PATIENT FIRST NAME: _____
PATIENT LAST NAME: _____
DOB: _____ S.S.NUMBER: _____
PHONE / CELL NUMBER: _____

ADDRESS: _____
EMAIL: _____
PRIMARY INSURANCE: _____ ID#: _____
SECONDARY INSURANCE: _____ ID#: _____
PHARMACY: _____ PHONE#: _____
REFERRAL SOURCE: _____ PHONE#: _____

Please indicate which lab you prefer or that is in network with your insurance: ☐ PRECISION LAB SERVICES ☐ Quest Diagnostics ☐ LabCorp

EMERGENCY CONTACT INFORMATION:

NAME: _____ PHONE# _____ CAN WE LEAVE MESSAGE: Y☐ N☐
RELATIONSHIP TO PATIENT: _____ POWER OF ATTORNEY: Y☐ N☐
NAME: _____ PHONE# _____ CAN WE LEAVE MESSAGE: Y☐ N☐
RELATIONSHIP TO PATIENT: _____ POWER OF ATTORNEY: Y☐ N☐

(If you have a POA, please submit a copy of the document)

Medication / Drug Allergies

Do you have any drug allergies? If yes, please list the drug(s) and reaction(s): _____
_____

Please list current or past medications, doses, and frequency taken:

	MEDICATION	DOSE (MG.)	FREQUENCY	PAST / PRESENT
1)				
2)				
3)				
4)				
5)				
6)				
7)				
8)				
9)				
10)				

(Note: If you have additional medications, please use the blank area on the bottom of page 14 to complete your prescription list.)

Do you take vitamins or over the counter (OTC) supplements? If yes, provide list: _____
_____
Have you had any seizures in the past? If yes, list the date(s): _____
Have you participated in: Inpatient Psychiatric Hospital or Intensive Outpatient Program(s)? If yes, list the date(s) and diagnosis given: _____
Are you currently pregnant, breastfeeding, or planning to become pregnant in the future? If so, please provide all details including dates: _____

My signature below certifies that the information provided above is complete and accurate to the best of my knowledge:

PATIENT SIGNATURE: _____ **DATE:** _____

Have you used any of the following substances in the last 6 months? If yes, please list how often you have used them, the last date of use and if prescribed.

Marijuana: ☐ No ☐ Yes Frequency: _____ Last Used:_____ Prescribed? ☐ No ☐ Yes
Opioids: ☐ No ☐ Yes Frequency: _____ Last Used:_____ Prescribed? ☐ No ☐ Yes
Ketamine: ☐ No ☐ Yes Frequency: _____ Last Used:_____ Prescribed? ☐ No ☐ Yes
Cocaine: ☐ No ☐ Yes Frequency: _____ Last Used:_____
Alcohol: ☐ No ☐ Yes Frequency: _____ Last Used:_____
Tobacco: ☐ No ☐ Yes Frequency: _____ Last Used:_____
Vape: ☐ No ☐ Yes Frequency: _____ Last Used:_____
Phencyclidine (PCP): ☐ No ☐ Yes Frequency: _____ Last Used:_____
Lysergic Acid Diethylamide (LSD): ☐ No ☐ Yes Frequency: _____ Last Used:_____
Psilocybin (magic mushrooms): ☐ No ☐ Yes Frequency: _____ Last Used:_____

Additional recreational drugs not listed? If yes, Provide List: _____ Last Used:_____

MEDICAL HISTORY & REVIEW OF SYMPTOMS

Do you now, or have you ever had, or have ever been treated for in the past, any of the following:

- ☐ Diabetes
- ☐ Obstructive Sleep Apnea
- ☐ Panic Disorder
- ☐ High blood Pressure
- ☐ Alcohol Dependency
- ☐ Substance Abuse
- ☐ Insomnia
- ☐ Personality Disorder
- ☐ Social Anxiety/ Social Phobia
- ☐ Hypothyroidism
- ☐ ADHD
- ☐ PTSD
- ☐ OCD
- ☐ Emphysema
- ☐ Chronic Fatigue
- ☐ Cancer (type:_____)
- ☐ Stroke
- ☐ Memory Loss
- ☐ Leukemia
- ☐ Schizophrenia
- ☐ Epilepsy (Seizures)
- ☐ Heart problems
- ☐ Psoriasis
- ☐ Generalized Anxiety Disorder
- ☐ Tuberculosis
- ☐ Angina
- ☐ Kidney disease
- ☐ HIV/AIDS
- ☐ Bipolar and/or Mood Disorder
- ☐ Food/Seasonal Allergies (type:_____)

In the past month, have you had any of the following symptoms or problems?

GENERAL
- ☐ Recent weight gain; how much
- ☐ Recent weight loss: how much
- ☐ Fatigue
- ☐ Weakness
- ☐ Fever
- ☐ Night sweats

MUSCLE/JOINTS/BONES
- ☐ Numbness
- ☐ Joint pain
- ☐ Muscle weakness
- ☐ Joint swelling (Location:_____)

EARS
- ☐ Ringing in ears
- ☐ Loss of hearing
- ☐ Vertigo

NOSE
- ☐ Difficulty breathing

THROAT
- ☐ Frequent sore throats
- ☐ Hoarseness
- ☐ Difficulty in swallowing
- ☐ Swelling or Pain in jaw throat or neck

HEART AND LUNGS
- ☐ Chest pain
- ☐ Palpitations
- ☐ Shortness of breath
- ☐ Fainting
- ☐ Swollen legs or feet
- ☐ Cough
- ☐ Wheezing

EYES
- ☐ Pain
- ☐ Redness or Dryness
- ☐ Loss of vision
- ☐ Double or blurred vision

NERVOUS SYSTEM
- ☐ Headaches
- ☐ Dizziness
- ☐ Fainting or loss of consciousness
- ☐ Numbness, weakness or tingling
- ☐ Memory loss

STOMACH AND INTESTINES
- ☐ Nausea
- ☐ Heartburn
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Yellow jaundice
- ☐ Increasing constipation
- ☐ Persistent diarrhea
- ☐ Blood in stools
- ☐ Black stools

KIDNEY/URINE/BLADDER
- ☐ Frequent or painful urination
- ☐ Blood in urine

Women Only:
- ☐ Abnormal Pap smear
- ☐ Irregular periods
- ☐ Bleeding between periods
- ☐ PMS

SKIN
- ☐ Redness
- ☐ Rash
- ☐ Nodules/bumps
- ☐ Hair loss
- ☐ Color changes of hands or feet

BLOOD
- ☐ Anemia
- ☐ Clots

PSYCHIATRIC
- ☐ Depression
- ☐ Excessive worries
- ☐ Difficulty falling/staying asleep
- ☐ Poor appetite
- ☐ Frequent crying
- ☐ Sensitivity
- ☐ Thoughts of suicide / attempts
- ☐ Stress
- ☐ Irritability
- ☐ Poor concentration
- ☐ Racing thoughts
- ☐ Hallucinations
- ☐ Rapid speech
- ☐ Guilty thoughts
- ☐ Paranoia
- ☐ Mood swings
- ☐ Anxiety
- ☐ Risky behavior

OTHER
- ☐ Snoring
- ☐ Daytime sleepiness
- ☐ Insomnia

Please select all of the following that you have tried *without* relief from symptoms:

Anti-depressants
- ❑ Prozac (fluoxetine)
- ❑ Zoloft (sertraline)
- ❑ Luvox (fluvoxamine)
- ❑ Paxil (paroxetine)
- ❑ Celexa (citalopram)
- ❑ Lexapro (escitalopram)
- ❑ Effexor (venlafaxine)
- ❑ Cymbalta (duloxetine)
- ❑ Wellbutrin (bupropion)
- ❑ Remeron (mirtazapine)
- ❑ Serzone (nefazodone)
- ❑ Anafranil (clomipramine)
- ❑ Pamelor (nortrptyline)
- ❑ Tofranil (imipramine)
- ❑ Trintellix (vortioxetine)
- ❑ Elavil (amitriptyline)

Mood Stabilizers
- ❑ Valproic Acid
- ❑ Tegretol (carbamazepine)
- ❑ Lithium
- ❑ Depakote (valproate)
- ❑ Lamictal (lamotrigine)
- ❑ Tegretol (carbamazepine)
- ❑ Topamax (topiramate)

Antipsychotics/Mood Stabilizers
- ❑ Seroquel (quetiapine)
- ❑ Zyprexa (olanzepine)
- ❑ Geodon (ziprasidone)
- ❑ Abilify (aripiprazole)
- ❑ Abilify Maintena Injection
- ❑ Aristada Injection
- ❑ Invega (paliperidone)
- ❑ Invega Sustenna Injection
- ❑ Invega Trinza Injection
- ❑ Clozaril (clozapine)
- ❑ Haldol (haloperidol)
- ❑ Prolixin (fluphenazine)
- ❑ Rexulti (brexpiprazole)
- ❑ Risperdal (risperidone)
- ❑ Saphris (asenapine)
- ❑ Vraylar (cariprazine)

Sedative/Hypnotics
- ❑ Ambien (zolpidem)
- ❑ Belsomra
- ❑ Lunesta (eszopiclone)
- ❑ Sonata (zaleplon)
- ❑ Rozerem (ramelteon)
- ❑ Restoril (temazepam)
- ❑ Desyrel (trazodone)

ADHD medications
- ❑ Adderall (amphetamine)
- ❑ Adderall XR (amphetamine XR)
- ❑ Concerta (methylphenidate)
- ❑ Evekeo (amphetamine)
- ❑ Focalin (dexmethylphenidate)
- ❑ Procentra (dextroamphetamine)
- ❑ Ritalin (methylphenidate)
- ❑ Strattera (atomoxetine)
- ❑ Vyvanse (lisdexamfetamine)
- ❑ Zenzedi (dextroamphetamine)

Anti-anxiety medications
- ❑ Xanax (alprazolam)
- ❑ Ativan (lorazepam)
- ❑ Klonopin (clonazepam)
- ❑ Valium (diazepam)
- ❑ Hydroxyzine
- ❑ Tranxene (clorazepate)
- ❑ Buspar (buspirone)

Substance/Alcohol Abuse
- ❑ Suboxone (buprenorphine/naloxone)
- ❑ Zubsolv (buprenorphine/naloxone)
- ❑ Bunavail (buprenorphine/naloxone)
- ❑ Subutex (buprenorphine)
- ❑ Vivitrol (naloxone)

Injection
- ❑ Naloxone tablets
- ❑ Campral (acomprosate)
- ❑ Antause (disulfiram)

Have you experienced intolerable side effects to antidepressants or other psych medications in the past? If yes, list the medication(s) and reaction(s):

_____

GAD-7 ANXIETY SEVERITY ASSESSMENT **PATIENT NAME:**_____ **DOB:**_____**DATE:**_____

Over the last two weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0 ☐	1 ☐	2 ☐	3 ☐
2. Not being able to stop or control worrying	0 ☐	1 ☐	2 ☐	3 ☐
3. Worrying too much about different things	0 ☐	1 ☐	2 ☐	3 ☐
4. Trouble relaxing	0 ☐	1 ☐	2 ☐	3 ☐
5. Being so restless that it is hard to sit still	0 ☐	1 ☐	2 ☐	3 ☐
6. Becoming easily annoyed or irritable	0 ☐	1 ☐	2 ☐	3 ☐
7. Feeling afraid, as if something awful might happen	0 ☐	1 ☐	2 ☐	3 ☐

If you indicated any problems, how difficult have they made it for you to do your work, take care of things at home, or get along with people?

- ☐ Not difficult at all
- ☐ Somewhat difficult
- ☐ Very difficult
- ☐ Extremely difficult

COLUMN TOTALS: _____+_____+_____+_____ = TOTAL SCORE: _____

MOOD DISORDER QUESTIONNAIRE

	YES	NO
1. Has there ever been a period of time when you were not your usual self and...	☐	☐
...you felt so good / hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	☐	☐
...you were so irritable that you shouted at people or started fights or arguments?	☐	☐
...you felt much more self-confident than usual?	☐	☐
...you got much less sleep than usual and found you didn't really miss it?	☐	☐
...you were much more talkative or spoke much faster than usual?	☐	☐
...thoughts raced through your head or you couldn't slow your mind down?	☐	☐
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	☐	☐

(PLEASE CONTINUE THIS ASSESSMENT ON NEXT PAGE)

(ASSESSMENT CONTINUED FROM PREVIOUS PAGE)

	YES	NO
...you had much more energy than usual?	☐	☐
...you were much more active or did many more things than usual?	☐	☐
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	☐	☐
...you were much more interested in sex than usual?	☐	☐
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	☐	☐
...spending money got you or your family into trouble?	☐	☐
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?	☐	☐
3. How much of a problem did any of these causes you – like being unable to work; having family, money, legal troubles; getting into arguments/fights? *Please only check ONE response below:* No Problem ☐ Minor Problem ☐ Moderate Problem ☐ Serious Problem ☐		
4. Have any of your blood relatives (children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?	☐	☐
5. Has a health professional ever told you that you have manic-depressive illness "" or bipolar disorder?	☐	☐

PHQ9 RATING SCALE: **PATIENT NAME:**_____ **DOB:**_____**DATE:**_____

Over the last TWO WEEKS, how often have you been bothered by any of the following problems *use the scale provided to answer each question*	**Not at all**	**Several days**	**More than 1/2 the day**	**Nearly everyday**
1. Little interest or pleasure in doing things	0 ☐	1 ☐	2 ☐	3 ☐
2. Feeling down, depressed, or hopeless	0 ☐	1 ☐	2 ☐	3 ☐
3. Trouble falling or staying asleep or sleeping too much	0 ☐	1 ☐	2 ☐	3 ☐
4. Feeling tired or having little energy	0 ☐	1 ☐	2 ☐	3 ☐
5. Poor appetite or overeating	0 ☐	1 ☐	2 ☐	3 ☐
6. Feeling bad about yourself- or that you are a failure or have let yourself or your family down	0 ☐	1 ☐	2 ☐	3 ☐
7. Trouble concentrating on things, such as reading the newspaper or watching television	0 ☐	1 ☐	2 ☐	3 ☐
8. Thought that you would be better off dead, or of hurting yourself	0 ☐	1 ☐	2 ☐	3 ☐
9. Moving or speaking so slow that other people could have noticed. Or the opposite- being so fidgety or restless that you have been moving around a lot more than usual	0 ☐	1 ☐	2 ☐	3 ☐
	↓	↓	↓	↓
ADD COLUMNS:				

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?
☐Not difficult at all ☐Somewhat difficult
☐Very difficult ☐Extremely difficult

PATIENT NAME:_____DOB:_____Date:_____

Brain Health Questionnaire:

Welcome to your Brain Health Assessment. As part of our commitment to your overall wellbeing, we recognize the importance of understanding and supporting your brain health. This assessment is a key step in evaluating your cognitive functions and mental fitness.

The information you provide will help us screen for any potential concerns and guide us in offering the best possible care for your brain health, so please take your time to answer the questions as accurately as possible.

Remember, this is not a test, but rather an opportunity to better understand and support your cognitive well-being.

Section 1: 95957

1. **Do you have any history of seizures or suspected seizures in the past? (G40.89)** Yes No
2. **Have you ever passed out in the past? (R55)** Yes No
3. **Do you have any neurological symptoms without a definite root cause? (F44.7)** Yes No
4. **Have you ever had a stroke in the past? (I67.9)** Yes No
5. **Have you ever been diagnosed with an abnormal heart rhythm that causes you to feel like you're going to pass out or actually pass out? (I45.9)** Yes No

Section 2: 95816

1. **Do you have any tremors anywhere in your body? (R25.1)** Yes No
2. **Do you have recurrent muscle cramps? (R25.2)** Yes No
3. **Do you have any muscle twitches in your body? (R25.3)** Yes No
4. **Do you have sleep apnea? (R06.81)** Yes No
5. **Do you ever feel disoriented even for a second? (R41.0)** Yes No
6. **Do you ever feel restless and agitated? (R45.1)** Yes No

Section 3: 92652

1. **Do you ever have involuntary jerks in your muscles? (G25.3)** Yes No
2. **Do you ever have restless legs at night? (G25.81)** Yes No
3. **Do you have vertigo (feel as if the room is spinning around) ever? (H81.4)** Yes No
4. **Do you have any hearing loss you or other people have noticed about you? (H.91.90)** Yes No
5. **Do you ever have ringing in either one of your ears? (H93.19)** Yes No

Section 4: 95930

1. **Do you have any problems with your vision? (H53.8)** Yes No
2. **Have you had any change in your vision in the past 3 years? (H53.143)** Yes No
3. **Do you ever feel like you're sensitive to lights or brightness? (H53.143)** Yes No
4. **Do you have trouble with nighttime driving due to light glares? (H53.71)** Yes No

Section 5: 93040

1. **Do you ever feel either your heart racing, slowing down, or skipping? (R00.2)** Yes No
2. **Do you have any diagnosed arrhythmias (abnormal heart rhythms) in the past? (I49.8)** Yes No
3. **Do you have a history of high blood pressure? (I10)** Yes No
4. **Do you have a history of high cholesterol or triglycerides? (E78.2)** Yes No

PATIENT NAME:_____DOB:_____Date:_____

Neurobehavioral Symptom Inventory NSI

Please rate the following symptoms with regard to how much they have disturbed you IN THE LAST 2 WEEKS.
The purpose of this inventory is to track symptoms over time. Please do not attempt to score.

0 = None: Rarely if ever present; not a problem at all

1 = Mild: Occasionally present, but it does not disrupt my activities; I can usually continue what I'm doing; doesn't really concern me.

2 = Moderate: Often present, occasionally disrupts my activities; I can usually continue what I'm doing with some effort; I feel somewhat concerned.

3 = Severe: Frequently present and disrupts activities; I can only do things that are fairly simple or take little effort; I feel I need help.

4 = Very Severe: Almost always present and I have been unable to perform at work, school or home due to this problem; I probably cannot function without help.

Symptoms and/or Episodes	0	1	2	3	4
Feeling Dizzy	0	1	2	3	4
Loss of balance	0	1	2	3	4
Poor coordination, clumsy	0	1	2	3	4
Headaches	0	1	2	3	4
Nausea	0	1	2	3	4
Vision problems, blurring, trouble seeing	0	1	2	3	4
Sensitivity to light	0	1	2	3	4
Hearing difficulty	0	1	2	3	4
Sensitivity to noise	0	1	2	3	4
Numbness or tingling on parts of my body	0	1	2	3	4
Change in taste and/or smell	0	1	2	3	4
Loss of appetite or increased appetite	0	1	2	3	4
Poor concentration, can't pay attention, easily distracted	0	1	2	3	4
Forgetfulness, can't remember things	0	1	2	3	4
Difficulty making decisions	0	1	2	3	4
Slowed thinking, difficulty getting organized, can't finish things	0	1	2	3	4
Fatigue, loss of energy, getting tired easily	0	1	2	3	4
Difficulty falling or staying asleep	0	1	2	3	4
Feeling anxious or tense	0	1	2	3	4
Feeling depressed or sad	0	1	2	3	4
Irritability, easily annoyed	0	1	2	3	4

PATIENT NAME:_____DOB:_____Date:_____

Adult ADHD Self-Report Scale / Symptom Checklist

Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an X in the box that best describes how you have felt and conducted yourself over the past 6 months.	Never	Rarely	Sometimes	Often	Very Often
1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?	☐	☐	☐	☐	☐
2. How often do you have difficulty getting things in order when you have to do a task that requires organization?	☐	☐	☐	☐	☐
3. How often do you have problems remembering appointments or obligations?	☐	☐	☐	☐	☐
4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?	☐	☐	☐	☐	☐
5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?	☐	☐	☐	☐	☐
6. How often do you feel overly active and compelled to do things, like you were driven by a motor?	☐	☐	☐	☐	☐
7. How often do you make careless mistakes when you have to work on a boring or difficult project?	☐	☐	☐	☐	☐
8. How often do you have difficulty keeping your attention when you are doing boring or repetitive work?	☐	☐	☐	☐	☐
9. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?	☐	☐	☐	☐	☐
10. How often do you misplace or have difficulty finding things at home or at work?	☐	☐	☐	☐	☐
11. How often are you distracted by activity or noise around you?	☐	☐	☐	☐	☐
12. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?	☐	☐	☐	☐	☐
13. How often do you feel restless or fidgety?	☐	☐	☐	☐	☐
14. How often do you have difficulty unwinding and relaxing when you have time to yourself?	☐	☐	☐	☐	☐
15. How often do you find yourself talking too much when you are in social situations?	☐	☐	☐	☐	☐
16. When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish them themselves?	☐	☐	☐	☐	☐
17. How often do you have difficulty waiting your turn in situations when turn taking is required?	☐	☐	☐	☐	☐
18. How often do you interrupt others when they are busy?	☐	☐	☐	☐	☐

PATIENT NAME:_____DOB:_____Date:_____

FATIGUE SEVERITY SCALE (FSS)

Please read each statement and choose a number between 1 and 7 which you feel best fits the following statement: This refers to your usual way of life within the last week.

1 indicates = strongly disagree 7 indicates = strongly agree

1. My motivation is lower when I am fatigued.	☐1	☐2	☐3	☐4	☐5	☐6	☐7
2. Exercise brings on my fatigue.	☐1	☐2	☐3	☐4	☐5	☐6	☐7
3. I am easily fatigued.	☐1	☐2	☐3	☐4	☐5	☐6	☐7
4. Fatigue interferes with my physical functioning.	☐1	☐2	☐3	☐4	☐5	☐6	☐7
5. Fatigue causes frequent problems for me.	☐1	☐2	☐3	☐4	☐5	☐6	☐7
6. My fatigue prevents sustained physical functioning.	☐1	☐2	☐3	☐4	☐5	☐6	☐7
7. Fatigue interferes with carrying out certain duties & responsibilities.	☐1	☐2	☐3	☐4	☐5	☐6	☐7
8. Fatigue is among my most disabling symptoms.	☐1	☐2	☐3	☐4	☐5	☐6	☐7
9. Fatigue interferes with my work, family, or social life.	☐1	☐2	☐3	☐4	☐5	☐6	☐7

VISUAL ANALOGUE FATIGUE SCALE (VAFS)

Please select only one choice on the number line which describes your global fatigue with 0 being worst and 10 being normal.

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

BERLIN QUESTIONNAIRE / SLEEP EVALUATION:

1. Complete the following:

Height:_____ Age:_____

Weight:_____ Male/Female:_____

2.Do you snore?

- ☐Yes
- ☐No
- ☐I do not know

If you snore.....

3.Your snoring is?

- ☐Slightly louder than breathing
- ☐As loud as talking
- ☐Louder than talking
- ☐Very loud. Can be heard in another room

4.How often do you snore?

- ☐Nearly every day
- ☐3-4 times a week
- ☐1-2 times a week
- ☐1-2 times a month
- ☐Never or nearly never

5.Has your snoring ever bothered other people?

- ☐Yes
- ☐No

6.Has anyone noticed that you quit breathing during your sleep?

- ☐Nearly every day
- ☐3-4 times a week
- ☐1-2 times a week
- ☐1-2 times a month
- ☐Never or nearly never

7.How often do you feel tired or fatigued *after* you sleep?

- ☐Nearly every day
- ☐3-4 times a week
- ☐1-2 times a week
- ☐1-2 times a month
- ☐Never or nearly never

8.During your wake time, do you feel tired, fatigued or not up to par?

- ☐Nearly every day
- ☐3-4 times a week
- ☐1-2 times a week
- ☐1-2 times a month
- ☐Never or nearly never

9.Have you ever nodded off or fallen asleep while driving a vehicle?

- ☐Yes
- ☐No

If yes, how often does it occur?

- ☐Nearly every day
- ☐3-4 times a week
- ☐1-2 times a week
- ☐1-2 times a month
- ☐Never or nearly never

10.Do you have high blood pressure?

- ☐Yes
- ☐No
- ☐I do not know

PRACTICE POLICIES:

PATIENT NAME:_____ DOB:_____ Date:_____

IDENTIFICATION & INSURANCE CARDS: To stay in compliance with various regulations, a valid government issued photo ID and current/ active insurance card MUST be presented at your FIRST visit. We are unable to see patients if these are not presented at the visit. If you cannot provide these items, please reschedule your appointment at least 48 hours in advance, to avoid the $50.00 late reschedule /cancellation fee. _____ (Initial)

FINANCIAL RESPONSIBILITY: All payments must be made at the time service is rendered. This includes balances, deductibles, coinsurance and/or copays. We are unable to see patients with balances or without payment. Our contract with your insurance company stipulates that we must collect your copay, coinsurance, or your portion of payment. If you are unable to pay your portion of the visit, please call the office at least 48 hours prior to your appointment to reschedule to a date you will be able to meet your payment obligations in order to avoid the $50.00 same day cancellation fee. Our physicians, nurse practitioners and healthcare providers do not get involved with payment for services. You may contact our billing department/ collection company with any financial questions. _____ (Initial)

NEW CASH PAY PATIENTS: New patients who do not have insurance are considered new "cash pay patients," and must pay a $100 deposit to secure their first appointment. This amount is applied as a partial payment towards their first appointment and is completely refundable up to 48 hours before the appointment. It is not refundable thereafter, as late cancellations are costly to the practice. _____ (Initial)

TIME: To respect your time, we advise that you do not arrive more than 15 minutes prior to your appointment time, UNLESS YOU ARE A NEW PATIENT AND HAVE NOT COMPLETED YOUR NEW PATIENT PAPERWORK. . New patients who have not completed their paperwork in advance need to arrive an hour early to complete paperwork. We try our best to stay on time for appointments, however, sometimes, patients need more time than was assigned. Our healthcare providers are committed to providing each patient with the time needed to maintain a good standard of care. For this reason, appointments may run late. Please be understanding if your provider is running behind. Please arrive on time for your appointment. Patients arriving late cause appointments to run behind. Out of respect for the time of other patients, you may be asked to reschedule if you arrive late for your appointment. _____ (Initial)

OFFICE CONDUCT: Oluyemi Aina MD PLLC/Tri-MED/Holistic MD PLLC strives to treat each patient with utmost dignity and respect. Likewise, we expect patients to show respect to our staff, providers, other patients and practice property. Disrespect of staff, providers or other patients in the office, practice property and/or practice policies will most likely result in termination of services to a patient. We do not tolerate intimidation or threats made to anyone. Patients who threaten the staff in any way WILL be reported to the police, removed from the premises, no longer treated at the office , and charges will be pressed if deemed appropriate. _____ (Initial)

SPACE FOR PATIENTS & VISITORS: Due to space constraints and respect for patients' privacy, we request that no more than one person accompany adult patients to appointments, unless otherwise requested by a provider. Patients under the age of 18 years or who have certain challenges may be accompanied by both parents. We also ask that every person in the office: patient, parent, guest or child respect the office property at all times. Please keep feet on the floor in the waiting rooms, and be mindful of those around you. _____ (Initial)

ITEMS NOT PERMITTED: Foods, drinks, cigarettes, electronic cigarettes are NOT permitted in our office at any time. The only animals allowed in the building are certified and registered service animals. If you plan on bringing a service animal to your appointment, you must also bring the proper documentation stating that it is a service animal. _____ (Initial)

CHILDREN: In the interest of child safety and as a courtesy to other patients, it is best not to bring children to the office unless they are patients of Oluyemi Aina MD PLLC/Tri-MED/Holistic MD PLLC. We do not assume liability for minors in our building. For your child's safety, you may be asked to reschedule your appointment, if your child is poorly supervised or unsupervised in the office premises. For safty reasons, children are not allowed in the treatment rooms. _____ (Initial)

PHONES & RECORDING DEVICES: To reduce the potential risk of a Federal HIPAA Violation, the use of cell phones, tablets, cameras, or recording device are strictly prohibited on the premises. If you must bring a device with you for emergency purposes, it must be set to silent or on vibrate mode. For privacy reasons, you may not operate the speaker function on your phone while in the building. All phone calls must be taken outside the office. _____ (Initial)

APPOINTMENT CONFIRMATION/CANCELLATION: We request 48 hours advance notice for appointment rescheduling or cancellation. Two (2) days prior to each appointment, we utilize an automated service to remind patients to confirm/reschedule their appointments. Although we provide this service as a courtesy, it is the patient's responsibility to note, remember, attend, reschedule or cancel their appointment at the appropriate time to avoid late-reschedule or no-show fees. It is the patient's responsibility to ensure that we have the most recent telephone number and email on file to facilitate the automated courtesy reminder._____ (Initial)

LATE RESCHEDULE/NO SHOW FEES: If you cannot make your appointment, please call us 48 hours or more before the appointment time to reschedule/cancel free of charge. This will give us an opportunity to offer your appointment to other patients. There is a charge of $50.00 for no-shows and appointments rescheduled 24 hours or less before the appointment time. This charge is the patient's responsibility. It will not be billed to insurance, and it must be paid in full before future appointments are scheduled. If a new patient no-shows on the day of their visit or cancels/ reschedules less than 24 hours before their visit time, they will need to pay a $50.00 deposit to secure a second new patient appointment. This fee will be applied to the cost of their visit or refunded if nothing is due for the visit. If the patient no-shows or cancels again 24 hours or less before the second appointment time, the $50.00 fee becomes non-refundable. Patients who no-show two consecutive times will not be rescheduled. _____ (Initial)

INSURANCE COVERAGE: If you have insurance, it is your responsibility to call your insurance company prior to scheduling your appointment to verify your benefits and learn what is covered under your plan. You are also responsible for learning if any pre-authorization or certification is required by your insurance company prior to your visit. Some services or parts of services may not be covered by health insurance. Charges for uncovered services will be your responsibility. This may include but is not limited to charges for written correspondence, or reports in connection with evaluation or treatment, and charges for missed/canceled appointments without a 48 hour prior notification. _____ (Initial)

PRACTICE POLICIES

MEDICAL RECORDS:
Fees for medical records are $30 for the first 20 pages, and $0.50 for each page thereafter and may take up to 15 business days to obtain. Report preparation fees are based on the time involved._____ (Initial)

DISABILITY/ LEAVE PAPERWORK:
Please discuss all disability / leave paperwork with your provider during your visit. The office of Oluyemi Aina MD PLLC/Tri-MED/Holistic MD PLLC cannot complete disability paperwork without prior discussion and will not complete paperwork for NEW PATIENTS. The initial fee for clinical documentation or medical paperwork supporting your disability or leave is $100.00. Payment is due at the time of your request for completion. If additional paperwork is required, an additional fee of $30 will be due for each follow up request. Completion of paperwork may take up to 15 business days after your request._____ (Initial)

CALLS TO YOUR PROVIDER:
Please endeavor to write down your questions prior to your appointment to avoid forgetting to ask them during your visit, and having to schedule a new appointment.We want to ensure that each patient gets the time they deserve and that providers are able to gather all the information they need directly from each patient to provide appropriate care and answers to questions. Therefore, if you have questions, you will be asked to make an appointment. Out of respect for each patient and to avoid distractions during patient care, we cannot interrupt patient appointments or keep patients waiting for providers to take calls or answer questions. If your call or message relates to a medical emergency, please call 911 or go to the nearest emergency room, regardless of the cause. If you are having a non-emergent side effect to your medication, please discontinue the medication immediately and call the office to request an urgent appointment with your prescriber or the first available provider. Be sure to specify the side effect(s) you are having and ask that your provider be informed. If your call or message is non-emergent, your healthcare provider may ask a member of staff to return your call with their directions or they may request that you schedule an appointment._____ (Initial)

AGREEMENT FOR CONTROLED SUBSTANCES:

1. I am responsible for my medications. If any of my medications are lost, misplaced, or stolen, regardless of the reason, I understand that my physician WILL NOT be replacing or refilling my medication. I further understand that early refills WILL NOT be approved. _____ (Initial)

2. I WILL NOT seek medications from any other physician or practitioner while I'm receiving the same or similar class of medications from my provider at Oluyemi Aina MD PLLC/Tri-MED/Holistic MD PLLC. We will regularly check the Texas Prescription Monitoring Program data base. The data base tells your provider of each prescription for controlled substances that you have filled from all practitioners and pharmacies. _____ (Initial)

3. I WILL NOT seek opiate medications from any other physician or practitioner if/while I'm receiving Suboxone therapy from my Provider at Oluyemi Aina MD PLLC/Tri-MED/Holistic MD PLLC . I further agree to inform my Provider at Oluyemi Aina MD PLLC/Tri-MED/Holistic MD PLLC of any and all medical or dental procedures that will require the use of opiate medications. I agree to disclose the fact to any surgical or medical physician that I am on Suboxone therapy and will sign a Release of Information for the physicians to consult regarding medications and all surgical or medical procedures. _____ (Initial)

4. I AGREE that refills of controlled substance medications will be made during my scheduled visit. It is my responsibility to take the medication as prescribed. Early refills will not be made, even if I have run out of medication early. _____ (Initial)

5. I WILL TAKE my medications as prescribed and as directed. I will not take extra medication without being advised to do so by my provider at Oluyemi Aina MD PLLC/Tri-MED/Holistic MD PLLC _____ (Initial)

6. I WILL NOT use any illicit drugs, as defined by law. These include marijuana, heroin, methamphetamine, cocaine, PCP and hallucinogens or any other mood altering substance that is illegal. _____ (Initial)

7. I understand that to comply with state regulations, random drug screening tests will be performed at my expense, to verify compliance of my medication contract. If I am found to be using illegal substances for any reason, my Controlled substance medications will be discontinued immediately. In addition, if my urine drug screen is negative for medications prescribed by my Oluyemi Aina MD PLLC/Tri-MED/Holistic MD PLLC practitioners, my controlled substances medications will be discontinued immediately and will not be re-prescribed by any provider at Oluyemi Aina MD PLLC/Tri-MED/Holistic MD PLLC.
_____ (Initial)

8. I understand that if I violate any of the above conditions, my controlled substance prescriptions will be immediately terminated, and it will be reported to my other healthcare providers, medical facilities and pharmacies. _____ (Initial)

9. I understand that my provider may discontinue my medication at any time if they no longer think it is clinically appropriate or in my best interest. Additionally, if my controlled substances are discontinued by my Oluyemi Aina MD PLLC/Tri-MED/Holistic MD PLLC provider, no other practitioner in this practice will prescribe any controlled substance to me. _____ (Initial)

Patient Name:_____Patient Signature:_____ DOB:_____ Date:_____

Your initials and signature above confirm that you have read the Practice Policies and the Agreement for controlled Substances, had the opportunity to have your questions answered, and agreed to the policies.

PRESCRIPTION/REFILL POLICY:

Please ensure you ask for your prescription or refill at the time of your appointment to ensure you have sufficient medication to last until your next visit. Please request refills 5 working days before you need them, to ensure you receive your refill on time. If you must submit a medication refill request outside of your appointment, please do so online via our website or through our text messaging app. This ensures that we have documentation of your request(s), along with the date and time of your request. Refills are often handled at the end of the day because we cannot interrupt providers while they are seeing patients to deal with prescription refills. It is your responsibility to confirm your preferred pharmacy during every visit/ refill request, and notify us of any pharmacy changes.

Prescription refills are given at the sole discretion of your healthcare provider. In the interest of your wellbeing, your provider reserves the right to refuse any medication refill or samples at any time.At the onset of new medication, your provider may ask to see you again within one (1) to four (4) weeks to assess how the medication is working for you. To maintain good standard of care, patients are typically seen monthly, unless the provider is certain that they are medically stable, at which point the patient may be seen every 60-90 days. Federal law / DEA policies do not allow providers to prescribe controlled substances (including, but not limited to most medicines for ADHD and anxiety), unless patients have been seen within 90 days/three months. For this reason, it is imperative that you schedule your appointments ahead of time and avoid reschedules or cancellations, bearing in mind that provider schedules fill up well in advance. We cannot prescribe medications if you have not attended an appointment in the last 3 months. Please do not ask us to break the law. If you have not had an appointment within the past 3 months and your provider has no appointments immediately available, you will need to see any provider that is available in order to be assessed and provided with a refill.

Although our providers are committed to sending prescriptions for compliant patients within 5 working days (per our policy), the electronic systems used by practices to send prescriptions to pharmacies are not always perfect, and there may occasionally be times when sent prescriptions may not be received by the pharmacy. If this happens, please let us know and we will send the prescription again, as soon as possible.

There are often national shortages of controlled substances. This is completely out of our control. To avoid delays during such shortages, please make sure your chosen pharmacy has supplies of your prescribed medication and dosage before you ask us to send your prescription(s) there, especially since we cannot interrupt providers seeing patients to have them re-send your prescription to a new pharmacy. If your specified pharmacy does not have your medication, it is your responsibility to find a pharmacy that has it and provide us with the pharmacy's information. Dealing with medication challenges can be frustrating for all sides, and we are committed to doing everything possible to make the process as seamless as possible.

Please be patient and respectful of our staff when making refill requests. Like providers, medical assistants are engaged in patient care throughout the work day and respond to messages at intervals in between patient care. Consequently, their responses may not be immediate. But be rest assured that they will handle your message(s) as soon as they are able.

It is best to ask for your prescription or refill at the time of your appointment, because there is a $20 prescription processing fee for controlled substance prescriptions outside of your appointment. This fee covers the time required to process, submit, and document an electronic refill that was not arranged during your scheduled appointment. This fee can be completely avoided by arranging your refill during your visit. The prescription processing fee does NOT apply to any planned refills already arranged during an appointment that took place within the last three months. It also does not apply when there are Pharmacy back-order issues that are out of your control for medications that were discussed and requested during your appointment.

Our goal is to make sure you have your medications on time every time. If you have concerns about your prescriptions or refills and you have followed all of the policies stated above, please ask to speak to the office manager.
Your signature below confirms that you have read both pages of our prescription and refill policies, had the opportunity to have your questions answered, and agreed to the policies.

Patient Name:_____Patient Signature:_____ DOB:_____ Date:_____

Your signature above confirms that you have read the Prescription / Refill policies, had the opportunity to have your questions answered, and agreed to the policies.

HIPAA NOTICE OF PRIVACY PRACTICES

As required by the Privacy Regulations Promulgated Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE OF PRIVACY PRACTICES DESCRIBES HOW YOU CAN OBTAIN ACCESS TO YOUR PROTECTED HEALTH INFORMATION (PHI) AT TRI-MED, AND HOW IT MAY BE DISCLOSED AND/OR USED TO CARRY OUT TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS AND OTHER PURPOSES THAT ARE REQUIRED OR PERMITTED BY

Protected health information "PHI" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Access: Only you, or someone you have authorized has a right to access your medical records. These include your medical and billing records.

Uses and Disclosures of Protected Health Information: Your PHI may be used and disclosed by our organization, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing healthcare services to you, to pay your healthcare bills, to support the operation of the organization, and any other use required or permitted by law. By receiving care from Oluyemi Aina MD PLLC/Tri-MED/Holistic MD PLLC, you are consenting to the disclosure and use of your PHI as described under HIPAA and on this page.

Treatment: We will use and disclose your PHI to provide, coordinate, or manage your treatment and related services. This includes acting as your agent in the coordination or management of your healthcare with a third party. For example, we would disclose your protected health information, as necessary, to a physician, pharmacy, laboratory, EMR and/or billing services provider, virtual assistant, durable medical device provider, etc., that will provide, or provides care and services to you. This ensures that the third party has the necessary information to diagnose, treat you, or provide a service needed as part of your care, diagnosis or treatment.

Notes Taken By Mental Health Professionals: Process/psychotherapy notes are notes recorded in any medium by a mental health professional documenting or analyzing the contents of conversation during a session with a patient. According to HIPAA, a patient does not have a right to access a Provider's process/psychotherapy notes. They are kept separate from the patient's billing and medical records. Psychotherapy notes exclude items such as medication prescriptions/treatment plan, results of clinical tests, etc.

Payment: Your protected health information will be used, as needed, to obtain payment for your healthcare services. For example, your protected health information may be disclosed to your health insurance provider to obtain payment or approval for coverage. By receiving care from us, you are consenting for us to act as your agent in obtaining approval for coverage and/or payment for services rendered by Oluyemi Aina MD PLLC/Tri-MED/Holistic MD PLLC.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in our operations. For example, we could use your information to identify whether you could benefit from new treatment options. We may use your information to contact you or call you by your name while you are in the office.

We may use or disclose your protected health information in the following situations without your authorization: as Required By Law, Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Criminal Activity, Inmates, Military Activity, National Security, and Workers' Compensation. Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only with Your Consent, Authorization or Opportunity to Object, unless required by law: You may revoke this authorization, at any time, in writing, except to the extent that your physician or this organization has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights:The following are statements of your rights with respect to your protected health information).

You have the right to inspect and receive copies of your protected health information. Under federal law, however, you may not inspect or copy the following records; process/psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must be in writing and state the specific restriction requested and to whom you want the restriction to apply. Our organization is not required to agree to a restriction that you may request, if our organization believes it is in your best interest to permit use and disclosure of your protected health information. In such a case, you have the right to use another healthcare organization or professional and receive copies of your medical records / have your medical records sent to your chosen provider.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, e.g. electronically.

You may have the right to have our organization amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

Concerns: Our goal is to meet your needs and fulfill our legal obligations to you. If you have any questions or concerns regarding your HIPAA-related rights at Oluyemi Aina MD PLLC/Tri-MED/Holistic MD PLLC, please ask to speak with the Office Manager in-person or by phone at any of our locations. If you are not satisfied and believe your privacy rights have been violated, you may complain to the OCR at the US Department of Health and Human Services, We will not retaliate against you for filing a complaint. For full details regarding HIPAA, please visit the official government website:https://www.hhs.gov/hipaa/for-individuals/index.html

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION & RELEASE MEDICAL RECORDS TO A ***HEALTHCARE PROVIDER/ CLINIC/ HOSPITAL:***

PROVIDER/PRACTICE:_____ PHONE#:_____ FAX#_____

☐ RELEASE ALL HEALTH INFORMATION ☐ RELEASE ALL BILLING / INSURANCE INFORMATION

☐ DO NOT RELEASE ANY INFORMATION OR SPEAK TO ANYONE /ORGANIZATION

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION & RELEASE MEDICAL RECORDS TO A ***SPOUSE, FRIEND, OR FAMILY MEMBER:***

NAME:_____ RELATIONSHIP:_____ PHONE#_____

☐ RELEASE ALL HEALTH INFORMATION ☐ RELEASE ALL BILLING / INSURANCE INFORMATION

CAN WE LEAVE A MESSAGE? ☐ YES ☐ NO *☐ DO NOT RELEASE ANY INFORMATION OR SPEAK TO ANYONE*

MY SIGNATURE BELOW CONFIRMS THAT I RECEIVED THE HIPPA NOTICE OF PRIVACY PRACTICES, UNDERSTAND MY RIGHTS UNDER HIPAA, CONSENT TO THE USE OF MY PHI AS DETAILED THEREIN, AND HAVE AUTHORIZED THE RELEASE OF MY PROTECTED HEALTH INFORMATION TO THOSE LISTED ABOVE.

Patient Name (Please Print):_____ Witness Signature:_____

PATIENT'S SIGNATURE/ GUARDIAN SIGNATURE :_____ DOB:_____ DATE:_____

Consent to Treatment Authorization Form

PATIENT NAME:_____ DOB:_____

PURPOSE: I understand that the purpose of this form is to obtain my consent to engage in either an in-person or a telemedicine consultation/ visit/ appointment with my healthcare provider (s) at Oluyemi Aina MD PLLC/Tri-MED/ Holistic MD PLLC.

NATURE OF SERVICE: I acknowledge that my healthcare provider(s) or their representatives have explained to me how the video conferencing technology will be used, should I choose to participate in them. I understand and accept that if selecting telemedicine visits, I will not be in the same room as my healthcare provider. Moreover, I understand that there are potential risks due to the nature of telephone/videoconferencing technology, including interruptions, unauthorized access and technical difficulties.

RIGHTS: I understand that my healthcare provider or I can discontinue the in-person or telemedicine visit at any time.

CONFIDENTIALITY: I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than my healthcare provider and consulting healthcare provider in order to operate the video equipment if needed for a telemedicine visit. The above-mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation or visit and thus will have the right to request the following: (a) omit specific details of my medical history/ condition that are personally sensitive to me; (b) ask non-medical personnel to leave the in-person or virtual telemedicine examination room: and or (c) terminate the consultation at any time.

MISCELLANEOUS: I have had both in-person and telemedicine consultation/visit(s) explained to me, and have been given the opportunity to participate in both. I understand that some parts of my visit/exam, particularly those involving physical examinations, may be conducted by others, including my provider's supporting staff, at the direction of my provider. Some medical data such as my last known weight, review of prescriptions/pharmacies, current contact information, insurance, and other relevant medical information may be obtained verbally if choosing a telemedicine visit, by my healthcare provider or supporting staff, at the direction of the healthcare provider.

EMERGENT CONSULTATIONS: In an emergent consultation, I understand that my provider may advise me to call 911 or proceed to my local emergency room. My provider's responsibility will conclude upon the termination of the phone call/ video conference, or in person consultation.

PAYMENT OF SERVICES: I understand that billing for the services I receive will occur from Oluyemi Aina MD PLLC/ Tri-MED/Holistic MD PLLC. If I have insurance, my insurance will be billed. I am responsible for any patient portion not paid by my insurance. I hereby authorize payments to be made directly to Oluyemi Aina MD PLLC/Tri-MED/Holistic MD PLLC.

DISPUTES: I agree that any disputes that arise from my in-person or telemedicine consult will be resolved in Texas and Texas State Law shall apply to all disputes.

Upon signing below, I hereby give Oluyemi Aina MD PLLC/Tri-MED/Holistic MD PLLC and/or their associates medical staff permission to examine me and treat me according to the diagnosis and treatment plan as explained to me in order to improve my medical condition.

I hereby authorize payment(s) by my insurance and/or other payers be made directly to Oluyemi Aina MD PLLC/Tri-MED/Holistic MD PLLC for medical services provided to me

By signing this form, I certify:

- That I have read this form and fully understand its contents including the potential risks and benefits of both the in-person and telemedicine visit(s).
- I have had a direct conversation with my provider or a supporting staff member from Oluyemi Aina MD PLLC/ Tri-MED/Holistic MD PLLC during which I had the opportunity to ask questions in regards to in-person and telemedicine visits. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

_____ _____

PATIENT'S SIGNATURE/ GUARDIAN SIGNATURE DATE

PATIENT ACTION PAGE

ELECTRONIC SUBMISSIONS OF PAPERWORK:

IF YOU ARE SUBMITING THESE FORMS ELECTRONICALLY, A COPY OF YOUR VALID GOVERNMENT ISSUED I.D. AND THE FRONT AND BACK OF YOUR CURRENT INSURANCE CARD MUST BE ATTACHED AND SENT TO THE OFFCE BEFORE YOUR SCHEDULED APPOINTMENT TIME.

Image of Government Issued ID (FRONT)

Image of Government Issued ID (BACK)

Image of Insurance Card (FRONT)

Image of Insurance Card (BACK)