



New Patient Packet



O. David Taunton, Jr., M.D.
Hip and Knee Replacement
Surgery

Howard W. Harris, M.D.
Sports Medicine and
Arthroscopy

Stephen J. Troum, M.D.
Surgery of the Hand and
Upper Extremity

Jason S. Ahuero, M.D.
Reconstructive Foot and
Ankle Surgery

Ryan E. Modlinski, M.D.
Non-Operative Orthopedics
and Sports Medicine

Welcome! Thank you for choosing Texas Orthopedic Specialists, P.A.

Appointments

Please bring the following items with you to your initial appointment, whether it is an x-ray appointment or an office appointment:

- Your completed forms for the New Patient Packet. Please have these filled out prior to your scheduled appointment time. Please arrive 15 minutes early for your appointment if you have not completed the forms
- Your insurance card and drivers license
- A family member must accompany the patient if coming by ambulance or from a nursing home
- Your referral, if required by your medical insurance policy. You need a referral that is appropriate for your diagnosis from your primary care doctor.
- Your initial visit will be for a consultation and surgical x-rays. This allows us to fully access your health history, your current needs, and explain the recommended treatment plan. After the doctor has seen you, and if surgery is recommended, we will schedule your surgical procedure from our office. Bring any recent x-rays and/or MRI films, along with the MRI report, that you may have had in the last 6 months. MRI's and x-rays are not the same type of imaging, so please bring both.
 - Dr. Taunton patients are requested to have their x-rays on film, not CD's. If a total hip or knee replacement is needed, the films are used to template for replacement parts. Templating cannot be done with a CD.
- A co-pay, and deductible if applicable, will be collected at the time of visit. If you do not have insurance coverage, payment in full is expected prior to each visit.
- Please contact our office with any questions you may have. It is always our pleasure to help you.

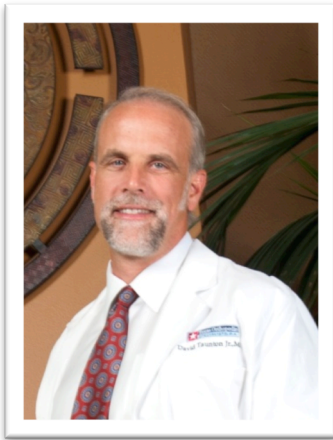
Disability Forms

Please give all forms regarding disability to the nursing or front desk staff. Please do not give these forms to the physician. Be aware there is a \$25.00 fee per form. You will need to expect 72 hours for these forms to be completed. Fill out the portion of the disability form that is for the patient and leave physician areas blank.



We would like to welcome you to Texas Orthopedic Specialists, and below is some information on the physician you will be seeing for your appointment.

Enclosed are the forms which need to be filled out prior to your appointment. Please feel free to contact our office staff at (817)540-4477 with any questions you may have regarding your appointment.



O. David Taunton, Jr., M.D.

Specializing in Hip and Knee Replacement Surgery

- **Minimally invasive hip and knee replacement**
- **Revision hip and knee replacement**
- **Complex replacement surgery**
- **Fellowship trained in hip & knee surgery**

Dr. O. David Taunton, Jr. is a joint replacement specialist who has practiced almost exclusively hip and knee replacement for the past five years. Originally from Alabama, Dr. Taunton graduated from Auburn University with honors. From there he went to the University of Alabama School of Medicine for both medical school and Orthopaedic residency training. During his residency, he performed research on hip and knee implants, and developed a strong interest in joint replacement surgery. He subsequently obtained additional joint replacement training at the prestigious Anderson Orthopaedic Research Institute in Washington, D.C.

Dr. Taunton has been a member of the Alabama Orthopaedic Society, and is currently a member of the Texas Medical Association, and the Tarrant County Medical Society. In addition, he is a diplomat of the American Academy of Orthopaedic Surgeons and a fellow of the American Board of Orthopaedic Surgeons. Dr. Taunton specializes in revision joint replacement as well as primary joint replacement.

For more information, please visit our website at www.txortho.net

Patient Questionnaire-Hip

Name _____ Date _____
Referring Doctor or Friend: _____ Your Age _____

History of Present Illness

Circle all that apply: **Work Related: Yes No Motor Vehicle Accident: Yes No**

Location of Pain: Left Hip: Groin/Thigh/Buttock Right Hip: Groin/Thigh
Buttock **Does the pain Radiate:** To your Back/To Knee/To Foot

Associated Signs and Symptoms:

Do you have: Catching/Locking/Giving Way/Stiffness/Weakness/Numbness/Tingling

Type of Pain: Aching/Burning/Constant/Diffuse/Dull/Infrequent/Pounding/Shooting
Sharp/Stabbing/Tearing/Throbbing

Severity: Mild Moderate Intense **Does the pain keep you up at night?** Yes No

Activity Quality of Life Limitations: Climbing Stairs/In & Out of Cars/ Kneeling
Walking

Frequency or Duration of limitations: Occasionally/Often/Constantly

Aggravating Factors: Climbing Stairs/Prolonged Sitting/Lying Down/Recreational
Activities/ Standing/ Routine Activities/Weather Changes/Getting up from a chair or
commode

Name All Health Problems: _____

Medical History: Check each one that applies: Recent Weight Loss__Recent Weight
Gain__ Diabetes__ HIV__ Stroke__ Blood Clot__ Heart Disease__ Murmurs, Irregular
Rhythm__ High Blood Pressure__ Thyroid__ Cancer__ Hepatitis__ DVT__ Pulmonary
Edema__ Kidney Disease__ GERD__ Diverticulitis__ Crohns Disease__ Lung
Disease__ Seizure Disorder__ High Cholesterol__ Sleep Apnea__

Are you: Improving/Unchanged/Worsening

What gives you relief? Avoiding Activities/Use of Brace/Cane/Crutches/Walker/Cold
Packs /Heat/Exercising/Joint Injections(Synvisc/Cortisone)/Physical Therapy Resting
Walking /Medication: (Advil, Tylenol, Cox 2 Inhibitors NSAIDS, Pain Pills)

Other Past Medical History: List all past surgeries and illnesses requiring hospitalization _____

Allergies: None _____ Iodine _____ Tape _____ X- Ray Dye _____ Latex _____
Allergies to Medications(please list) _____

Medications: Please list all medications you are presently taking that a Physician has Prescribed: _____

REVIEW OF SYMPTOMS IN THE PAST 6 WEEKS YOU HAVE EXPERIENCED:

Fever/Chills _____ Light Headed/dizziness/fainting _____ Headaches/Migraines _____ Sore Throat/cough/runny nose _____ Chest Pain/shortness of breath _____ Abdominal pain/vomiting blood _____ Painful urination _____ Blood in stool _____ Swelling/skin rash _____
Pain Level (Rate 1-10) _____

Social History: Married _____ Single _____ Divorced _____ Widow(er) _____ Number of children _____ Employer: _____ Job Description _____

Recreational Activities: _____
Do You Smoke: _____ Approximate Amount Daily _____ Have You Ever Smoked: _____
Do You Drink Alcoholic Beverages: _____ Approximate Amount _____
Daily Weekly or Monthly Recreational Drugs: _____ Type/Approximate Amount Daily: _____

Past Family Medical History: Mother Alive _____ Deceased _____ Health Issues: _____
Father: Alive _____ Deceased _____ Health Issues: _____ Hereditary Diseases _____
Please Circle Family Health Issues:

Excessive Bleeding Yes No Tuberculosis Yes No Diabetes Yes No Heart Disease Yes No Strokes Yes No Amputation Yes No High Blood Pressure Yes No Cancer Yes No

Review by Physician/PA Physician Initials _____ PA Initials _____

DATE _____

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I hereby authorize: _____
Physician and/or Facility

Address

Physician and/or Facility

Address

Relative or Significant Other

Address

The Following information from the medical records for:

Patient Name: _____ Date of Birth : _____

Medical Records #: _____ Daytime Phone # : ____ / ____ / ____

_____ History/Physical Exam _____ Lab Reports (including HIV test results)

_____ X-Ray reports _____ Progress Notes

_____ Other _____

The above information is being released for the following purpose and that purpose only. Any other use is forbidden.

This authorization shall be in force and effective until the following event and/or date:

I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance to it.

_____ Date : ____ / ____ / ____
Signature of Patient

_____ Relationship to Patient
Signature of Parent or other Responsible Party

PROHIBITION OR REDISCLOSURE. This information is being disclosed to you from confidential records. As their confidentiality is protected by law, you are prohibited from making any further disclosure of this information except with specific written consent of the person to whom it pertains and the facility from which the information originates.

Hip Score

Patient Name: _____

Thank you for taking the time to help us better understand how your hip problem affects your daily life.

Please check the answer that best describes your hip:

1. Rate your pain:
 - None or ignores it
 - Slight, occasional, no compromise in activities
 - Mild pain, no effect on average activities, rarely moderate pain with unusual activity, may take aspirin
 - Moderate pain, tolerable but makes concessions to pain. Some limitations of ordinary activity or work. May require occasional pain medicine stronger than aspirin
 - Marked pain, serious limitation of activities
 - Totally disabled, crippled, pain in bed, bedridden
2. Do you walk with a limp?
 - None Slight Moderate Severe
3. Do you walk with support?
 - None
 - Cane for long walks
 - Cane most of the time
 - One crutch
 - Two canes
 - Two crutches
 - Not able to walk (please specify reason) _____
4. How does your hip affect your walking ability?
 - I can walk unlimited distances
 - I can walk up to 6 blocks
 - I can walk up to 3 blocks
 - I can walk indoors only
 - I can walk from bed to a chair
5. How do you go up and down stairs?
 - Normally without using a railing
 - Normally using a railing
 - In an matter
 - Unable to use stairs
6. Can you put shoes and socks on?
 - With ease
 - With difficulty
 - Unable
7. Do you have pain while sitting?
 - I can sit in any type of chair for an hour or more
 - Higher chairs are easier to sit in for up to a ½ hour
 - I am unable to sit in any chair for longer than ½ hour



**PATIENT AUTHORIZATION
ASSIGNMENT OF BENEFITS
CONSENT TO TREATMENT AND RELEASE OF INFORMATION**

ASSIGNMENT OF BENEFITS: I, hereby, assign all medical and/or surgical benefits to include Major Medical benefits for which I'm entitled, including Medicare, Private Insurance, PIP, Third Party and any other health plans, related to Texas Orthopedic Specialists.

I further authorize the release of all information necessary, including medical information, to secure payment for service rendered, including the processing of insurance claims, to also include the release of any information necessary to secure payment for any additional expenses that may be incurred by the Orthopedic Institute of Texas resulting from payment securing process (administrative/clerical expenses and/or fee, postage, telephone expenses etc).

CONSENT TO TREATMENT I GIVE MY CONSENT TO Texas Orthopedic Specialists to perform any and all examinations, tests, treatment, physical therapy, blood and urine specimen procurement, and any other reasonable measure it deems necessary to diagnose and to treat my condition.

I acknowledge that my plan of care may include admission to Harris Southlake, a licensed Medicare certified ambulatory surgery center in which Dr. Taunton, Dr. Harris and Dr. Troum have a financial interest.

NO WARRANTY OR GUARANTEE I (we) understand that no warranty or guarantee has been made to me as to result or care.

NOTICE OF PRIVACY PRACTICES: I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

This agreement will remain in effect until revoked by me in writing and a photocopy of this assignment shall be considered as valid as the original.

I FURTHER UNDERSTAND THAT I AM PERSONALLY RESPONSIBLE FOR ANY CHARGES INCURRED BY ME, REGARDLESS OF ANY INSURANCE COVERAGE I MAY HAVE, AND SHALL BE PAYABLE TO TEXAS ORTHOPEDIC SPECIALISTS. TEXAS ORTHOPEDIC SPECIALISTS WILL BE GLAD TO FILE TO OUR INSURANCE CARRIER FOR ANY CHARGES INCURRED, HOWEVER.

My signature affirms all the statements made above:

Date: ___/___/____ Signature: _____

Date: ___/___/____ Witness: _____



Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Signature of Patient or Personal Representative

Date

Name of Patient or Personal Representative

Description of Personal Representative's Authority



Security of Patient and Public Personal Property.

I understand and agree that Texas Orthopedic Specialists, P.A. is not responsible for the security and protection from loss or theft of my personal property while on its premises (including the parking lot and other contiguous areas outside of the building) and further understand and agree that I am personally and directly responsible for security of all of my personal belongings including without limitation, articles of clothing, purses, wallets, cash, jewelry, and personally owned equipment.

Patient Signature

Date

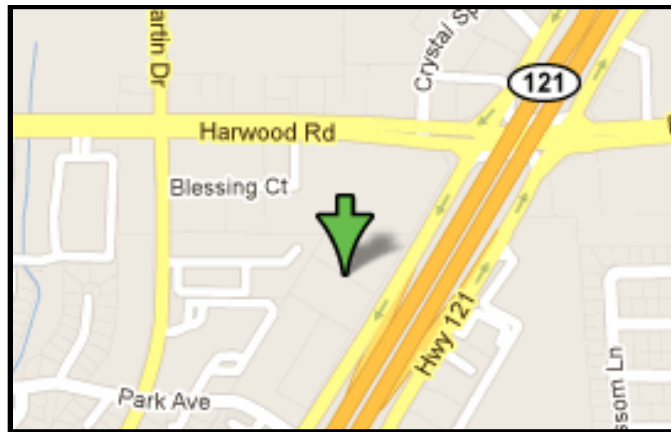


Directions to Our Office

**2425 Highway 121
Bedford, TX 76021**

Directions from Airport Freeway/183 area, take 121 North towards Grapevine
Exit Harwood Road
Turn LEFT on Harwood Road.
Turn LEFT on South bound access road
Stay on access road and go down about a quarter of a mile
The building will be on the right hand side

Directions from Hwy 114 area, take 121 South towards Fort Worth
Exit Harwood Road.
Do not turn on Harwood Road.
Stay straight on access road and go down about a quarter of a mile
The building will be on the right hand side



Texas Orthopedic Specialists, P.A. - Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This practice uses and discloses health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care you receive. This notice describes our privacy practices. You can request a copy of this notice at any time. For more information about this notice or our privacy practices and policies, please contact the person listed below.

Treatment, Payment, Health Care Operations

Treatment

We are permitted to use and disclose your medical information to those involved in your treatment. For example, your care may require involvement of a specialist other than ourselves. If we were to refer you to another specialist, we will share some or all of your medical information with that physician to facilitate the delivery of care.

Payment

We are permitted to use and disclose your medical information to bill and collect payment for services provided to you. For example, we may complete a claim form to obtain payment from your insurer or HMO. The form will contain medical information, such as description of the medical service provided to you, that your insurer or HMO needs to approve payment to us.

Health Care Operations

We are permitted to use or disclose your medical information for the purposes of health care operations, which are activities that support this practice and ensure that quality care is delivered. For example, we may engage the services of a professional to aid this practice in its compliance program. This person will review billing and medical files to ensure we maintain our compliance with regulations and the law.

Disclosures That Can Be Made Without Your Authorization

There are situations in which we are permitted by law to disclose or use your medical information without your written authorization or an opportunity to object. In other situations we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization, in writing, to stop future uses and disclosures. However, any revocation will not apply to disclosures or uses already made or taken in reliance on that authorization.

Public Health, Abuse or Neglect, and Health Oversight

We may disclose your medical information for public health activities. Public health activities are mandated by federal, state, or local government for the collection of information about disease, vital statistics (like births and deaths), or injury by a public health authority. We may disclose medical information, if authorized by law, to a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition. We may disclose your medical information to report reactions to medications, problems with products, or to notify people of recalls of products they may be using.

We may also disclose medical information to a public agency authorized to receive reports of child abuse or neglect. Texas law requires physicians to report child abuse or neglect. Regulations also permit the disclosure of information to report abuse or neglect of elders or the disabled. We may disclose your medical information to a health oversight agency for those activities authorized by law. Examples of these activities are audits, investigations, licensure applications, and inspections which are all government activities undertaken to monitor the health care delivery system and compliance with other laws, such as civil rights laws.

Legal Proceedings and Law Enforcement

We may disclose your medical information in the course of judicial or administrative proceedings in response to an order of the court (or the administrative decision-maker) or other appropriate legal process. Certain requirements must be met before the information is disclosed.

If asked by a law enforcement official, we may disclose your medical information under limited circumstances provided that the information:

- Is released pursuant to legal process, such as a warrant or subpoena;
- Pertains to a victim of crime and you are incapacitated;
- Pertains to a person who has died under circumstances that may be related to criminal conduct;
- Is about a victim of crime and we are unable to obtain the person's agreement;
- Is released because of a crime that has occurred on these premises;
- Is released to locate a fugitive, missing person, or suspect

We may also release information if we believe the disclosure is necessary to prevent or lessen an imminent threat to the health or safety of a person.

Workers' Compensation

We may disclose your medical information as required by the Texas workers' compensation law.

Inmates

If you are an inmate or under the custody of law enforcement, we may release your medical information to the correctional institution or law enforcement official. This release is permitted to allow the institution to provide you with medical care, to protect your health or the health and safety of others, or for the safety and security of the institution.

Military, National Security and Intelligence Activities, Protection of the President

We may disclose your medical information for specialized governmental functions such as separation or discharge from military service, requests as necessary by appropriate military command officers(if you are in the military), authorized national security and intelligence activities, as well as authorized activities for the provision of protective services for the President of the United States, other authorized government officials, or foreign heads of state.

Research, Organ Donation, Coroners, Medical Examiners, and Funeral Directors

When a research project and its privacy protections have been approved by an Institutional Review Board or privacy board, we may release medical information to researchers for research purposes. We may release medical information to organ procurement organizations for the purpose of facilitating organ, eye, or tissue donation if you are a donor. Also, we may release your medical information to a coroner or medical examiner to identify a deceased or a cause of death. Further, we may release your medical information to a funeral director where such a disclosure is necessary for the director to carry out his duties.

Required by Law

We may release your medical information where the disclosure is required by law.

Your Rights Under Federal Privacy Regulations

The United States Department of Health and Human Services created regulations intended to protect patient privacy as required by the Health Insurance Portability and Accountability Act (HIPAA). Those regulations create several privileges that patients may exercise. We will not retaliate against a patient that exercises their HIPAA rights.

Requested Restrictions

You may request that we restrict or limit how your protected health information is used or disclosed for treatment, payment, or healthcare operations. We do NOT have to agree to this restriction, but if we do agree, we will comply with your request except under emergency circumstances.

To request a restriction, submit the following in writing: (a) The information to be restricted (b) what kind of restriction you are requesting (i.e. on the use of information, disclosure of information or both), and (c) to whom the limits apply. Please send the request to the address and person listed below.

You may also request that we limit disclosure to family members, other relatives, or close personal friends that may or may not be involved in your care.

Receiving Confidential Communications by Alternative Means

You may request that we send communications of protected health information by alternative means or to an alternative location. This request must be made in writing to the person listed below. We are required to accommodate only reasonable requests. Please specify in your correspondence exactly how you want us to communicate with you and, if you are directing us to send it to a particular place, the contact/address information.

Inspection and Copies of Protected Health Information

You may inspect and/or copy health information that is within the designated record set, which is information that is used to make decisions about your care. Texas law requires that requests for copies be made in writing and we ask that requests for inspection of your health information also be made in writing. Please send your request to the person listed below.

We can refuse to provide some of the information you ask to inspect or ask to be copied if the information:

- Includes psychotherapy notes
- Includes the identity of a person who provided information if it was obtained under a promise of confidentiality
- Is subject to the Clinical Laboratory Improvements Amendments of 1988
- Has been compiled in anticipation of litigation

We can refuse to provide access to or copies of some information for other reasons, provided that we provide a review of our decisions on your request. Another licensed health care provider who was not involved in the prior decision to deny access will make any such review.

Texas law requires that we are ready to provide copies or a narrative within 15 days of your request. We will inform you of when the records are ready and if we believe access should be limited. If we deny access, we will inform you in writing.

HIPAA permits us to charge a reasonable cost based fee. The Texas State Board of Medical Examiners (TSBME) has set limits on fees for copies of medical records that under some circumstances may be lower than the charges permitted by HIPAA. In any event, the lower of the fee permitted by HIPAA or the fee permitted by the TSBME will be charged.

Amendment of Medical Information

You may request an amendment of your medical information in the designated record set. Any such request must be made in writing to the person listed below. We will respond within 60 days of your request. We may refuse to allow an amendment if the information:

- Wasn't created by this practice or the physicians here in this practice
- Is not part of the Designated Record Set
- Is not available for inspection because of an appropriate denial
- If the information is accurate and complete

Even if we refuse to allow an amendment you are permitted to include a patient statement about the information at issue in your medical record. If we refuse to allow an amendment, we will inform you in writing. If we approve

the amendment, we will inform you in writing, allow the amendment to be made, and tell others that we now have the correct information.

Accounting of Certain Disclosures

The HIPAA privacy regulations permit you to request, and us to provide, an accounting of disclosures that are other than for treatment, payment, health care operations, or made via an authorization signed by you or your representative. Please submit any request for an accounting to the person listed below. Your first accounting of disclosures (within a 12 month period) will be free. For additional requests within that period, we are permitted to charge for the cost of providing the list. If there is a charge, we will notify you and you may choose to withdraw or modify your request before any costs are incurred.

Appointment Reminders, Treatment Alternatives, and Other Health-related Benefits

We may contact you by telephone, email, or both to provide appointment reminders, information about treatment alternatives, or other health-related benefits and services that may be of interest to you.

Complaints

If you are concerned that your privacy rights have been violated, you may contact the person listed below. You may also send a written complaint to the United States Department of Health and Human Services. We will not retaliate against you for filing a complaint with the government or us. The contact information for the United States Department of Health and Human Services is:

U.S. Department of Health and Human Services
HTPAA Complaint
7500 Security Blvd. C5-24-04
Baltimore, MD 21244

Our Promise to You

We are required by law and regulation to protect the privacy of your medical information, to provide you with this notice of our privacy practices with respect to protected health information, and to abide by the terms of the notice of privacy practices in effect.

Questions and Contact Person for Requests

If you have any questions or want to make a request pursuant to the rights described above, please contact:

Administrator
2425 Highway 121
Bedford, TX 76021
Office: 817-540-4477 Fax: 817-540-5633

This notice is effective on the following date: April 14, 2003

We may change our policies and this notice at any time and have those revised policies apply to all the protected health information we maintain. If, or when, we change our notice, we will post the new notice in the office where it can be seen.

FINANCIAL POLICY

Texas Orthopedic Specialists, P.A. recognizes the need for a clear understanding between patient and physician regarding financial arrangements for medical care. The following information is provided to help avoid misunderstanding concerning your responsibility for payment for services that we provide to you. Please allow us to answer any questions that you may have before your visit.

1. **Proof of Insurance:** Patients are required to show both proof of insurance and a Government-issued Photo ID at their initial visit and before any subsequent visit thereafter.
2. **Changes In Insurance:** The patient (parent or legal guardian) is responsible for informing our Front Desk Supervisor of any changes in your insurance coverage since your last visit. Please assure that notification is made no later than 24 hours prior to your appointment to avoid you having to re-schedule your appointment.
3. **Payment:** Payment is expected at the time of service. We will file your insurance as a courtesy to you. If your deductible has not been met and/or if you are responsible for a co-payment under your plan, we will expect the payment of such upon the delivery of services and immediately upon the end of your visit. There will be a \$30 fee for returned checks.
 - a. **Managed Care:** Co-payment amounts for all HMO's, PPO's, POS's are due at the time of check-in. **IMPORTANT!** If your insurance plan requires a referral authorization from a primary care physician, please present the referral at your initial visit. *Failure to obtain the referral and/or to present it to the Front Desk may result in your having to pay more for the services.* Payors/plans that require the referral are quick to either deny or reduce coverage based on "out of network" or "non-covered treatment" when care is provided without the referral.
 - b. **Medicare:** Texas Orthopedic Specialists, PA is a participating provider with the Medicare program and accepts, *as a condition of participation in that program*, payment toward your deductible and co-insurance. We require a copy of your supplemental insurance card(s) and/or policy(ies) if you do not have the card(s).
 - c. **Children of Divorced and/or Legally Separated Parents:** The parent who seeks care for a dependent under the age of eighteen is responsible for payment of all services rendered, the decree of divorce or separation or child support order notwithstanding.
 - d. **Missed Appointment Policy:** We must be notified at least 24 hours in advance of an appointment cancellation/need to reschedule. A \$50.00 fee may be charged for no show or late cancellation of appointments. Payment of this fee is the responsibility of the patient and is not covered by insurance plans.
 - e. **Physician Assistant Services:** An integral part of your care is likely to be delivered by one or more of our Licensed Physician Assistants (PA's). Not all insurance companies agree to reimburse for all of the services provided by the PA's. The services that the PA's provide are services that are needed, directly ordered by the physician as services that are both necessary and appropriate to your care plan. The patient is responsible for payment of any and all amounts not reimbursed by the insurance company or plan for services provided by the PA's.
 - f. **Charges for Forms:** A \$25.00 fee will be charged for completion of disability, life insurance, and other forms requested by a third party payors or patients.
4. **Acknowledgement.** Your signature(s) below affirm that you have carefully read, understand, and fully agree to the Financial Policies of Texas Orthopedic Specialists, P.A. If you have any questions or need clarification regarding any of the financial policies, please contact us at (817) 540-4477.

Patient Name (please print)

Signature

_____/_____/_____
Date