PREMIER SPINE INSTITUTE
BONAVENTURE NGU, M.D.

REGISTRATION

Date_____ Patient Last Name_____ First Name_____ Initial_____
Home Phone_____ Work Phone_____ Email_____
Street Address_____
City_____ State_____ Zip_____
Sex ☐ M ☐ F Age_____ Birth date_____ Email_____
Social Security #_____ State & Driver's License #_____
Insured Name_____ How and where did you learn about our clinic? _____
Last Name First Name Initial
Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other
Condition/ Illness Related To ☐ Illness ☐ Employment ☐ Auto ☐ Other

EMPLOYER	Company Name_____ Occupation_____ Address_____ Phone_____ ☐ Full-time ☐ Part-time City _____ State _____ Zip_____ Years Employed_____
SPOUSE (PARENT)	Name_____ Birthdate_____SSN:_____ Last Name First Name Initial Employer Name_____ Years Employed_____ Address_____Phone_____ Occupation_____ City_____ State _____ Zip_____ ☐ Full-time ☐ Part-time
PATIENT INSURANCE INFORMATION	Please list any and all insurance and/or employee health care plan coverage you or your spouse may have Insurance Company or Health Care Plan Name_____ Policy/Group #:_____ Effective Date:_____ Name of Insured:_____ ID #:_____
SPOUSE COINSURANCE INFORMATION	Please list any and all coinsurance and/or employee health care plan coverage you or your spouse may have Insurance Company or Health Care Plan Name_____ Policy/Group #:_____ Effective Date:_____ Name of Insured:_____ ID #:_____
MEDICAL AND LEGAL INFORMATION	**Are your present symptoms or conditions related to or the result of an auto accident, work-related injury, or other personal injury someone else might be legally liable for? ☐ Yes ☐ No** Your Initials:_____ If you answered yes, please fill out accident specific form, available at the front desk. Pregnant ☐ Yes ☐ No Pacemaker ☐ Yes ☐ No Family Physician_____ Person to contact in emergency (Name and Phone #)_____ Attorney_____ Telephone:_____ Address_____ City _____ State _____ Zip_____ Alt #_____
EMERGENCY CONTACT	Name_____ Relation _____ Address_____ Phone_____ Cell _____ City _____ State _____ Zip_____ Alt #_____
PRIMARY CARE PHYSICIAN	Name_____ NP/PA Name _____ Address_____ Phone_____ Fax _____ City _____ State _____ Zip_____
CARDIO PHYSICIAN	Name_____ NP/PA Name _____ Address_____ Phone_____ Fax _____ City _____ State _____ Zip_____
OTHER SPECIALITY PHYSICIAN	Name_____ NP/PA Name _____ Address_____ Phone_____ Fax _____ City _____ State _____ Zip_____

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PLEASE LIST YOUR CURRENT PROBLEM OR CHIEF COMPLAINT & REASON FOR VISIT TODAY	_____ _____ _____ _____
REFERRED BY	PRIMARY CARE PHYSICIAN PAIN MANAGEMENT PHYSICIAN ORTHOPAEDIC PHYSICIAN Dr. _____ OTHER: Name: _____ INSURANCE WEBSITE INTERNET PREVIOUS PATIENT: _____
ONSET OF PAIN OR INJURY	DATE: _____ or YEAR: _____ CAUSE: _____ or CAUSE UNKNOWN
DESCRIBE YOUR CURRENT SYMPTOMS	RADIATES DOWN EXTREMITY: ARM or LEG - RIGHT or LEFT or BOTH SYMPTOMS: PAIN TINGLING NUMBNESS BURNING WEAKNESS AGGRAVATED BY: BENDING LIFTING SITTING STANDING WALKING LAYING PAIN WORSENS: UPON WAKING GOING TO BED WITH DAILY ACTIVITY PAIN SCALE: _____ Rated 1 - 10 (10 being the worst pain level)
PREVIOUS OR CURRENT DIAGNOSTIC TESTING OR TREATMENT	RECENT X-RAYS: yes or no IF SO, LOCATION: _____ RECENT MRI: yes or no IF SO, LOCATION: _____ RECENT CT: yes or no IF SO, LOCATION: _____ PHYSICAL THERAPY: yes or no IF SO, LOCATION: _____ ACUPUNCTURE: yes or no IF SO, WHEN: _____ CHIROPRACTIC CARE: yes or no IF SO, WHEN: _____ PER DR.: _____ EPIDURAL INJECTIONS: yes or no IF SO, WHEN: _____ HOW MANY: _____ PER DR.: _____ PREVIOUS SPINE SURGERY? yes or no IF SO, WHEN: _____ PER DR.: _____ ANY INFO PERTINENT TO CURRENT PROBLEM: _____ _____ _____

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INFORMATION REQUIRED FOR MEANINGFUL USE BY CMS	RACE: ☐ White ☐ Black ☐ Hispanic ☐ Multi-Racial ☐ Other _____ ☐ Single ☐ Married ☐ Life Partner ☐ Widowed ☐ Separated ☐ Divorced Children: YES or NONE If so, how many BOYS? _____ How Many GIRLS? _____ Veteran: Yes or No Branch: _____ Years Served _____ Discharged Status_____ Tobacco Usage: Yes or No What Type: _____ If so, HOW MUCH per Day? _____ How Long? _____ Have you ever tried to Quit? Yes or No If so, by what methods? _____ Year Quit: _____ Alcohol Usage: Yes or No What Type: _____ If so, HOW MUCH per Day? _____ Rate your Usage: Daily Weekly Monthly Occasionally Rarely Socially If previous Abuse noted, did you receive treatment? _____ Year Quit: _____
ANNUAL HEALTH MAINTENANCE QUESTIONAIRE	If Female, date of last Mammogram? _____ If Male, date of last Prostate Exam? _____ Last Pap Smear? _____ Last EGD/Colonoscopy? _____ Last Flu Shot? _____ Immunizations? _____ Any FALL Precautions? _____
PERFERRED PHARMACY	NAME: _____ ADDRESS: _____ PHONE: _____
LIST OF MEDICATIONS **(Must List Name & Dosage)**	_____ _____ _____ _____ _____ _____ _____
ALLERGIES TO MEDICATIONS	☐ NO KNOWN DRUG ALLERGIES or ☐ Known Medication Allergy listed along with Reaction noted _____ _____ _____
DO YOU HAVE ANY OTHER ALLERGIES?	(Metals, Food, Contrast, Dyes, Tape) _____ _____ _____
PAST MEDICAL HISTORY	☐ AIDS/HIV ☐ Drug Abuse ☐ Migraine Headaches ☐ SLE - Lupus ☐ Alcoholism ☐ Diabetes ☐ Multiple Sclerosis ☐ Spinal Stenosis

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	▢ Alzheimer's ▢ Deep Vein Thrombosis ▢ Myocardial Infarction ▢ Spondylolisthesis ▢ Anemia ▢ Fibromyalgia ▢ Obesity ▢ Thyroid Disease ▢ Angina ▢ Gallbladder Disease ▢ Osteoarthritis ▢ Valvular Heart Disease ▢ Arthritis ▢ GERD ▢ Osteoporosis ▢ Heart Murmur ▢ Asthma ▢ Gout ▢ Parkinson Disease ▢ _____ ▢ Atrial Fibrillation ▢ Hepatitis ▢ Peptic Ulcer Disease ▢ Benign Prostatic Hypertrophy ▢ Hyperlipidemia ▢ Psoriasis ▢ _____ ▢ Cerebrovascular Accident ▢ Hypertension ▢ Peripheral Vascular Disease ▢ Congestive Heart Failure ▢ IBS ▢ Renal Disease ▢ _____ ▢ COPD ▢ Juvenile RA ▢ RA – Rheumatoid Arthritis ▢ Coronary Artery Disease ▢ Kidney Disease ▢ Scoliosis ▢ _____ ▢ Crohn's Disease ▢ Liver Disease ▢ Seizure Disorder ▢ Degenerative Joint Disease ▢ Lyme Disease ▢ Sleep Apnea ▢ _____ ▢ Depression Surgery ▢ Scoliosis Surgery ▢ Cancer - Type: _____Year: _____ - Treatment: _____
ANY OTHER PERTINENT MEDICAL HISTORY	_____ _____ _____ _____ _____
PAST SURGERY HISTORY	▢ Back Surgery - Year: _____ ▢ Neck Surgery - Year: _____ ▢ Scoliosis Surgery - Year: _____ ▢ Bowel Resection - Year: _____ ▢ C-Section - Year: _____ ▢ Tubal Ligation - Year: _____ ▢ Appendectomy - Year: _____ ▢ Gallbladder - Year: _____ ▢ Hysterectomy - Year: _____ ▢ CABG x ___ - Year: _____ ▢ Angioplasty - Year: _____ ▢ Heart Cath: _____ - Year: _____ ▢ Hip – Side: _____ - Year: _____ ▢ Knee – Side: _____- Year: _____ ▢ Ankle – Side: _____- Year: _____ ▢ Shoulder – Side: _____ - Year: _____ ▢ Elbow – Side: _____ - Year: _____ ▢ Wrist – Side: _____ - Year: _____ ▢ Hand – Side: _____ - Year: _____ ▢ Carpal Tunnel Release – Side: _____ - Year: _____ ▢ Elbow – Side: _____ - Year: _____ Cancer - Type: _____Year: _____ - Treatment: _____
ANY OTHER PERTINENT SURGICAL HISTORY	_____ _____ _____ _____
REVIEW OF SYSTEMS	**GENERAL:** ▢ Fatigue ▢ Weight Loss ▢ Fevers **SKIN:** ▢ Rashes ▢ Sores ▢ Psoriasis ▢ Scars ▢ Tattoos **NEUROLOGICAL:** ▢ Headaches ▢ Fainting ▢ Seizures ▢ Weakness ▢ Numbness

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Please Check any of the following that apply	**EYES:** ▢ Blurred Vision ▢ Double Vision ▢ Wears Glasses ▢ Wears Contacts **EARS, NOSE, THROAT:** ▢ Trouble Hearing ▢ Frequent Sinus Infections ▢ Frequent Sore Throats **CARDIOVASCULAR:** ▢ Heart Trouble ▢ High BP ▢ Chest Pain ▢ Trouble Exercising ▢ Abnormal Heart Test **RESPIRATORY:** ▢ Productive Cough ▢ Coughing Up Blood ▢ Wheezing ▢ History of Pneumonia **GASTROINSTESTINAL:** ▢ Trouble Swallowing ▢ Abdominal Pain ▢ Nausea or Vomiting ▢ Constipation ▢ Diarrhea ▢ Change in Bowel Habits or Change in Size of Stools ▢ Rectal Bleeding ▢ Decreased Appetite **BREASTS:** ▢ Lumps ▢ Breast Pain ▢ Nipple Discharge ▢ History of Breast Cancer or Treatment **ENDOCRINE:** ▢ Thyroid Trouble ▢ Excessive Sweating ▢ Diabetes ▢ Excessive Thirst **GENITOURINARY:** ▢ Painful Urination ▢ Increased Frequency of Urinating ▢ Urinating at Night ▢ Incontinence (Trouble Holding Urine) ▢ Urinary Tract Infections **HEMATOLOGICAL:** ▢ Anemia ▢ Easy Bruising ▢ Abnormal Bleeding ▢ History of Blood Transfusion **MUSCULOSKELETAL:** ▢ Muscle or Joint Pain ▢ History of Arthritis ▢ Back Pain ▢ History of FX Bone **PSYCHIATRIC:** ▢ Anxiety ▢ Depression ▢ Bipolar ▢ Maniac/Depressive ▢ Thoughts of Suicide
PATIENT AGREEMENT & AUTHORIZATION FOR THE RELEASE OF MEDICAL & HEALTH PLAN DOCUMENTS FOR THE CLAIMS PROCESSING & REIMBURSEMENT AS REQUIRED BY FEDERAL AND STATE LAWS	**Legal Assignment of Benefits and Designation of Authorized Representative** In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to the above named healthcare provider(s), as my designated Authorized Representative(s), all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such provider(s), regardless of such provider's managed care network participation status. I understand and agree that I am legally responsible for any and all actual total charges expressly authorized by me regardless of any applicable insurance or benefit payments. I hereby authorize the above-named provider(s) to release all medical information necessary to process my claims under HIPAA. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such provider(s) any and all plan documents, insurance policy and/or settlement information upon written request from such provider(s) in order to claim such medical benefits, reimbursement, or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions. I hereby convey to the above named provider(s), to the full extent permissible under the laws, including but not limited to, ERISA §502(a)(1)(B) and §502(a)(3), under any applicable employee group health plan(s), insurance policies or public policies, any benefit claim, liability or tort claim, chose in action, appropriate equitable relief, surcharge remedy or other right I may have to such group health plans, health insurance issuers or tortfeasor insurer(s), with respect to any and all medical expenses legally incurred as a result of the medical services I received from the above named provider(s), and to the full extent permissible under the laws to claim or lien such medical benefits, settlement, insurance reimbursement and any applicable remedies, including, but are not limited to, (1) obtaining information about the claim to the same extent as the assignor; (2) submitting evidence; (3) making statements about facts or law; (4) making any request, or giving, or receiving any notice about appeal proceedings; and (5) any administrative and judicial actions by such provider(s) to pursue such claim, chose in action or right against any liable party or employee group health plan(s), including, if necessary, bring suit by such provider(s) against any such liable party or employee group health plan in my name with derivative standing but at such provider(s) expenses. Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA, ERISA, Medicare and applicable federal or state laws. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement. _____ _____ Signature of Insured / Guardian Date

PREMIER SPINE INSTITUTE
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PHYSICIAN DISCLOSURE INFORMATION

During your physician/patient relationship with **Dr. Bonaventure Ngu**, you may be referred by **Dr. Bonaventure Ngu** to the following Facilities:

- "Humble Surgical Hospital" located at 1475 FM 1960 Bypass Road East, Humble TX 77338
- "The Pines Surgery Center" located at 9303 New Trails., The Woodlands TX 77381
- "Globus Medical" located at 2560 General Armistead Avenue, Audubon, PA 19403
- "Sentinel PA" located at 13161 Misty Willow Dr., Houston, TX 77070
- "ESA Toxicology" located at 625 Dallas Dr., Suite 400., Denton, TX 76205
- "Spine Frontier" located at 350 Main St, Third Floor, Malden, MA 02148
- "Vision Park Imaging Center" located at 111 Vision Park Blvd, Ste. 130, Shenandoah, TX 77384
- "Pinecroft Pharmacy" located at 9505 Pinecroft Dr., The Woodlands, TX 77380
- "Woodridge Surgical Center" located at 6701 Lake Woodlands Drive, The Woodlands, TX 77382

In connection with any referral to these Facilities you are hereby advised that **Dr. Bonaventure Ngu** has an investment interest in the facilities and therefore will receive, directly or indirectly, remuneration as a result of such referral.

This information is being provided to you both at the time of **Dr. Bonaventure Ngu's** first contact with you as a patient and at the time of referral to help you make an informed decision about your health care. You have the right to choose your health care provider. You have the option of obtaining health care ordered by your physician at a different facility other than the Facility. You will not be treated differently by your physician or the Facility if you choose to use a different facility.

By signing below, you certify that you were advised of alternative health care providers and your right to choose one of the alternative health care providers. Further, you confirm and agree that you were assured by your physician that you will not be treated differently by the physician or the physician's staff if you choose an alternative health care provider or entity. Lastly, you further acknowledge by signing below that you signed this Physician Ownership Disclosure Form on the date of your first contact with **Dr. Bonaventure Ngu** as a patient and also at the time of **Dr. Bonaventure Ngu's** referral of you to the Facility.

_____ _____

Signature of Insured / Guardian Date

PATIENT FINANCIAL RESPONSIBILITY

Patients are responsible for full payment of charges incurred during each appointment. Staff collects payment based on the patient's insurance coverage and benefits. **All financial responsibility amounts quoted to patient are estimates and responsibility may change once insurance has processed and paid the patient's claim.** Patients with delinquent balances are asked to pay before seeing the provider or clinical support staff.

You can assign the benefits from any insurance or third party to Bonaventure Ngu, MD for medical services provided to you. Bonaventure Ngu, MD has the right to decline or accept assignment of such benefits. If these benefits are not assigned to Bonaventure Ngu, MD, the patient must agree to forward to the practice, upon receipt, any insurance, or third-party payments I receive for services rendered to me.

We accept Cash, Checks, Visa and MasterCard, and HSA Accounts.

Patients with delinquent accounts must pay in full for future services. If a patient does not make payment, management can determine that the practice will refuse to provide services to the patient.

If a patient maintains a delinquent balance for more than 150 days without making any payments or contacting the practice about assistance because of financial hardship, the patient may be terminated and/or his/her balance may be transferred to a collection agency.

There will be a **$25.00 fee** for all paperwork that is required by the patient regardless if it is for personal or work-related employment request.

_____ _____

Signature of Patient Date

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NO SHOW APPOINTMENT POLICY	We fully understand that there are unforeseen circumstances that arise where office visits cannot be kept; therefore, we ask that you contact us accordingly so that other patients may be scheduled and treated. Should you need to cancel any appointment, please notify us at least **24 HOURS IN ADVANCE**!!! If you miss your scheduled appointment, a **NO SHOW fee of $50.00** will be charged to your account. We also reserve the right to terminate medical care for multiple NO SHOW's or noncompliance issues regarding scheduled appointments. _____ _____ Signature of Patient Date
CONSENT FOR TREATMENT	I hereby give my consent to Bonaventure Ngu, MD and authorize him to provide my medical treatment. I understand that Bonaventure Ngu, MD will explain my condition(s), foreseeable risks, and methods of treatment for my condition before treatment is provided. I authorize Bonaventure Ngu, MD to perform any additional or different treatment that is thought necessary if, in an emergency situation, a condition is discovered that was not known previously. I have carefully read and I fully understand this Patient Consent to Treat form and have had the opportunity to discuss my condition and the above procedure(s) with the care provider. All my questions have been adequately answered. Patient Name _____ Patient Signature _____ Date _____ Parent or Legal Guardian Signature (for minor) _____ Printed Name of Legal Guardian _____ Relationship to the Patient _____ Who is responsible for this account? (if patient is a minor) _____ Signature of Staff Member _____ Date _____
NOTICE OF PRIVACY PRACTICES ACKNOW-LEDGEMENT	Patient Name _____ Date of Birth _____ Social Security Number _____ I acknowledge that Premier Spine Institute, Bonaventure Ngu, MD provided me with a written copy of his/her Notice of Privacy Practices. I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions. _____ _____ Patient Signature Date _____ _____ Personal Representative Signature (if applicable) Relationship to Patient _____ _____ Witness Date

PREMIER SPINE INSTITUTE
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PATIENT AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

I understand Premier Spine Institute/Bonaventure Ngu, MD is authorized by me to use or disclose my protected health information ("PHI") for a purpose other than treatment, payment, or health care operations. I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information, and the recipient(s) of that information. I understand that treatment, payment, enrollment, or eligibility for benefits may not be conditioned upon my signing this authorization.

I specifically authorize Premier Spine Institute/Bonaventure Ngu, MD or its designated employee(s) to disclose my PHI as described on this form to the recipients listed below. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by state or federal privacy regulations. I further understand that I retain the right to revoke this authorization if I do so in accordance with the steps set forth below.

Description of the information to be used or disclosed *(check all that apply)*:

☐ My entire record
Note: This requires an explanation of why it is necessary to disclose the entire record.

_____

_____

_____

_____

☐ My demographic information *(check all that apply)*:

□ Name □ Address □ State/Zip Code only □ Telephone
□ Age □ Gender □ Race □ Other _____

☐ Medical Data/Information related to:

□ Specific condition(s)_____
□ Specific professional service(s) _____
□ Specific medication(s)_____
□ Other _____

☐ Other _____

Please disclose the above information to:

Name _____ Phone Number _____

Address _____

_____

I ☐ **DO** ☐ **DO NOT** authorize this information to be faxed. If yes, fax number _____

Name(s) or class of person(s) to whom Premier Spine Institute/Bonaventure Ngu, MD may disclose my PHI

_____

_____

Purpose(s) for the disclosure of the information:

_____

_____

PHI RELEASE CONTINUED….

I have a right to revoke this authorization in writing, except to the extent that action has been taken in reliance on this authorization. For the revocation of this authorization to be effective, Premier Spine Institute/Bonaventure Ngu, MD must receive the revocation in writing and the revocation must include:

- My name and address
- The effective date of this authorization and the recipients of the PHI according to this authorization
- My desire to revoke this authorization
- The date of the revocation, and
- My signature.

Premier Spine Institute/Bonaventure Ngu, MD will accept written revocations of this authorization via:

☐ Certified U.S. mail
☐ Facsimile at this number: _____

All revocations must be sent to Premier Spine Institute/Bonaventure Ngu, MD and are not effective until received in our offices.

This authorization shall expire one year from the signature date unless revised by patient prior to that date.

I fully understand and accept the terms of this authorization.

Patient Name _____

Patient Signature _____ Date _____

Name of Representative_____

Relationship to Patient _____

_____

FOR OFFICE USE ONLY

☐ Authorization added to the patient's record on _____.
☐ Authorization verified by _____ on_____.
☐ Patient has been provided with a copy of the signed authorization.

NOTES:

PATIENT

- I understand that this Agreement is essential to the trust & confidence necessary in a physician/patient

MEDICATION & TREATMENT AGREEMENT ALONG WITH USE OF TOXICOLOGY LAB

relationship and that my physician undertakes treatment based on this agreement.

- I understand that if I breach this agreement my physician will be forced to stop prescribing controlled substances.
- I will not share, sell, or trade my medication with anyone.
- I understand that my medications are my responsibility; I will safeguard my medication from "loss" or "theft". I understand that **lost or stolen medications will not be replaced under any circumstances.**
- I understand that such mishandling of my medications is a serious violation of this agreement and would result in my treatment being terminated without any recourse for appeal.
- I understand that refills of controlled substances will be made only at the time of an office appointment during normal business hours.
- Refills for controlled medication will not be made over the phone. You must come to the office for an appointment. **No refills will be made during evenings (after hours) or on weekends.**
- I agree to take my medication exactly as prescribed so as to not run out of medication. I understand that use of my medication at a greater rate will result in my being without medication for a period of time. **Our office does not provide early refills for medications;** any medication changes must be approved by the doctor.
- I agree to adhere to the payment policy outlined by this office.
- I agree to conduct myself in a *courteous manner at all times* when in the doctor's office. Inappropriate language or behavior towards administrative or clinical staff will not be tolerated.
- I agree to provide random urine samples for drug testing at Dr. Ngu's request.

I understand that violation of the above may be grounds for termination from this practice. Our Clinic will make all notifications of termination of care in writing.

_____ _____

PATIENT SIGNATURE DATE

In order to allow you to make a fully-informed decision about your health care, Bonaventure Ngu, M.D./Premier Spine Institute would like to inform you that at some point during the course of your treatment, the Practice may use ESA Toxicology LLC ("***ESA Labs***") to perform certain laboratory services involving your biological samples. The Practice wishes to advise you that the physician has a direct ownership interest in ESA, and in addition, Drug screens will be obtained at office visits as a risk evaluation and mitigation strategy as required by the US FDA and as a recognized standard of care to establish a baseline for the patient and to promote a safe appropriate pharmaceutical distribution and use for patients who may require dependency producing medications used in the treatment of their spinal disorders.

All of the Practicing Physicians in the spine industry will make referrals to laboratories based upon the best interests of a patient's health and any other factors that a patient would like his or her physicians to consider, regardless of any ownership interest or compensation arrangement that a physician may have with a particular laboratory or other facility.

You, as the patient, have the right to choose the provider of your healthcare services and the laboratories and other facilities where you receive services or treatment. You have the right to have your laboratory services provided by ESA Labs or to choose to have your laboratory services provided by an alternative laboratory. For information about alternative laboratories, please ask your physician or a member of our staff. If you choose another laboratory, you will not be treated differently by any of the physicians affiliated with the Practice.

If you have any questions concerning this notice, please feel free to ask your physician or any member of our staff. We welcome you as a patient and value our relationship with you.

By signing below, you acknowledge that you have read and fully understand this notice.

_____ _____

Signature of Patient Signature of Parent or Guardian (if applicable)

_____ _____

Typed or Printed Name of Patient Typed or Printed Name of Parent or Guardian (if applicable)

_____

Date