Allergy & Asthma Specialists, Ltd.

Welcome to our practice!

We are looking forward to meeting you and assisting with your medical care. In an effort to ensure an optimal appointment experience, please arrive 30 minutes prior to your appointment time.

Please begin by completing your registration forms online at www.allergydocs.net. Print, complete all necessary sections, and bring them to your appointment along with:

- picture ID
- insurance cards
- list of all current medications
- notes from referring physician
- pertinent medical records
- referral/authorization (if required)

Your appointment will need to be rescheduled in the event that the above documentation is not presented at the time of check-in.

In the event that **allergy testing** is performed, please refer to the guidelines below:

Please wear two piece clothing with an undershirt if possible.

Do not apply any moisturizers to your skin on the day of your appointment.

Abstain from antihistamines 5 days prior to your appointment. These include but are not limited to:

- Benadryl (diphenhydramine)
- Zyrtec (cetirizine)
- Xyzal (levocetirizine)
- Claritin (loratadine)
- Clarinex (desloratadine)
- Allegra (fexofenadine)
- Zantac (ranitidine)
- Atarax (hydroxyzine)
- Doxepin/Elavil
- Pepcid (famotidine)
- Chlorpheniramine/Chlor-Trimeton
- Pataday/Pazeo
- Patanol
- Patanase
- Astepro (astelin)
- Allergy eye drops
- All medications containing “PM”

You may continue ALL other medications including any asthma inhaler(s). If you have questions regarding stopping any medication, please call our office and speak with a member of our nursing staff.

In consideration of our asthmatic patient population, we request that you refrain from using scented lotions, perfumes, and colognes while visiting our office.

If you are unable to keep your appointment, please notify our office 24 hours in advance. Patients will be charged a $75.00 “no show” fee if appointments are not canceled 24 hours prior to their scheduled time. Payment is due at the time of service.

Thank you for taking the time to prepare for your visit to our office. We look forward to seeing you!

-Allergy and Asthma Staff

Allergy & Asthma Specialists, LTD

New Patient Questionnaire

Patient's Name:

Date of Birth:

Reason for visit:

Patient's Primary Care Physician:

PCP's Phone Number:

PCP's Address:

Other Physician's Involved in Patient's Care:

Preferred Pharmacy & Street Address:

Preferred Lab: ☐Sentara ☐Labcorp☐CHKD ☐Quest ☐Bon Secour☐Other:_____

Medications: Please provide a list of all current medications (prescription and over the counter medications)

Medication	Strength	Frequency

Known Drug Allergies:

☐ No known drug allergies

Drug	Reaction	Drug	Reaction

Past Medical History:

☐ No past medical history

☐ Asthma	☐ Stroke	☐ Cancer	☐ Other/Explain:
☐ Eczema	☐ Thyroid disease	☐ Anxiety	_____
☐ COPD	☐ Arthritis	☐ Depression	_____
☐ Allergic rhinitis	☐ Diabetes	☐ Infections, recurring	_____
☐ Hives	☐ Reflux (GERD)	☐ Latex allergy	_____
☐ High blood pressure	☐ Irritable bowel	☐ Bee/stinging insect allergy	_____
☐ High cholesterol	☐ Celiac disease	☐ Food allergy	_____
☐ Heart disease		Foods:_____	

Last Flu Vaccine:_____ **Last Pneumonia Vaccine**:_____

Surgical History:

☐ No surgical history

New Patient Questionnaire

Social History: **Please check all that apply**

Work History	☐Full time ☐Part time ☐Retired ☐Not currently working ☐Works from home **Occupation**:_____
Student	☐Full time ☐Part time ☐N/A **Name of school/daycare**:_____
Work/School Exposure	☐Dust ☐Air contaminants ☐Chemicals ☐Second hand smoke ☐Symptoms get better at home, worse at work/school
Sports/Hobbies	_____
Smoking History	☐Never smoked ☐Previous smoker: **Start Age**:_____ **Stop Age**:_____ **Pack(s) per day:**_____ ☐Current smoker: **Start Age**:_____ **Pack(s) per day:**_____
Alcohol Use	☐Never ☐Rarely ☐Socially ☐Daily

Family History:

☐Patient Adopted

	Total Number of:	**Please indicate number of siblings/children impacted by the following:**
Father		☐Deceased ☐ Environmental Allergies☐Asthma ☐Eczema ☐Drug Allergy ☐Food Allergy ☐Insect Allergy ☐Latex Allergy ☐Hives ☐Angioedema☐Cancer
Mother		☐Deceased ☐ Environmental Allergies☐Asthma ☐Eczema ☐Drug Allergy ☐Food Allergy ☐Insect Allergy ☐Latex Allergy ☐Hives ☐Angioedema☐Cancer
Brother(s)	_____	__Deceased __Environmental Allergies__Asthma __Eczema __Drug Allergy __Food Allergy __Insect Allergy __Latex Allergy __Hives __Angioedema__Cancer
Sister(s)	_____	__Deceased __Environmental Allergies__Asthma __Eczema __Drug Allergy __Food Allergy __Insect Allergy __Latex Allergy __Hives __Angioedema__Cancer
Child(ren)	_____	__Deceased __Environmental Allergies__Asthma __Eczema __Drug Allergy __Food Allergy __Insect Allergy __Latex Allergy __Hives __Angioedema__Cancer
Additional <u>immediate</u> family history:		

Environmental History: **Please check all that apply**

Home	☐House ☐Condo ☐Townhome ☐Apartment ☐Mobile home ☐Dorm ☐Farm
	Year residence was built:Patient has lived there since:
Foundation	☐Slab ☐Crawl space* ☐Basement *Is crawl space sealed? ☐Yes ☐No
Heating	☐Central ☐Baseboard ☐Radiator ☐Wood stove ☐Space heater
Cooling	☐Central ☐Window Units ☐Open windows
Air Quality	Air filters are changed/cleaned every: ☐Month ☐3 months ☐6 months ☐Year
	The home has a(n) ☐Humidifier ☐Dehumidifier ☐HEPA filter ☐Air purifier ☐None
Smoke Exposure	☐No exposure to smoke ☐Exposure to second hand smoke ☐Patient smokes
Animal Exposure (Indicate # of animals)	☐None __Dog(s) __Cat(s) __Bird(s) __Rabbit(s) __Horse(s) __Goat(s) __Mice/Rat(s) __Guinea pig(s) __Hamster(s)
Pests Issues	☐None ☐Cockroaches ☐Mice/Rodents ☐Extermination is performed regularly
Mold Issues	☐None ☐Current ☐Previous history
Indoor Plants	☐None ☐ A few ☐A lot
Linens	Washed: ☐Every few days ☐Weekly ☐Every 2 weeks ☐Monthly ☐Infrequently
	Water Temperature: ☐Hot ☐Cold ☐Warm
Pillows	☐Feather ☐Synthetic ☐Dust mite covers
Comforter/Mattress	☐Feather ☐Synthetic ☐Dust mite covers
Flooring	☐Carpet ☐Wood ☐Tile
Overall Cleanliness	☐Clean ☐Dusty ☐Neat ☐Cluttered

New Patient Questionnaire

Review of Systems: **Please mark current AND/OR recurring symptoms**

Constitutional	☐Fever ☐Chills ☐Fatigue ☐Decrease appetite ☐Night Sweats
Eyes	☐Itchy ☐Redness ☐Watery ☐Redness of eyelid ☐Discharge ☐Dry ☐Worsening vision ☐Swelling of eyelid ☐Gritty ☐Currently wearing contacts ☐Currently wearing glasses
Ears	☐Itchy ☐Full ☐Pressure ☐Popping ☐Earache ☐Ringing ☐Vertigo ☐Hearing loss ☐Drainage
Nose	☐Itching ☐Discharge ☐Sneezing ☐Stuffy ☐Nose bleeds ☐Loss of smell ☐Snoring ☐Mouth breathing
Throat	☐Itchy ☐Postnasal drip ☐Constantly clearing throat ☐Sore throat ☐Hoarseness ☐Difficulty swallowing ☐Mouth sores ☐Mouth dryness
Head/Neck	☐Headache ☐Sinus pain/pressure ☐Headaches during certain seasons ☐Sinus infections ☐Swollen neck glands
Respiratory	☐Difficulty breathing ☐Wheezing ☐Chest tightness ☐Cough ☐Sleep apnea ☐Breathing interrupts sleep ☐Wheezing with exercise
Cardiovascular	☐Chest pain ☐Palpitations ☐Heart murmur ☐Dizziness
Gastrointestinal	☐Heart burn ☐Abdominal discomfort ☐Nausea ☐Vomiting ☐Bloating ☐Diarrhea ☐Constipation
Genitourinary	☐Decreased urine output ☐Feeling dehydrated ☐Urinary incontinence ☐Frequent awakenings to urinate ☐Pain during urination
Psychiatric	☐Anxiety ☐Depression
Neurological	☐Fainting ☐Tingling ☐Numbness ☐Paralysis ☐Limb weakness ☐Confusion ☐Decreased consciousness ☐Memory loss ☐Abnormality of walk ☐Difficulty with balance
Musculoskeletal	☐Muscle aches ☐Joint pain ☐Limb swelling
Endocrine	☐Increased thirst ☐Increased urination ☐Heat intolerance ☐Cold intolerance ☐Alternately too hot/too cold ☐Excessive sweating
Skin	☐Itching ☐Rash ☐Eczema ☐Skin lesions ☐Hives ☐Dermatographic ☐Seborrheic dermatitis☐ Angioedema☐Dry ☐Contact dermatitis
Hematology	☐Bruise easily ☐Bleed easily ☐Anemic

Additional pertinent information for today's visit: _____

_____

_____

_____

_____

Name of Person Completing Form: _____

Relationship to Patient: _____

Signature: _____ **Date:** _____

Please bring a copy of all pertinent labs and medical records to your appointment.

Allergy & Asthma Specialists, Ltd.

PATIENT INFORMATION

Name:	**Preferred language: ___English Other _____**
Address:	**Date of Birth:**
City:	**Social Security #**
State: Zip:	**Sex: Male____ Female____**
Home Phone#:	**Referring Physician:**
Work Phone#:	**Family Dr:**
Cell Phone#:	**Emergency Contact:**
Email address:	**Emergency Phone#:**
Marital Status: Single Married Widowed Divorced	**Emergency Relationship:**
Possibility of Pregnancy: Yes No	**Employer:**
Race: ___Black/ African American ___White ____Asian	**Employer address:**
___Pacific Islander ___Native American ___Other	**Spouse's Name:**
Ethnicity: ___ Hispanic/Latino ____ Non-Hispanic/Latino	**Spouse's Employer:**

RESPONSIBLE PARTY INFORMATION

Name:	**Date of Birth:**
Address:	**Social Security#:**
City:	**Employer:**
State: Zip:	**Employer Address:**
Home Phone#:	**Employer City:**
Work Phone#:	**Employer State: Zip:**
Cell Phone#:	**Relationship to Patient**

INSURANCE INFORMATION

Primary Insurance:	**Secondary Insurance:**
Member#:	**Member#:**
Group Number:	**Group Number:**
Group Name:	**Group Name:**
Effective Date:	**Effective Date:**
Subscriber Name:	**Subscriber Name:**
Subscriber Date of Birth:	**Subscriber Date of Birth:**

Treatment and Financial Responsibility Statement

A. I hereby apply for treatment by the above physicians and/or their assistants. Such treatment is to include X-Rays, injections, preparation of allergy serum, skin testing and such other office procedures as they deem necessary.

B. I, (patient,guarantor) accept responsibility to pay for all services rendered on my behalf.

In the event of default on any payments due ALLERY & ASTHMA SPECIALISTS, LTD, I agree to pay all collection agency fees of 33.3% and/or 33.3% of attorney fees.

C. I understand that my insurance policy is a contract between me and my insurance company and that I am financially responsible to ALLERGY & ASTHMA SPECIALISTS, LTD.

Signature of Patient/Guarantor: _____ Date: _____ Witness: _____

Notice of Deemed Consent HIV Blood Testing

A law was enacted in Virginia in 1989 which authorizes health care providers to test their patients for HIV antibodies when the health care provider is exposed to the body fluids of the patient in a manner which may transmit human immunodeficiency virus (HIV). Pursuant to this law, in the event of exposure, you will be deemed to have consented to such testing and to have consented to the release of the test results to the health care provider who may have been exposed. However, you would be informed before any of your blood would be tested for HIV antibodies pursuant to this provision. The testing would be explained and you would be given the opportunity to ask any questions you might have. I have read and understand the above "Notice of Deemed Consent to HIV Blood Testing

Date: _____ Patient/Legal Representative: _____

Witness:: _____

ALLERGY & ASTHMA SPECIALISTS, LTD.
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.

If you have any questions about this Notice please contact the Privacy Officer at:

481-4383

Effective Date: April 14, 2003 **Revised: April 1, 2013**

We are committed to protect the privacy of your personal health information (PHI).

This Notice of Privacy Practices (Notice) describes how we may use within our practice or network and disclose (share outside of our practice or network) your PHI to carry out treatment, payment or health care operations. We may also share your information for other purposes that are permitted or required by law. This Notice also describes your rights to access and control your PHI.

We are required by law to maintain the privacy of your PHI. We will follow the terms outlined in this Notice.

We may change our Notice, at any time. Any changes will apply to all PHI. Upon your request, we will provide you with any revised Notice by:

- Posting the new Notice in our office.
- If requested, making copies of the new Notice available in our office or by mail.
- Posting the revised Notice on our website: **www.allergydocs.net**

Uses and Disclosures of Protected Health Information

We may use or disclose (share) your PHI to provide health care treatment for you.

Your PHI may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you.

EXAMPLE: Your PHI may be provided to a physician to whom you have been referred for evaluation to ensure that the physician has the necessary information to diagnose or treat you. We may also share your PHI from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

We may also share your PHI with people outside of our practice that may provide medical care for you such as home health agencies.

We may use and disclose your PHI to obtain payment for services. We may provide your PHI to others in order to bill or collect payment for services. There may be services for which we share information with your health plan to determine if the service will be paid for.

PHI may be shared with the following:

- Billing companies
- Insurance companies, health plans
- Government agencies in order to assist with qualification of benefits
- Collection agencies

EXAMPLE: You are seen at our practice for a procedure. We will need to provide a listing of services such as x-rays to your insurance company so that we can get paid for the procedure. We may at times contact your health care plan to receive approval PRIOR to performing certain procedures to ensure the services will be paid for. This will require sharing of your PHI.

We may use or disclose, as-needed, your PHI in order to support the business activities of this practice which are called health care operations.

EXAMPLES:

- Training students, other health care providers, or ancillary staff such as billing personnel to help them learn or improve their skills.
- Quality improvement processes which look at delivery of health care and for improvement in processes which will provide safer, more effective care for you.
- Use of information to assist in resolving problems or complaints within the practice.

We may use and disclosure your PHI in other situations without your permission:

- <u>If required by law:</u> The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. For example, we may be required to report gunshot wounds or suspected abuse or neglect.
- <u>Public health activities:</u> The disclosure will be made for the purpose of controlling disease, injury or disability and only to public health authorities permitted by law to collect or receive information. We may also notify individuals who may have been exposed to a disease or may be at risk of contracting or spreading a disease or condition.
- <u>Health oversight agencies:</u> We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.
- <u>Legal proceedings:</u> To assist in any legal proceeding or in response to a court order, in certain conditions in response to a subpoena, or other lawful process.
- <u>Police or other law enforcement purposes</u>: The release of PHI will meet all applicable legal requirements for release.

- Coroners, funeral directors: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law
- Medical research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.
- Special government purposes: Information may be shared for national security purposes, or if you are a member of the military, to the military under limited circumstances.
- Correctional institutions: Information may be shared if you are an inmate or under custody of law which is necessary for your health or the health and safety of other individuals.
- Workers' Compensation: Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.

Other uses and disclosures of your health information.

Business Associates: Some services are provided through the use of contracted entities called "business associates". We will always release only the minimum amount of PHI necessary so that the business associate can perform the identified services. We require the business associate(s) to appropriately safeguard your information. Examples of business associates include billing companies or transcription services.

Health Information Exchange: We may make your health information available electronically to other healthcare providers outside of our facility who are involved in your care.

Fundraising activities: We may contact you in an effort to raise money. You may opt out of receiving such communications.

Treatment alternatives: We may provide you notice of treatment options or other health related services that may improve your overall health.

Appointment reminders: We may contact you as a reminder about upcoming appointments or treatment.

We may use or disclose your PHI in the following situations UNLESS you object.

- We may share your information with friends or family members, or other persons directly identified by you at the level they are involved in your care or payment of services. If you are not present or able to agree/object, the healthcare provider using professional judgment will determine if it is in your best interest to share the information. For example, we may discuss post procedure instructions with the person who drove you to the facility unless you tell us specifically not to share the information.
- We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death.

- We may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts.

The following uses and disclosures of PHI require your written authorization:

- Marketing
- Disclosures of for any purposes which require the sale of your information
- Release of psychotherapy notes: Psychotherapy notes are notes by a mental health professional for the purpose of documenting a conversation during a private session. This session could be with an individual or with a group. These notes are kept separate from the rest of the medical record and do not include: medications and how they affect you, start and stop time of counseling sessions, types of treatments provided, results of tests, diagnosis, treatment plan, symptoms, prognosis.

<u>All other uses and disclosures not recorded in this Notice will require a written authorization from you or your personal representative.</u>

Written authorization simply explains how you want your information used and disclosed. Your written authorization may be revoked at any time, in writing. Except to the extent that your doctor or this practice has used or released information based on the direction provided in the authorization, no further use or disclosure will occur.

<u>Your Privacy Rights</u>

You have certain rights related to your protected health information. All requests to exercise your rights must be made in writing. [Describe how the patient may obtain the written request document and to whom the request should be directed, i.e. practice manager, privacy officer.]

You have the right to see and obtain a copy of your protected health information.

This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. If requested we will provide you a copy of your records in an electronic format. There are some exceptions to records which may be copied and the request may be denied. We may charge you a reasonable cost based fee for a copy of the records.

You have the right to request a restriction of your protected health information.

You may request for this practice not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. We are not required to agree with these requests. If we agree to a restriction request we will honor the restriction request unless the information is needed to provide emergency treatment.

There is one exception: we must accept a restriction request to restrict disclosure of information to a health plan if you pay out of pocket in full for a service or product unless it is otherwise required by law.

You have the right to request for us to communicate in different ways or in different locations.

We will agree to reasonable requests. We may also request alternative address or other method of contact such as mailing information to a post office box. We will not ask for an explanation from you about the request.

You may have the right to request an amendment of your health information.

You may request an amendment of your health information if you feel that the information is not correct along with an explanation of the reason for the request. In certain cases, we may deny your request for an amendment at which time you will have an opportunity to disagree.

You have the right to a list of people or organizations who have received your health information from us.

This right applies to disclosures for purposes other than treatment, payment or healthcare operations. You have the right to obtain a listing of these disclosures that occurred after April 14, 2003. You may request them for the previous six years or a shorter timeframe. If you request more than one list within a 12 month period you may be charged a reasonable fee.

Additional Privacy Rights

- You have the right to obtain a paper copy of this notice from us, upon request. We will provide you a copy of this Notice the first day we treat you at our facility. In an emergency situation we will give you this Notice as soon as possible.
- You have a right to receive notification of any breach of your protected health information.

Complaints

If you think we have violated your rights or you have a complaint about our privacy practices you can contact:

Privacy Officer , 481-4383

You may also complain to the United States Secretary of Health and Human Services if you believe your privacy rights have been violated by us.

If you file a complaint we will not retaliate against you for filing a complaint.

This notice was published and becomes effective on April 1, 2003

Allergy and Asthma Specialists, Ltd.

ACKNOWLEDGEMENT

I, _____ (patient/responsible party) acknowledge that I have received a copy of Allergy and Asthma Specialists' "Notice of Privacy Practices".

Date: _____ _____
(patient or responsible party)

Allergy and Asthma Specialists, Ltd.

Written Financial Policy

Thank you for choosing Allergy and Asthma Specialists, Ltd. Our primary mission is to deliver the best and most comprehensive care available. An Important part of our mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options

You can choose from:

- Payment in full
- In-house payment plans
- Convenient Monthly Payment Plans[1] from CareCredit
    - Allow you to pay over time
    - No annual fees or pre-payment penalties

Please note:

We also offer In-house payment plans with multiple options of weekly, bi-weekly and monthly payments, and require a partial payment at the beginning of your treatment.

For patients with insurance, we are happy to work with your carrier to maximize your benefit and bill them for services rendered.[2]

A fee of $75 is charged for patients who miss or cancel appointments with lass than 24-hour notice.

Allergy and Asthma Specialists, Ltd. charges $25 for returned checks.

Copays and co-insurances are due at the time of services are rendered.

If you have any questions, please do not hesitate to ask. We are here to help you get the treatment and care you want and need.

_____

Patient, Parent or Guardian Signature Date

_____

Patient Name (Please Print) Date of Birth

[1] Subject to credit approval

[2] However, if we do not receive payment from your insurance carrier, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.

Allergy and Asthma Specialists, Ltd.

STANDARD AUTHORIZATION OF USE AND RELEASE OF PROTECTED HEALTH INFORMATION

INFORMATION TO BE USED OR RELEASED

[ ] Medical
[ ] Financial

PERSONS AUTHORIZED TO USE OR RELEASE INFORMATION

Allergy and Asthma Specialists, Ltd.

PERSONS TO WHOM INFORMATION MAY BE RELEASED AND RELATIONSHIP (This does not apply to physicians)

NAME: _____RELATIONSHIP:_____

NAME: _____RELATIONSHIP:_____

NAME: _____RELATIONSHIP:_____

EXPIRATION DATE OF AUTHORIZATION

This authorization is effective through __/__/__ unless revoked or terminated by the patient or the patient's personal representative.
[ ] Indefinite

Patient Rights

- I have the right to revoke this authorization by submitting a written revocation to this office.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
- I may refuse to sign this authorization and my treatment will not be conditioned on signing.

SIGNATURE

Name of Patient (Print): _____Date of Birth_____

Signature of patient: _____ Date_____

Signature of patient representative:_____ Date_____

Relationship of representative to patient: _____

Rv: 7/2018

Allergy and Asthma Specialists, Ltd.

APPOINTMENT CANCELLATION, LATE ARRIVAL AND/OR NO SHOW POLICY

We are always happy to be able to work with you and your health care needs and reserve a time in your provider's schedule just for you. However, in consideration of other patients who wish to be seen as soon as possible, we do request at least 24 hours notice prior to cancellation of your appointment to provide us with an opportunity to schedule those patients. A cancellation or no show fee of $75.00 will apply if our office is not notified at least 24 hours I advance that you will be unable to make your appointment.

As a courtesy, we do call in advance to confirm appointments; however, we consider the patient responsible for remembering the date and time of the appointment.

Patients that are running late are asked to call the office as soon as possible to check with the staff if they will be able to keep their appointment.

Patients who are more than 15 minutes late for their appointment may need to be rescheduled to another day and time, in consideration of other patients and their scheduled appointments times.

We greatly appreciate your understanding of and cooperation with our office policies and assisting us with accommodating our patients' scheduling needs.

Please sign below that you have read and acknowledge the above information provided to you. If you would like a copy of any of your paperwork, please ask one of team to make copies for you.

Patient Name_____ Date of Birth_____

Patient/Responsible Party signature_____

Date_____