Georgetown Center for Adult Medicine Patient Registration Form

PATIENT INFORMATION (Please Print)

☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Jr. ☐ Sr. ☐ Other_____

Patient's Name (Last)_____ (First)_____ (Middle)_____

Also Known As Name (Last)_____(First)_____

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Other

Social Security Number _____-____-_____ ☐ Female ☐ Male Date of Birth_____/_____/_____

E-Mail Address_____

Phone Numbers Work_____ ☐ Day ☐ Evening Home_____ ☐ Day ☐ Evening

Cellular_____ Pager_____

Address_____

City, State, ZIP (+4)_____

Employment Status ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐ Retired ☐ Self-Employed ☐ Unemployed

Employer_____ Occupation_____

Emergency Contact Name_____ Phone Number_____

Emergency Contact Relationship to Patient_____

Referring Provider Name_____

RESPONSIBLE PARTY INFORMATION

Responsible Party Name (Last)_____ (First)_____ (Middle)_____

Also Known As Name (Last)_____(First)_____

Social Security Number _____-____-_____ ☐ Female ☐ Male Date of Birth_____/_____/_____

E-Mail Address_____

Phone Numbers Work_____ ☐ Day ☐ Evening Home_____ ☐ Day ☐ Evening

Address_____

City, State, ZIP (+4)_____

Employment Status ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐ Retired ☐ Self-Employed ☐ Unemployed

Employer_____ Employer Phone Number_____

Patient Relationship to Responsible Party_____

PRIMARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Name of Insured_____ Patient Relationship to Insured_____

Insured Employer Name_____

Insurance Company/Phone Number_____ (_____)_____

Subscriber ID (Policy Number)_____ Group ID_____ Copay Amount_____

Effective Date_____ Termination Date_____ ☐ Female ☐ Male

Insured Date of Birth_____/_____/_____ Insured's Social Security Number _____-____-_____

Insurance Company Address_____

SECONDARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Name of Insured_____ Patient Relationship to Insured_____

Insured Employer Name_____

Insurance Company/Phone Number_____ (_____)_____

Subscriber ID (Policy Number)_____ Group ID_____ Copay Amount_____

Effective Date_____ Termination Date_____ ☐ Female ☐ Male

Insured Date of Birth_____/_____/_____ Insured's Social Security Number _____-____-_____

Insurance Company Address_____

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient (or Responsible Party) Signature_____ ***Date***_____

Name: _____ Date: _____

Date of Birth (dd/mm/yyyy): _____

Current Medications: (include over-the-counter medications used on routine basis)

Name of Medication	Strength/Dose	Indication/Use	Frequency

Additional medications can be listed on a separate sheet of paper

Past Medical History: (check all that apply)

- o None
- o Depression/Anxiety
- o Hypothyroidism
- o Blood Clots
- o Diabetes
- o Hyperthyroidism
- o Coronary Artery Disease
- o High Cholesterol
- o Asthma
- o High Blood Pressure
- o COPD
- o Arthritis
- o Stroke/TIA
- o Osteoporosis

Cancer: Type/Treatment _____

Other: _____

_____

Allergies:

Any Medication Allergies? ☐Yes☐No Allergic to latex or latex products? ☐Yes ☐No

If yes, list any medications and type of reaction experienced

Medication	Reaction

Surgical History:

Type of Surgery	Day/Month/Year

Prior Hospitalization:

Day/Month/Year	Reason	Hospital / Facility Name

Screenings:

Test	Day/Month/Year	No
Abdominal Aortic Aneurysm – US		
Colonoscopy		
Hepatitis C (born 1945-1965)		
Mammogram		
Osteoporosis		
Prostate		
PAP & Pelvic		

Family History: Do you have any family members who currently have or in the past any of the follow?

Disease	Yes/No	Diagnosis	Relationship
Cancer			
Osteoporosis			
Dementia			
Heart Disease			
Diabetes			
Psychiatric (specify)			
Other:			

Social History:

Do you drive? (yes/no) _____ If no, how do you run errands? _____

Do you manage your medication(s) alone without assistance? (i.e. follow dosing schedule without reminders from friends or family, load medication tray/box) (yes/no) _____

If no, who assists you? _____

Do you live with anyone? (yes/no) _____ If yes, name/relationship _____

Do you have a Living Will? (yes/no)_____ Advanced Directive? (yes/no) _____ POA _____

Do you have an Out of Hospital (OOH) DNR? (yes/no) _____

Assisted Aides and Mobility:

Have you fallen in the last 6 months? (yes/no) _____ Date of Last Fall _____

Do you use: Walker _____ Wheelchair _____ Cane _____

Do you use hearing aids? (yes/no) _____ If yes, Left _____ Right _____ Both _____

Do you wear glasses or contacts? (yes/no) _____

Personal Habits: (check all that apply)

Tobacco Use	**Alcohol Use**	**Drug Use**
o Never	o Never	o Never
o Former Smoker, Year Quit_____	o Social	o Amphetamine
o Current Pipe/Cigar/Cigarette	o Daily	o Marijuana
o Current- Chewing Tobacco	o Heavy	o Other: _____

Education: (Mark Highest Completed)

o Grade School o High School o GED o College Degree o Post-Graduate

Current Occupation: _____

Preventative/Immunization:

Vaccine	Day/Month/Year	No
Diphtheria, Tetanus, Pertussis		
Hepatitis B		
Influenza		
Pneumococcal-13		
Pneumococcal-23		
Shingles		

Physician Information:

Name of Physician	Address	Telephone

Please return this form to the front desk.

Notes:

PATIENT HIPAA ACKNOWLEDGMENT AND CONSENT FORM

Location Name			
Patient Last Name (Printed)	Patient First Name (Printed)	MI	Date of Birth (MM/DD/YYYY)

Notice of Privacy Practice/clinics

_____ (**Patient/Representative initials)** I acknowledge that I have received the Notice of Privacy Practice, which describes the ways in which the practice/clinic may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the Notice of Privacy Practice.

Disclosures to Friends and/or Family Members

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM? I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

	Name	Relationship	Contact Number
1:			
2:			
3:			

Patient/Representative may revoke or modify this specific authorization and that revocation or modification must be in writing.

Communications about My Healthcare

I agree the Provider or an agent of the Provider or an independent physician's office may contact me for the purposes of scheduling necessary follow-up visits recommended by the treating physician.

Consent for Photographing or Other Recording for Security and/or Health Care Operations

I consent to photographs, digital or audio recordings, and/or images of me being recorded for patient care, security purposes and/or the practice's/clinic's health care operations purposes (e.g., quality improvement activities). I understand that the practice/clinic retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used outside the facility without a specific written authorization from me or my legal representative unless otherwise permitted or required by law.

Consent to Email, Cellular Telephone, or Text Usage for Appointment Reminders and Other Healthcare Communications

If at any time I provide an email address or cellphone number at which I may be contacted, I consent to receiving unsecure instructions and other healthcare communications at the email or text address I have provided or you or your EBO Servicer have obtained, at any text number forwarded, or transferred from that number. These instructions may include, but not be limited to: post-procedure instructions, follow-up instructions, educational information, and prescription information. Other healthcare communications may include, but are not limited to, communications to family or designated representatives regarding my treatment or condition, or reminder messages to me regarding appointments for medical care.

Note: You may opt out of these communications at any time. The practice/clinic does not charge for this service, but standard text messaging rates or cellular telephone minutes may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

Note: This location uses an Electronic Health Record that will update all your demographics and consents to the information that you just provided. Please note this information will also be updated for your convenience to all our affiliated locations that share an electronic health record in which you have a relationship.

PATIENT HIPAA ACKNOWLEDGMENT AND CONSENT FORM

Location Name			
Patient Last Name (Printed)	Patient First Name (Printed)	MI	Date of Birth (MM/DD/YYYY)

Release of Information.

I hereby permit practice/clinic and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

- Healthcare information regarding a prior service(s) at other HCA affiliated providers may be made available to subsequent HCA-affiliated providers to coordinate care. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.
- If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.
- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

I certify that I have read and fully understand the above statements from all pages and consent fully and voluntarily to its contents.

Patient/Representative Signature	Relationship to Patient (self, parent, legal guardian/representative, etc)	Date

Practice:OPTIONAL ON FORM- REMOVE THIS Prescription Order Pick up Section **ONLY** if NA to your practice/clinic]

Prescription Order Pick-up. There may be times when you need a friend or family member to pick-up a prescription order (script) from your physician's office. In order for us to release a prescription to your family member or friend, we will need to have a record of their name. Prior to release of the script, your designee will need to present valid picture identification and sign for the prescription.

- ***I do want*** ____ (Patient/Representative Initials) to designate the following individual to pick up a prescription order on my behalf:

NAME	Relationship to Patient

- ***I do not want*** ____ (Patient/ Representative Initials) to designate anyone to pick-up my prescription order.

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Georgetown Center for Adult Medicine Fax: 512-763-4088 Phone: 512-763-4060

Section A: This section must be completed for all Authorizations

Patient Name:	**Birth Date:**	**Patient 's Phone:**	**Last Four Digits SSN *(optional)*:**

Provider's Name:	**Recipient's Name:**		
Georgetown Center for Adult Medicine			
Provider's Address:	**Address 1:**		
105 Wildwood Drive, Suite 105 Georgetown, Texas 78633	**Address 2:**	**Recipient's Phone:**	**Recipient's Fax:**
	City:	**State:**	**Zip:**

Request Delivery (If left blank, a paper copy will be provided):

☒ **Paper Copy** ☒ **Electronic Media, if available (*e.g.,* USB drive, CD/DVD)** ☐ **Encrypted Email** ☐ **Unencrypted Email**

NOTE: In the event the facility is unable to accommodate an electronic delivery as requested, an alternative delivery method will be provided (e.g., paper copy). There is some level of risk that a third party could see your PHI without your consent when receiving unencrypted electronic media or email. We are not responsible for unauthorized access to the PHI contained in this format or any risks (e.g., virus) potentially introduced to your computer/device when receiving PHI in electronic format or email.

Email Address (If email checked above. Please print legibly):

This authorization will expire on the following: (Fill in the Date or the Event but not both.)

Date: **Event:**

Purpose of disclosure:

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☒ No, then you may check as many items below as you need.

Description:	**Date(s):**	**Description:**	**Date(s):**	**Description:**	**Date(s):**
☒ All PHI in medical record		☐ Operative Information		☐ Labor/delivery summary	
☐ Admission form		☐ Cath lab		☐ OB nursing assess	
☐ Dictation reports		☐ Special test/therapy		☐ Postpartum flow sheet	
☐ Physician orders		☐ Rhythm Strips		☐ Itemized bill:	
☐ Intake/outtake		☐ Nursing Information		☐ UB-92:	
☐ Clinical Test		☐ Transfer forms		☐ Other:	
☐ Medication Sheets		☐ ER Information		☐ Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, genetic information, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial)

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
6. I get a copy of this form after I sign it

Section B: Is the request of PHI for the purpose of marketing and/or does it involve the sale of PHI? ☐ Yes ☒ No

If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.

Will the recipient receive financial remuneration in exchange for using or disclosing this information? ☐ Yes ☒ No

If yes, describe:

May the recipient of the PHI further exchange the information for financial remuneration? ☐ Yes ☒ No

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Patient's Representative:	**Date:**
Print Name of Patient's Representative:	**Relationship to Patient:**

Photo ID Verified: _____

Patient Identification/Label

Patient name: _____

Date of birth: _____

Patient Consent for Financial Communications

Financial Agreement

- I acknowledge, that as a courtesy, **Georgetown Center for Adult Medicine** may bill my insurance company for services provided to me.
- I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductible, or charges not covered by insurance.
- I understand there is a fee for returned checks.

Third Party Collection. I acknowledge **Georgetown Center for Adult Medicine** may use the services of a third-party business associate or affiliated entity as an extended business office ("EBO Servicer") for medical account billing and servicing.

Assignment of Benefits. I hereby assign to **Georgetown Center for Adult Medicine** any insurance or other third-party benefits available for health care services provided to me. I understand **Georgetown Center for Adult Medicine** has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to **Georgetown Center for Adult Medicine**, I agree to forward all health insurance or third-party payments that I receive for services rendered to me immediately upon receipt.

Medicare Patient Certification and Assignment of Benefit. I certify that any information I provide, if any, in applying for payment under Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to **Georgetown Center for Adult Medicine** by the Medicare or Medicaid program.

Consent to Telephone Calls for Financial Communications. I agree that, in order for **Georgetown Center for Adult Medicine**, or Extended Business Office (EBO) Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that **Georgetown Center for Adult Medicine** or EBO Servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or **Georgetown Center for Adult Medicine** or EBO Servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

A photocopy of this consent shall be considered as valid as the original.

Patient/patient representative signature: _____ **Date:** _____

If you are not the patient, please identify your relationship to the patient. Circle or mark relationship(s) from list below:

☐Spouse
☐Parent
☐Legal Guardian
☐Guarantor
☐Healthcare Power of Attorney
☐Other (please specify) _____

Medicare Secondary Payor Development Form

Facility Name GCAM	COID 19563	Patient's Retirement Date	Spouse's Retirement Date	Spouse's Deceased Date
Patient's Name		Account No.	Medicare No.	

You must ask the patient each question in sequence and comply with any instructions which follow an answer. Failure to obtain information regarding Medicare as a secondary payor is a violation of your Provider agreement with Medicare.

Does the patient have an HMO policy? ☐ No ☐ Yes
If Yes, name, address and phone of HMO:

_____

_____

Does the HMO replace Medicare? ☐ No ☐ Yes
If Yes, the HMO will be primary. If No, it will be secondary.

Is this patient an inpatient? ☐ No ☐ Yes

Was the patient given Important Message? ☐ No ☐ Yes

If No, why not? _____

Has patient been an Inpatient in a health care facility within the last 60 days? ☐ No ☐ Yes
If Yes, name, address and phone of facility:

_____

_____

Has the patient had any outpatient medical services in the last 72 hours? ☐ No ☐ Yes
If Yes, name, address and phone of facility:

_____

_____

1. Are you receiving Black Lung (BL) Benefits?
   ☐ No
   ☐ Yes; Date benefits began: _____
   If Yes, BL is Primary only for claims related to BL.

2. Are the services to be paid by a government program such as a research grant?
   ☐ No
   ☐ Yes; *Government program will pay primary benefits for these services.*

3. Has the Department of Veterans Affairs (DVA) authorized and agreed to pay for care at this facility?
   ☐ No
   ☐ Yes; *DVA is primary for these services.*

4. Was the illness/injury due to work related accident or condition?
   ☐ No; **Go to Question 5.**
   ☐ Yes; Date of injury/illness: _____
   Name, address and phone of Workers Compensation Plan:

   _____

   _____

   _____

   Policy or ID Number: _____
   Name, address and phone number of your employer:

   _____

   _____

   If Yes, Workers Compensation is Primary Payor only for claims related to work related injury or illness. **Go to Question 8.**

5. Was the illness/injury due to a non-work related accident?
   ☐ No; **Go to Question 8.**
   ☐ Yes; Date of accident:

6. What type of accident caused the illness/injury?
   ☐ Automobile ☐ Non-Automobile
   Name, address and phone of no-fault or liability insurer:

   _____

   _____

   _____

   Insurance Claim Number: _____
   No-Fault insurer is Primary payor only for those claims related to the accident. **Go to Question 8.**
   ☐ Other (explain) _____

7. Was another party responsible for this accident?
   ☐ No; **Go to Question 8.**
   ☐ Yes; Provide name, address and phone of any liability insurer:

   _____

   _____

   _____

   Insurance claim number: _____
   If yes, liability insurer is Primary only for those claims related to the accident. **Go to Question 8.**

8. Are you entitled to Medicare based on:
   ☐ Age; **Go to Questions 9 – 12.**
   ☐ Disability; **Go to Questions 13 – 16.**
   ☐ ESRD; **Go to Questions 17 – 23.**

9. Are you currently employed?
   ☐ No; Date of retirement: _____
   ☐ Yes; Provide name, address and phone of your employer:

   _____

   _____

10. Is your spouse currently employed?
    ☐ No; Date of retirement: _____
    ☐ Yes; Provide name, address and phone of spouse's employer.

    _____

    _____

    If the patient answered No to both questions 9 and 10, Medicare is primary. If the patient answered "Yes" to questions 1 – 4 or 5 – 7 then Medicare is NOT primary payer.
    Do not proceed any further.
    If yes to questions 9 or 10, go to questions 11 and 12.

11. Do you have group health plan (GHP) coverage based on your own, or a spouse's current employment?
    ☐ No; **Stop.** *Medicare is primary payer unless the patient answered Yes to questions 1 – 4 or 5 – 7.*
    ☐ Yes

Medicare requires this form to be completed for every Medicare patient. The information is used to determine if other payors are primary to Medicare. Medicare requires the patient to sign the MSP form.

Medicare Secondary Payor Development Form

Patient's Name	Account No.	Medicare No.

12. Does the employer that sponsors your GHP employ 20 or more employees?
- ☐ No; **Stop.** *Medicare is Primary payer unless the patient answered "Yes" to questions 1-4 or 5 – 7.*
- ☐ Yes; **Stop.** *Group Health Plan is Primary. Obtain the following information.*

Name, address and phone of GHP:

_____

_____

_____

Policy ID Number: _____

Group ID Number: _____

Name of Policy Holder _____ Relationship to Patient _____

13. Are you currently employed?
- ☐ No; Date of Retirement _____
- ☐ Yes; Provide name, address and phone of your employer:

_____

_____

_____

14. Is a family member currently employed?
- ☐ No
- ☐ Yes; Provide name, address and phone of employer:

_____

_____

_____

If patient answers "No" to both questions 13 and 14, Medicare is Primary unless the patient answered "Yes" to questions 1–4 or 5–7. **Do not proceed any further.**
If Yes to questions 13 or 14, go to question 15 and 16.

15. Do you have your group health plan (GHP) coverage based on your own, or a family member's current employment?
- ☐ No; **Stop.** *Medicare is Primary unless the patient answered "Yes" to questions 1 – 4 or 5 – 7.*
- ☐ Yes

16. Does the employer that sponsors your GHP, employ 100 or more employees?
- ☐ No; **Stop.** *Medicare is Primary unless the patient answered "Yes" to questions 1 – 4 or 5 – 7.*
- ☐ Yes; **Stop.** *Group Health Plan is Primary. Obtain the following information:*

Name, address and phone of GHP:

_____

_____

_____

Policy ID Number: _____

Group ID Number: _____

Name of Policy Holder _____ Relationship to Patient _____

17. Do you have group health plan (GHP) coverage?
- ☐ No: Stop. *Medicare is Primary.*
- ☐ Yes; Provide name, address and phone of GHP:

_____

_____

_____

Policy ID Number _____

Group ID Number: _____

Name of Policy Holder _____ Relationship to Patient _____

Name, address and phone of employer, if any from which you received GHP coverage:

_____

_____

_____

18. Have you received a kidney transplant?
- ☐ No
- ☐ Yes; Date of Transplant: _____

19. Have you received maintenance dialysis treatments?
- ☐ No
- ☐ Yes; Date dialysis began: _____

If you participated in self dialysis training program, provide date training started: _____

20. Are you within the 30 month coordination period?
- ☐ No; **Stop.** *Medicare is Primary.*
- ☐ Yes

21. Are you entitled to Medicare on the basis of either ESRD and age, or ESRD and disability?
- ☐ No; **Stop.** *GHP is Primary during the 30 month coordination period*
- ☐ Yes

22. Was your initial entitlement to Medicare (including simultaneous Entitlement) based on ESRD?
- ☐ No; *Initial entitlement based on age or disability.*
- ☐ Yes; **Stop.** *GHP continues to pay Primary during the 30th month coordination period.*

23. Does the working aged or disability MSP provision apply (i.e., is the GHP primary based on age or disability entitlement)?
- ☐ No; *Medicare continues to pay Primary.*
- ☐ Yes; *GHP continues to pay Primary during the 30 month coordination period.*

I understand that I am responsible for charges not covered by the Medicare program, and that such services include, but are not limited to the following: Cosmetic surgery, dental care, take-home drugs, private duty nurses, custodial care, television, telephone, private room (unless medically necessary), personal convenience items, non-FDA approved medical devices.

X _____ X _____

Patient or Representative / Relationship — Witness — Date