PEEK A BOO

Pediatrics

821 N. 2nd Street
Philadelphia, PA 19123
Office (267)7023850
Fax (267) 8584617

NEW PATIENTS

1. VACCINATION

- We follow the AAP guidelines for vaccinations
- ALL our patients are expected to get the mandatory vaccines

2. INSURANCES

- *We take all Major Insurances -*

CURRENTLY WE DO NOT ACCEPT: ALL HMO PLANS AND MEDICAID
Some of which are but not a complete list:

a. Independence Blue Cross Keystone Health Plan East
b. Independence Blue Cross Keystone First
c. United Health Partners
d. AETNA Better Health
e. AETNA HMO Plans
f. United Health Care Community Plan
g. United Healthcare Compass
h. CIGNA Healthspring
i. Highmark Blueshield Special Care
j. Tricare Prime

PLEASE CALL OUR OFFICE ANYTIME AND WE CAN FACILITATE AND CONFIRM YOUR INSURANCE

PEEKABOO PEDIATRICS . 821 N. 2nd St. Philadelphia, PA 19123 . (P) 267.702.3850 (F) 267.858.4617

UNDERSTANDING OFFICE VISITS AND BILLING PRACTICES

PEEKABOO PEDIATRICS is committed to providing and maintaining the best possible care for our patients. Your review of billing practices in advance allows for good communication and common understanding.

Insurance company billing policies dictate that we differentiate between two types of services.

- Wellness Services
- Problem Oriented Services

What may be included in Wellness Services? (also known as Preventative Visit or Physical/Well Child Check)

- Age appropriate history
- Preventive counseling (e.g. proper nutrition)
- Age appropriate medical exam
- Review of vaccine history
- Anticipatory guidance (e.g reducing fall risks)
- Review and interpretation of any recommended labs

What other Wellness Visit Related Services that may/will be billed separately?

- Vaccine products
- Vaccine administration services (including counseling)
- Routinely recommended labs
- Screenings (e.g, Vision, Hearing, Developmental Screens, Depression Screen, Postpartum Depression Screen)

During Wellness Visits we perform ALL RECOMMENDED SCREENINGS APPROPRIATE to age and gender and seek to uncover any conditions that would lead to suboptimal health in the years to come. These screens are RECOMMENDED BY THE AMERICAN ACADEMY OF PEDIATRICS. The use of screening tools also allows us to begin treating conditions in their earliest stages. ***These screens are considered a problem oriented service by most insurance plans and therefore may generate cost sharing in the form of a copayment, co-insurance, and/or deductible.***

The Affordable Care Act makes many wellness and/or preventative services covered in full by most insurance plans. However, this is not true of many problem-oriented services. Management of medical diagnoses, including the need for medication refills of any sort, are categorized by insurance companies as problem-oriented services. Evaluation and/or management of ***any complaint and/or symptom*** offered by a patient or identified upon questioning during a wellness exam constitutes a problem-oriented service which may result in your insurance company processing your claim using both wellness benefits and problem oriented benefits.

Problem Oriented Services

Some common examples of problem –oriented services include but are not limited to:

- Illness addressed (ears, eyes, nose, throat, cough, fever, etc)
- Chronic conditions addressed e.g., obesity, asthma, ADHD/ADD
- Suture/Staple Removal
- Allergy Shots
- Follow-ups: Newborn weight checks, Ear recheck, etc.
- Behavior Concerns

Examples of screening services include but are not limited to:

- Cholesterol, Lead, Hemoglobin Screening
- Hearing screening
- Developmental Screenings (ie: 9, 12mo questionnaires)
- Spirometry
- Mental Health questionnaires
- Vision Screening
- Adolescent questionnaire
- Autism screening (MCHAT)

Examples of office procedures include but are not limited to:

- Urine dip/urinalysis
- Rapid Strep Test
- Rapid Monospot Test
- Pregnancy test
- Hemoglobin Test
- Rapid Fllu, RSV
- Lipid Panel
- Nebulizer treatments
- Umbilical Cauterization (Silver Nitrate)
- Fecal occult test
- Hearing screen

**all laboratory, radiology and/or pathology services performed or referred by our providers may result in additional bills and/or charges from other companies that may include but are not limited to: such as Quest, Labcorp. You may receive separate billing statements for these services.

Our medical practice wants to provide the most up to date, comprehensive care possible, which is why we address these issues during wellness visits. Additionally, we try to eliminate the need for the patient to return to the office, whenever possible.

It is the responsibility of the policy holder to be aware of their insurance plan's benefits and coverage. Deductible, copay, coinsurance or out of pocket expenses agreed upon between you and your insurance company are out of our control

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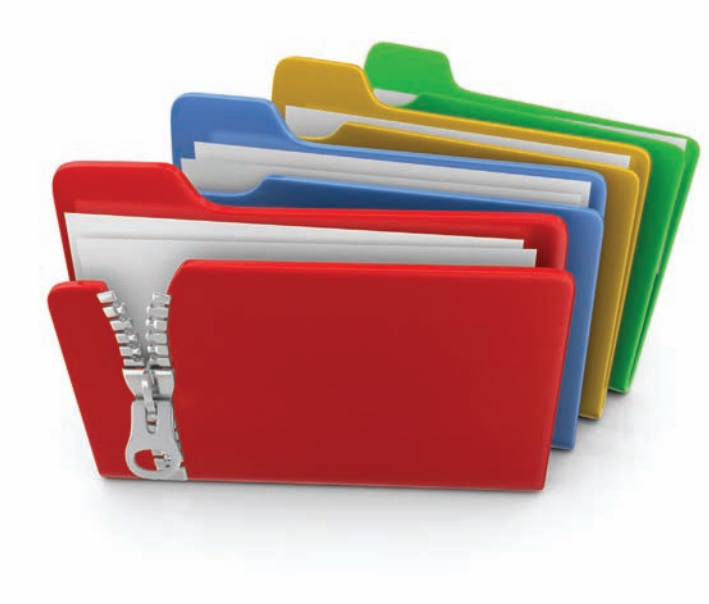

Your Information. Your Rights. Our Responsibilities.

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.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.

continued on next page

Your Rights *continued*

Ask us to limit what we use or share

- You can ask us **not** to use or share certain health information for treatment, payment, or our operations.
  - We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
  - We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory • Contact you for fundraising efforts *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

This Notice of Privacy Practices applies to the following organizations.

PEEKABOO PEDIATRICS
821 N. 2nd Street
Philadelphia, PA 19123
Phone: (267) 702 3850
Fax: (267) 858 4617

PRIVACY OFFICER
Katrina Poblete, M.D.
821 N. 2nd Street
Philadelphia, PA 19123
Phone: (267) 702 3850
Fax: (267) 858 4617

PEEK A BOO
Pediatrics

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

We are required by State and Federal laws, including the HIPAA rules, to safeguard general and health-related information about you. We have a Notice of Privacy Practices that explains how your protected health information is handled and how we may use and/or disclose your protected health information. The Notice of Privacy Practices is provided to patients (and/or their authorized representatives) when they first become our patient.

We are asking you to sign this form to show that we offered you a copy of our Notice of Privacy Practices. Copies are available on our website, in the waiting room, and personal copies can be requested from our staff. By signing below you are only acknowledging that you were offered or received a copy of the **Notice of Privacy Practices**. You may refuse to sign this acknowledgment if you wish. You are not making any statement about the content of the Notice of Privacy Practices or about your agreement or disagreement with any portion of it.

Acknowledgment
I acknowledge that Peekaboo Pediatrics has offered or provided me with a copy of its Notice of Privacy Practices, which describes how medical information about me may be used and/or disclosed, and how I can access this information.

I understand that if I have questions or complaints I may contact: **Privacy Officer Katrina Poblete, MD, at 267 702 3850.** I also understand that I am entitled to receive updates upon request if Peekaboo Pediatrics amends or changes its Notice of Privacy Practices in a material way.

_____ _____
Signature of patient or patient's representative Date

_____ _____
Printed name of patient/patient's representative Relationship to patient

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For OFFICE USE ONLY
I made a good faith effort to obtain a written acknowledgment of receipt of the Notice of Privacy Practices from the above-named patient, but was unable to because:

[ ] Patient declined to sign this Written Acknowledgment.

[ ] Other (Specify): _____

_____ _____
Name and Title of Employee Date

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Thank you for choosing Peekaboo Pediatrics.

How did you hear about us? ( )Friend/Family _____ ( ) Internet ( ) Physician ( )Others _____

Patient and Family Information

Child 1: Last Name:_____ First Name:_____ MI: ___

DOB:____/____/_____ Sex: ☐M ☐F

Child 2: Last Name:_____ First Name:_____ MI: ___

DOB:____/____/_____ Sex: ☐M ☐F

Child 3: Last Name:_____ First Name:_____ MI: ___

DOB:____/____/_____ Sex: ☐M ☐F

Child 4: Last Name:_____ First Name:_____ MI: ___

DOB:____/____/_____ Sex: ☐M ☐F

Parent/Legal Guardian #1

Child(ren)'s parents are: ☐ Married ☐Divorced ☐Never Married ☐Separated ☐ Widow(er) ☐Other

Name: _____ Relationship to Patient: _____

DOB:____/____/____ Home phone: _____ Cell phone: _____

Work phone: _____ Email:_____

Address: _____

Employer: _____ Occupation: _____

Best number to reach me is: ☐Home ☐Cell ☐Work

Peekaboo Pediatrics may contact me via: ☐Home ☐Cell ☐Work ☐Email

Peekaboo Pediatrics may leave messages or lab results via: ☐Home ☐Cell ☐Work ☐Email

Lives with patient? ☐ Yes ☐ No If you do not live with the patient, please provide the address:

_____

(Street) (City/State/Zipcode)

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Fax:(267) 858 4617

Parent/Legal Guardian #2

Name: _____ Relationship to Patient: _____

DOB:____/___/____ Home phone: _____ Cell phone: _____
Work phone: _____ Email:_____
Employer: _____ Occupation: _____
Address:_____

Best number to reach me is: ☐Home ☐Cell ☐Work

Peekaboo Pediatrics may contact me via: ☐Home ☐Cell ☐Work ☐Email

Peekaboo Pediatrics may leave messages or lab results via: ☐Home ☐Cell ☐Work ☐Email

Lives with patient? ☐ Yes ☐ No If you do not live with the patient, please provide the address (please disregard if same as Parent/Legal Guardian #1):

_____
(Street) (City/State/Zipcode)

Insurance Information

PLEASE PUT BOTH INSURANCES IF PARENTS INSURANCE ARE DIFFERENT TO CHECK ELIGIBILITY. IT IS THE PARENTS RESPONSIBILITY TO CHECK WHICH INSURANCE WILL BE APPLICABLE TO THE PATIENT. PLEASE ASK ABOUT THE BIRTHDAY RULE IF PARENTS HAVE DIFFFERENT INSURANCES

☐Self-Pay ☐Insurance Coverage

Primary Insurance: _____

Claims/Insurance Mailing Address: _____
(Street) (City/State/Zipcode)
Member ID #: _____ Group #: _____

Insured Parent/Policy Holder: _____ Policy Holder's DOB: _____

Policy Holder's SSN: _____ Policy Holder's Employer: _____

Secondary Insurance: _____

Claims/Insurance Mailing Address: _____
(Street) (City/State/Zipcode)
Member ID #: _____ Group #: _____

Insured Parent/Policy Holder: _____ Policy Holder's DOB: _____

Policy Holder's SSN: _____ Policy Holder's Employer: _____

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Person Responsible for Payment of Account

Name : _____

Address: _____

Phone # : _____ Email: _____

Relationship To Child: _____

Additional Contact Questions:

Who should receive billing statements? _____

May all contacts have access to the patient's records? ( ) Yes ( ) No

If parents are divorced or separated please fill out this section:

Who has custody? _____

Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? ( ) Yes ( )No

If yes, please explain and provide a copy of any legal paperwork that supports this restriction.

_____

Emergency Contacts, other than parents. Name & Relationship:

Name:_____ Relationship _____ Phone #: _____

Name:_____ Relationship _____ Phone #: _____

Name:_____ Relationship _____ Phone #: _____

I understand that if any of the above information changes that it is my responsibility to provide Peekaboo Pediatrics with a written update of information indicating all necessary changes.

Signature: _____ Date: _____

Relationship to Patient : _____

Office Use:

*Reveiwed by:*_____ *Insurance verified by:*_____ *Updated by:*_____

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Financial Policy

Thank you for choosing Peekaboo Pediatrics as your healthcare provider. If you have any questions we will be happy to discuss our fees and policy with you anytime.

Payment for services is due at the time services are rendered. For any portion of your balance that is not covered by insurance, or for our private pay patients, we accept cash, check or credit card.

Insurance Policy

We participate with most insurance plans. Each insurance policy is different and it is therefore impossible for us to know know what are your particular benefits may be.

1. Your insurance policy is a contract between you (your employer) and the insurance carrier. We are NOT a party to that contract. Our relationship is with you. We cannot become involved in disputes between you and your insurer regarding deductibles, co-payments, covered charges, secondary insurances, and "usual and customary charges". Therefore it is important to contact your insurance company if you have any questions regarding your benefits and for you to know what your payment obligations will be at the time of service.

2. If your insurance company does not pay your claim within 30 days, it is your responsibility to contact your insurance to expedite payment. If your insurance company does not pay within 60 days you will be responsible for payment.

Copayments and Deductibles

1. Depending on your insurance policy, a copayment and/or deductible may be required at the time of service. These payments are expected at the time of service. Payment may be made in cash, by check or by card. We also accept Health Savings Account (HSA) cards for payment.

2. Please note that the copayment is a contractual requirement from the insurance company and cannot be written off by the office. If you participate in a High Deductible Health Plan (HDHP) and have not yet paid your deductible in full , it is likely than any non-preventive servise will require payment at the time of those services are rendered.

3. All charges are your responsibility whether your insurance company pays or does not pay. Not all services are a covered benefit in all contracts. Please check your insurance plan or document for any questions.

4. Copayments NOT PAID at the time of service are subject to a $10 processing fee. All balances more than 60 days past due are subject to a penalty of $10 per month to cover the cost of sending additional statements.

Please ensure that if you are unable to bring your child in yourself, whoever brings the child in is prepared to make all payments.

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Checks

1. Returned checks and balances older than 90 days may be subject to collection placement and collection fees which will be charged to the responsible party.

2. There will be a $25 NSF charge on all returned checks

Overpayment

Occasionally payment results in overpayment on your account and generally this balance remains on your account as a credit for use at a future visit. You may request a refund of overpayment by notifying the Office.

Credit Card On File

In order to make sure that we can collect your portion of the bill once your insurance company processes the claim, we require that a valid credit card be kept on file with the practice. Your card will only be charged the outstanding amount that your insurance company determines to be 'patient responsibility', as spelled out in your Explanation Of Benefits (EOB). Once your card is charged, a receipt will be sent to you by email.

Appointments

Missing an appointment without giving prior notice to the practice deprives other patients of the chance to take a slot that opens up. We require notice of at least 1 business day for all cancellations. Failure to notify the office in a timely manner more than once may result in a no show fee of $25 which will not be covered by your insurance plan.

We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate with our office any such problems so that we can assist you in management of your account with a payment plan.

Again, Thank You for choosing Peekaboo Pediatrics. We appreciate the opportunity to serve you.

I have read and understood the above policy and agree to it.

Parent/Guardian Name _____ Relationship to patient _____

Signature _____ Date ____/____/____

Patient/Child's Name _____

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CREDIT CARD ON FILE POLICY

At Peekaboo Pediatrics, we require keeping your credit or debit card on file as a convenient method of payment for the portion of services that your insurance doesn't cover, but for which you are liable.

Your credit card information is kept confidential and secure and payments to your card are processed only after the claim has been filed and processed by your insurer, and the insurance portion of the claim has paid and posted to the account.

I authorize Peekaboo Pediatrics to charge the portion of my bill that is my financial responsibility to the following credit or debit card:

☐ **Amex** ☐ **Visa** ☐ **Mastercard** ☐ **Discover**

Credit Card Number _____

Expiration Date _____ / _____

Cardholder's Name _____

Signature _____

Billing Address _____ Apt/Ste _____

City_____ State _____ **Zip** _____

EMAIL to send Receipt : _____

I/We the undersigned, authorize and request Peekaboo Pediatrics to charge my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility.

This authorization relates to all payments not covered by my insurance company for services provided to me by Peekaboo Pediatrics.

This authorization will remain in effect until I/We cancel this authorization. To cancel, I/We must give a 60 day notification to Peekaboo Pediatrics in writing and the account must be in good standing.

Patient/s Name (Print) : _____ _____

_____ _____

Cardholder's Signature : _____

Date : _____

PEEK A BOO
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Credit Card On File

In order to make sure that we can collect your portion of the bill once your insurance company processes the claim, we require that a valid credit card be kept on file with the practice. Your card will only be charged the outstanding amount that your insurance company determines to be 'patient responsibility', as spelled out in your Explanation Of Benefits (EOB). Once your card is charged, a receipt will be sent to you by email.

Patient/s Name (Print) : _____ _____

_____ _____

Cardholder's Signature : _____

Date : _____

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ASSIGNMENT OF BENEFITS FORM

All professional services rendered are charged to the patient and are due at the time of service, unless insurance coverage is verified and Peekaboo Pediatrics is a participating provider. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits
I hereby assign all medical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including private insurance and any other health/medical plan, to issue payment check(s) directly to Peekaboo Pediatrics for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information
I hereby authorize Peekaboo Pediatrics to: (1) release any information necessary to insurance carriers regarding myself and/or my dependent's illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

I have requested medical services from Peekaboo Pediatrics on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges (copay, coinsurance and/or deductible) incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

_____ _____
Patient/Responsible Party Signature Date

Child/Children(s) Name(s):

_____ _____

_____ _____

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Consent To Treat Minor

I hereby give consent to Peekaboo Pediatrics to perform any radiology or lab testing, examination, anesthetic, medical, or surgical diagnosis or treatment and hospital care as deemed advisable by a licensed physician as well as any assistant on the staff of Peekaboo Pediatrics.

I understand that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required.

This consent is given to any and all such diagnoses, treatments and hospital care which a licensed physician at Peekaboo Pediatrics recommends.

This authorization will remain in effect until revoked in writing by the parent or legal guardian.

Signed: _____

Print Name: _____

Date: _____

Please specify relationship to minor:

- ☐ Parent with legal custody
- ☐ Guardian with legal custody

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Fax: (267) 858 4617

Authorization for Release of Medical Information

Patient Name: _____ DOB: ____/____/____

I, _____ hereby authorize the release of medical information **TO**: Peekaboo Pediatrics
821 N. 2nd Street
Philadelphia, PA 19123
Phone: (267) 702 3850
Fax: (267) 858 4617

FROM:
Doctor/Clinic/Hospital: _____

Address: _____

_____

Telephone: _____ Fax : _____

Please release the following:
___ **All health information (including growth charts and vaccination records)**
___ History/Physical Exam
___ Progress Notes
___ Discharge Summary
___ Consultation Reports
___ Other (specify): _____
___ Diagnostic Test Reports
___ Radiology/Images
___ Lab Results
___ Pathology Reports

I consent to the release of information related to HIV/AIDS or infection with any other communicable diseases and information related to behavioral or mental health services and treatment for alcohol and drug abuse, with the rest of the medical records

___ Yes, I consent to the release of this information.
___ No, I do not consent to the release of this information.

Purpose of disclosure:
___ Treatment/ Continuing medical care
___ Change of Physician
___ Personal Use
___ Attorney/Legal
___ Change of Insurance Please Specify your new carrier _____
___ Other _____

I understand that I may revoke this authorization in writing at any time. Otherwise, this authorization shall remain valid until such time as it is revoked in writing.

Signature: _____

Date: _ _____

Print Name: _____

Relationship to Patient:_____