health condition due to exceptional circumstances, please understand that our practice, Gorman Medical, P.C., and our providers, will not be involved in any legal litigation or provide you care at that time. For example, we will be able to provide care for a patient after a motor vehicle accident, if there is no plan to follow up with legal litigation or if the case is settled before establishing care with our facility. We do not have the resources for medical, or legal litigations and choose not to be accountable in any legal matter.

PLEASE READ THE NEXT TWO STATEMENTS CAREFULLY AND PRINT YOUR NAME ON THE LINE NEXT TO THE STATEMENT THAT IS TRUE. PLEASE DO NOT SIGN BOTH!!!!!

If you DO have an active/impending legal litigation:

I, ____ understand that Gorman Medical, P.C. will not be involved with my care at this time. I will be able to return to clinic if I provide Settlement of Suit documents or settlement papers clearing up my legal litigation.

If you DO NOT have an active/impending legal litigation:

I, ____ do NOT have an active, planned or a possible upcoming litigation regarding/involving other medical providers or concerning my pain/health condition.

YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

- "Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.
- "Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

- **Emergency services**

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You can't be balanced billed for these emergency services. This includes services you may get after you're in stable condition unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

If you have a "CO_DOI" on your health insurance ID card and you are receiving care and services provided at a regulated facility or agency in Colorado you can only be billed for your plan's in-network cost-sharing amounts, which are copayments, deductibles, and/or coinsurance. You cannot be billed for anything else. This applies only to services related to and billed as an "emergency service".

- **Certain services at an in-network hospital or ambulatory surgical center**

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

- **You're never required to give up your protection from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.**

If you have a "CO_DOI" on your health insurance ID card and you are receiving care and services provided at a regulated facility or agency in Colorado:

Non-emergency Services at an In-Network or Out-of-Network Facility

Facility or agency staff must tell you if you are at an out-of-network location or if they are using out-of-network providers when known. Staff must also tell you what types of services you will be using that might be provided by an out-of-network provider.

You have the right to request that in-network providers perform all covered medical services. However, you may have to receive medical services from an out-of-network provider if an in-network provider is unavailable. If your insurer covers the service, you can only be billed for your in-network cost-sharing amount, which are copayments, deductibles, and/or coinsurance.

Additional Protections

- Your insurer will pay out-of-network providers and facilities directly.
- The provider or facility or agency must refund any amount you overpay within 60 days of being notified.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
  - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact 800.985.3059 regarding federal regulations, the Colorado Division of Insurance at 303.894.7499 or 1.800.930.3745 for Colorado regulations, or the facility's or agency's billing department.

Visit cms.gov/nosurprises/consumers for more information about your rights under federal law.
My signature acknowledges receiving this notice and does not waive my rights under the law.

Patient Printed Name: ____ Date: ________________

Patient Signature: ____

PRIMARY CARE CONTRACT

The purpose of this Agreement is to prevent misunderstanding about office policies and to help you and your provider improve your healthcare.

↓ Initials

_____ Abusive, unprofessional, uncontrolled behavior results in AUTOMATIC DISMISSAL from the practice.

_____ I understand that this Agreement is essential to the trust and confidence necessary in a provider/patient relationship and that my provider undertakes to treat me based on this Agreement.

_____ I will provide my provider with updates on medications that are prescribed to me by any other provider. (Opioids, blood pressure, diabetes, ADD/ADHD, seizure, psychiatric medications, etc.)

_____ I will not share my medication with anyone.

_____ I agree to properly dispose of old, unused, or discontinued medications. If a medication is discontinued for any reason, I WILL NOT continue to take that medication at the risk of interactions or overdose.

_____ To ensure you receive the best possible care, we prefer to send all medication to ONE pharmacy.

Name of local Pharmacy: ___________________________________

Address and/or Cross Streets: ____

_____ I understand that **I am ultimately responsible** for scheduling my appointments **before** my medication due dates. When scheduling my appointments, I would need to take weather conditions, Cordant delivery time, and unforeseen/emergencies into consideration. Special circumstances will be considered, however, not guaranteed.

_____ I understand that I need to fill my medication in its entirety. If my Pharmacy cannot fill the full quantity of my prescription, I will inform my provider to resolve this issue.

_____ I authorize my provider to provide a copy of this Agreement to my pharmacy, primary care provider, and local emergency room. I agree to waive any applicable privilege or right of privacy or confidentiality concerning these authorizations.

If you have any questions or concerns regarding this agreement and your treatment, please let us know before signing below. You may request a copy of this document.

Patient Printed Name: ____ Date: ______________

Patient Signature: ____

THANK YOU FOR ADHERING TO OUR POLICIES