AUGUSTA ONCOLOGY
AIKEN ONCOLOGY

Miriam J. Atkins, MD
David R. Squires, MD
Brent H. Limbaugh, MD
Bunja Rungruang, MD
Aaron Flanders, MD
Reena Patel, MD
Sharad A. Ghamande, MD
Derek LaFont, PA
Nicole Wolbert, FNP-C
Tamara Coleman, FNP-C
Alice K. David, MD
John K. Hudson, MD
Jeremy Wells, MD
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Jean-Pierre Blaize, MD
Marian Symmes Johnson, MD
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Shannon Egan, PA-C
Kristen Bradley, NP

3696 Wheeler Road
Augusta, GA 30909
Phone: (706) 736-1830
Fax: (706) 650-7553

222 University Parkway
Aiken, SC 29803
Phone: (803) 306-1438
Fax: (732) 702-6069

1303 D'Antignac Street
Augusta, GA 30901
Phone: (706) 821-2944
Fax: (706) 821-2966

Please complete the enclosed forms in the New Patient Packet and return them to us when you arrive for your office visit. Please try to arrive at least 30 minutes before your scheduled appointment time.

We pride ourselves in going above and beyond the ordinary measure to ease our patient's financial burdens to the extent available to us. We have patient representatives to assist you with community resources and payment arrangements.

For patients without insurance or whose insurance does not cover all the costs, there are many sources of financial assistance that may be available. You will find that we also have financial resources for a number of chemotherapy medications prescribed by our providers.

For patients undergoing treatment, you may make an appointment with a patient representative to see if you qualify for any patient assistance. At that time, you will be counseled on assistance eligibility and you will need to bring the following documents for the entire household; *please be advised that you cannot be screened for eligibility without these documents:*

- 1040 page 1 & 2 of previous tax year
- Social Security Statement

Financial counseling can lead to peace of mind about medical expenses, leaving you free to concentrate on recovering.

Patient Name: _____ DOB: _____

New Patient Information **Date:** _____

Phone numbers:

Home: _____ **Preferred Pharmacy:** _____

Mobile: _____ **Pharmacy Phone Number:** _____

Work: _____ **Preferred Hospital:** _____

Please list your Doctors: _____

_____

Please list all ALLERGIES (and reactions). If none, check this box: ☐

_____

Please list all your medications (with dose and frequency):

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Medical History

Please list all medical problems and surgeries:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Last Colonoscopy or Sigmoidoscopy: _____

Last PSA or Prostate Exam: _____

Last PAP Smear: _____ **Last Mammogram:** _____

Last Flu Shot: _____ **Last Pneumovax:** _____

Social History **Date:** _____

Marital Status: _____ **Occupation:** _____

Tobacco Use: # of packs per day_____ # of years _____ # of years quit _____
Alcohol Use: # of drinks per day_____ # of years _____ # of years quit _____
Exposure to: Radiation_____ Asbestos _____ Benzene _____ Lead _____ Illegal Drugs ____

Number of Daughters? _____ **Number of Sons?** _____

Which family members or friends help you make medical decisions?

_____

Family History

Family members who have had cancer and what type: _____

_____

_____

Family members with blood problems: _____

Review of Systems

Please circle any of the symptoms below that you are feeling:

Constitutional: Fever, chills, hot flashes, drenching night sweats, fatigue, weight loss (how many lbs): _____.
Head: Headache, dizziness, hearing loss, vision changes, mouth sores, hoarseness, runny nose, nasal/sinus congestion, sputum
Lungs: Shortness of breath (at rest, lying down, or with exertion), cough, congestion
Heart: Chest pain or discomfort, palpitations
Abdomen/GI: Decreased appetite, nausea, vomiting, pain, heartburn (reflux), indigestion, diarrhea, constipation, change in bowel habits, blood in stool, hemorrhoids
Genitals/Urinary: Incontinence, difficulty urinating, frequent urination in day or night, pain or burning, bleeding, discharge, kidney stones
Arms, Back & Legs: Weakness, pain, swelling - if so where? _____
Neurologic: Numbness, tingling, burning, memory loss, seizures
Psychologic: Anxiety, depression, insomnia
Skin/Breasts: Rash, redness, new lumps or lesions
Blood: Bruising, bleeding, blood clots

Anything else?

_____ _____

_____ _____

_____ _____

Social Security #: _____ **Date of Birth:** _____

Your E-mail address: _____

Street Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Where do you live? Home ___ Apartment ___ Assisted Living ___ Nursing Home ___ With Relative ___ Other

Sex: Male Female **Preferred Language**_____

Ethnicity:_____ **Race**_____

Employer: _____ **Business Phone:** _____

Business Address: _____

Occupation: _____ **Referring Physician:** _____

Spouse's Name: _____ **Date of Birth:** _____

Spouse's Social Security #: _____

Advanced Directives

Please inform the front desk and indicate below with a checkmark if you have any legal documentation for any of the following items:

___ Healthcare Durable Power of Attorney

___ Organ Donor

___ Autopsy Request

___ Living Will / Personal Directive

___ Do Not Hospitalize Status

___ Do Not Resuscitate Status

___ Feeding Restrictions

___ Medication Restrictions

___ Other Treatment Restrictions

___ No Advanced Directives

Please provide us a copy of your Advance Directive for your chart if you have one.

Do you need information on Advance Directives? _____

Financial Policy

Thank you for choosing Augusta Oncology as your healthcare provider. In order to provide our patients with the best possible service, we want to communicate to you our financial policies. A copy will be provided to you upon request.

Health Insurance Coverage: Our practice participates in most health insurance plans. As a service to you, we will submit your claims and assist you in any way we reasonably can in order to get your claims processed correctly. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request.

Proof of Insurance: Our practice requires a copy of your driver's license & current valid health insurance card. Failure to provide correct insurance information in a timely manner may result in the balance of a claim becoming your responsibility. If your health insurance changes, please notify us as soon as possible so we can make the appropriate changes to help you receive your maximum benefits. All bills for patient balances are mailed to the address of record. Therefore, it is imperative that you update us with any and all changes to your account whether it is a change of address, phone number, insurance coverage, etc.

Insurance Benefits: Prior to your visit, our staff will verify your health insurance benefits. However, if you have any questions concerning your benefits, please contact your insurance company for clarification.

Co-payments and Deductibles: All copayments must be paid at the time of service. Payment plans are available for deductible and out of pocket costs. We accept cash, personal checks and major credit cards (Visa, Master Card, and Discover). We cannot waive any copayments, coinsurance, and/or deductibles. Please understand that payment plans will be separate from any per-visit copay required by your insurance company.

Referrals and Pre-Certification: Your insurance company may require a referral from a primary care physician (PCP) in order for you to see a specialist. Your insurance company may also require precertification of office or outpatient services. Pre-certification may also be required for admissions, CT scans, X-rays, and other diagnostic tests. As a courtesy, our office will make every reasonable effort to obtain these referrals and pre-certifications for you. However, it is ultimately your responsibility to ensure that all requirements are met before services are rendered. Please contact your insurance company to notify them of all services you are scheduled for.

Outside Lab Services: Our practice utilizes an outside lab company for certain tests. You are responsible for informing our staff which outside lab your insurance company covers.

I hereby authorize payment directly to **Augusta Oncology** for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf.

I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

I verify that I have read and understand this Financial Policy.

Signature of Responsible Party: _____

Please Print Name of Responsible Party: _____

Date: _____

Patient Name: _____ DOB: _____

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RECORDS REQUEST AUTHORIZATION

Patient Name: _____

Date of Birth: _____

I AUTHORIZE THE RELEASE OF MY MEDICAL RECORDS FROM ALL TREATING INSTITUTIONS TO AUGUSTA ONCOLOGY. THIS FORM HAS NO EXPIRATION DATE UNLESS THE FOLLOWING HAS OCCURRED:

WRITTEN NOTIFICATION FROM PATIENT TO REVOKE PRIVILEGES.

AUGUSTA ONCOLOGY HAS THE RIGHT TO REVOKE THESE PRIVILEGES.

This information will include any records pertaining to physical or mental health, alcohol, drugs, tobacco, and the diagnosis or treatment of HIV (AIDS virus) infection or other sexually transmitted diseases.

I release Augusta Oncology and any member of their staff from all liability regarding the disclosure of this information.

_____ **DATE:** _____
Signature of Patient

_____ **DATE:** _____
Signature of Witness

AUGUSTA ONCOLOGY ASSOCIATES PC

Notice of Privacy Practices

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

If you have any questions about this Notice, please contact Nicki Shannon at (706) 736-1830. This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment, or health care operations and for other purposes that are permitted or required by law. It also describes your right to access and control your protected health information. "Protected health information" 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.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices by accessing our web site **www.augonc.com,** calling the office and requesting that a revised copy be sent to you in the mail, or asking for one at the time of your next appointment.

YOUR CONSENT IS REQUIRED FOR US TO USE AND DISCLOSE YOUR MEDICAL INFORMATION

If you do not give your consent for us to use and disclose your medical information as outlined in this Notice, we will only use and disclose your medical information in the following circumstances:

- To providers who are personally involved in providing care pursuant to your consent to treatment (whether such consent is expressed, implied by law, or through substituted consent as authorized by law), but only during the period of time they are providing care to you;
- To bill you for the charges you incurred while you were a patient of ours, which means we cannot bill your third-party insurance company;
- To third parties when required by law or by appropriate legal process issued by a court or governmental agency with jurisdiction;
- If you are a Medicare, Medicaid, CHAMPUS/TriCare, or other federal or state program beneficiary or enrollee, for treatment and payment purposes as outlined in this Notice;
- In the case of an emergency, when we are transferring you to a receiving facility for care; and
- In the case of an emergency, in order to provide you with care that is required by federal and state law.

Should you give your consent, we will use and disclose your medical information as outlined in this Notice. The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of these categories.

1. Uses and Disclosures of Protected Health Information

Treatment. We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information, For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you, We will also disclose protected health information to other physicians who may be treating you when we have the necessary permission from you to disclose your protected health information. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician. Also, your protected health information may be disclosed to Patient Assistance Programs from time-to-time for those patients who require assistance with medications and/or other financial needs. If you are a patient receiving chemotherapy treatments, you may be required to sit in an open area with other patients receiving chemotherapy treatments and thus we cannot guarantee your complete personal privacy during these

Patient Name: _____ DOB: _____

treatment sessions.

Payment. Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as, making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations. We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training *of* medical students, licensing , marketing and fund-raising activities, and conducting or arranging for other business activities.

- For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose our protected health information, as necessary, to contact you to remind you of your appointment.

- We will share your protected health information with third party "business associates" that perform various activities, (e.g., billing or transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

- We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send out information about products or services that we believe may be beneficial to you. You may contact our Privacy Official to request that these materials not be sent to you.

- We may use or disclose your demographic information and the dates that you received treatment from your physician, as necessary, in order to contact you for fund-raising activities supported by our office. If you do not want to receive these materials, please contact our Privacy Official and request that these fund-raising materials not be sent to you.

Permitted and Required Uses and Disclosures That May be Made with your Authorization or Opportunity to Object: We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

- Unless you object, we may disclose to a member of your family, a relative, a closefriend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.
- We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death.
- We may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Other Permitted and Required Uses and Disclosures That May Be Made <u>Without</u> Your Authorization or Opportunity to Object. We may use or disclose your protected health information in the following situations without your authorization. These situations include:

- **Required by Law:** We may use or disclose your protected health information to the extent that the

use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, if and as required by law, of any such uses or disclosures.

- **Public Health Risks.** We may disclose without your consent medical information about you for public health activities. These activities generally include but are not limited to the following:
  - To report, prevent or control disease, injury, or disability;
  - To report births, deaths, and certain injuries or illnesses;
  - To report reactions to medications or problems with products;
  - To notify people of recalls of products they may be using;
  - To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and
  - To report suspected abuse or neglect as required by law.

- **Workers' Compensation:** Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally established programs.

- **Inmates:** If you are an inmate of a correctional institution or in the custody of law enforcement, we may release medical information about you to the correctional institution or law enforcement official who has custody of you, if the correctional institution or law enforcement official represents to us that such medical information is necessary: (1) to provide you with health care; (2) to protect your health and safety or the health and safety of others; (3) to protect the safety and security of officers, employees, or others at the correctional institution or involved in transporting you; (4) for law enforcement to maintain safety and good order at the correctional institution; or (5) to obtain payment for services provided to you. If you are in the custody of the Georgia Department of Corrections ("DOC") and the DOC requests your medical records, we are required to provide the DOC with access to your records.

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretaryof the Department of Health and Human Services to investigate or determine our compliance with the requirements of the Privacy Rules that are a part of HIPAA.

2. Your Rights Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

- **You have the right to inspect and copy your protected health information.** This means you may inspect and obtain a copy of protected health information about yourself that is contained in a designated record set for as long as we maintain the information. If you need a paper copy of your protected health information, the first copy will be free. Any paper copy thereafter will follow the fee chart designated by state law. Electronic copies of your records are always free if we can transmit them to you electronically without having to copy them onto a CD, DVD, or other media. A "designated record set" contains medical and billing records and any other records that your physician and the practice use for making decisions about you. Under federal law, however, you may not inspect or copy the following records: 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. Depending on the circumstances, a decision to deny access may be re-viewable. Please contact our Privacy Contact if you have questions about access to your medical record.

- **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 your healthcare provider not tell your health insurance company about care you receive or drugs you take if you pay for the care or drugs in full and the provider does not need to get paid by your insurance company. 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 state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician. You may request a restriction by contacting our PrivacyOfficer.

You may request that we not disclose your medical information to your health insurance plan for some or all of the services you receive during a visit to any Augusta Oncology location. If you pay the charges for those services you do not want disclosed in full at the time of such service, we are required to agree to your request. "In full" means the amount we charge for the service, not your copay, coinsurance, or deductible responsibility when your insurer pays for your care. Please note that once information about a service has been submitted to your health plan, we cannot agree to your request. If you think you may wish to restrict the disclosure of your medical information for a certain service, please let us know as early in your visit as possible.

- **You have the right to request to receive confidential communications from us by alternative means or at an alternative location.** We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Official.

- **You may have the right to have your physician amend your protected health information.** This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. 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. Please contact our Privacy Official to determine if you have questions about amending your medical record.

- **You have the right to receive an accounting of certain disclosure we have made, if any, of your protected health information.** This right applies to disclosures for purposes other than treatment, payment, or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, to family members or friends involved in your care, as a result of a signed authorization by you or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003 for up to the previous six years. You may request a shorter time frame. The right to receive this information is subject to certain exemptions, restrictions, and limitations.

- **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 electronically.

3. Investigations. We will investigate any discovered unauthorized use or disclosure of your medical information to determine if it constitutes a breach of the federal privacy or security regulations addressing such information. If we determine that such a breach has occurred, we will provide you with notice of the breach and advise you what we intend to do to mitigate the damage (if any) caused by the breach, and about the steps you should take to protect yourself from potential harm resulting from the breach.

4. Complaints You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Contact of your complaint. We will not retaliate against you for filing a complaint. You may contact our Privacy Officer, Nicki Shannon at (706) 736-1830, or nshannon@augonc.com for further information about the complaint process. You will not be penalized in any way for filing a complaint.

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Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

This Notice is effective April 1, 2021

Patient Name: _____ DOB: _____

Notice of Privacy Practices
Patient Acknowledgment and Consent

Patient Name: _____

I have received and reviewed Augusta Oncology's Notice of Privacy Practices (Notice) written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information. I consent to the uses and disclosures of my protected health information as outlined in the Notice.

I understand Augusta Oncology reserves the right to change the terms of the Notice and to make new provisions regarding all protected health information maintained by this practice. I understand that if a provision is made, I will receive an addendum explaining the change and will have another opportunity to consent to any new terms regarding the use and disclosure of my protected health information. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

_____ _____

Signature of Patient (Or personal representative of patient) **Date**

FOR OFFICE USE ONLY

We were unable to obtain a written acknowledgment of receipt of the Notice of Privacy Practices because:

_____ An emergency existed and a signature was not possible at the time.

_____ The individual refused to sign.

_____ A copy was mailed with a request for a signature by return mail.

Other:_____

_____

Relationship to Patient (If signed by a personal representative of patient)

Authorization for Release of Information

Augusta Oncology is authorized to release protected health information about the above-named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Patient Name: _____

Person(s) who can receive information:

Name: _____ **Relationship**: _____
Last *First*

Phone Numbers: _____ _____ _____
Home *Cell phone* *Work*

Name: _____ **Relationship**: _____
Last *First*

Phone Numbers: _____ _____ _____
Home *Cell phone* *Work*

Name: _____ **Relationship**: _____
Last *First*

Phone Numbers: _____ _____ _____
Home *Cell phone* *Work*

Is it okay to leave **protected health information** on voice mail? **(circle one)** **YES** **NO**

Is it okay to leave **financial information** on voice mail? **(circle one)** **YES** **NO**

RIGHTS OF THE PATIENT:

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to **Practice Site Manager.** I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by Federal or State law. I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient. I understand that I have the right to have someone accompany me during my visits and that my protected health information will be disclosed.

_____ Date: _____
Signature of Patient or Personal Representative

**Attach additional forms if more contacts are needed.*
**Attach necessary documentation if personal representative is needed.*

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RECORDS RELEASE AUTHORIZATION

Patient Name: _____

Date of Birth: _____

I AUTHORIZE THE RELEASE OF MY MEDICAL RECORDS FROM AUGUSTA ONCOLOGY TO:

_____

_____.

THIS FORM HAS NO EXPIRATION DATE UNLESS THE FOLLOWING HAS OCCURRED:

WRITTEN NOTIFICATION FROM PATIENT TO REVOKE PRIVILEGES.

AUGUSTA ONCOLOGY HAS THE RIGHT TO REVOKE THESE PRIVILEGES.

This information will include any records pertaining to physical or mental health, alcohol, drugs, tobacco, and the diagnosis or treatment of HIV (AIDS virus) infection or other sexually transmitted diseases.

I release Augusta Oncology and any member of their staff from all liability regarding the disclosure of this information.

_____ **Date:** _____
Signature of Patient

_____ **Date:** _____
Signature of Witness