EZRA B. RIBER, M.D.

Medical Director

Board Certified and Fellowship Trained

In Anesthesiology and Pain Medicine

Board Certified in Addiction Medicine

REGISTRATION FORM

FIRST NAME:	MIDDLE INITIAL:	LAST NAME:	
SSN:	DOB:	DL#:	
STREET ADDRESS:	CITY:	STATE:	ZIP:
HOME#:	CELL#:	WORK#:	
EMPLOYER:		**OCCUPATION**:	
EMAIL ADDRESS:	PRIMARY PHYSICIAN:	REFERRING PHYSICIAN:	

INSURANCE INFORMATION			
PRIMARY INSURANCE COMPANY NAME:			
POLICY#:		GROUP #:	GROUP NAME:
SUBSCRIBER NAME:	SUBSCRIBER DOB	SUBSCRIBER SSN:	RELATIONSHIP
SECONDARY INSURANCE COMPANY NAME:			
POLICY#:		GROUP #:	GROUP NAME:
SUBSCRIBER NAME:	SUBSCRIBER DOB	SUBSCRIBER SSN:	RELATIONSHIP

IN CASE OF EMERGENCY			
NAME:	RELATIONSHIP:	HOME#:	CELL# :

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Palmetto Pain Management to release any information required in order to process my claims.

Patient/Guardian Signature ______________________ Date ______________________

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GENERAL INFORMATION

NAME:		DATE:
GENDER:	**DATE OF BIRTH:**	**COUNTRY OF BIRTH :**
	RACE	
	PRESENT MARTIAL STATUS:	
	EMPLOYMENT	
	EDUCATION	
Grade: 1 2 3 4 5 6 7 8 9 10 11 12	College: 13 14 15 16	Other: ______________________

HOW MANY CHILDREN DO YOU HAVE? _______________

HOW MANY PERSONS ARE LIVING WITH YOU IN YOUR PERSONAL HOUSEHOLD? _______________

YOUR USUAL OCCUPATION IS: ____

IS THERE CURRENTLY A QUESITON OR A LAW SUIT OR DISABILITY CONCERNING YOUR PAIN CONDITION? ( ) YES ( ) NO

IF YES: ATTORNEY NAME: ____

ATTORNEY ADDRESS: ____

DO YOU HAVE AN ADVANCE DIRECTIVE/LIVING WILL? ( ) YES ( ) NO

DO YOU HAVE A POWER OF ATTORNEY? ( ) YES ( ) NO

IF YES: PLEASE LIST NAME OF SURROGATE DECISION MAKER: ______________________________

DESIGNATION OF CARE PROVIDERS: (Please specify name, relationship, authorized HIPAA person(s), healthcare provider, etc. that will be allowed information as needed for your treatment). If you wish for any family member to call us and speak with us they must be listed below.

____
____
____
____

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For Your Safety and Our Compliance:
Pain Management and Opioid Use Agreement

1. I, ______________________________________ will only receive narcotic pain medication or other controlled substance prescriptions from Palmetto Pain Management and I agree to take medications as prescribed.
2. I will only fill narcotic pain or controlled substance medication prescriptions at ____________________________________ pharmacy.
3. If I use the medication more frequently than prescribed it is likely that I am going to be without medication for a period of time.
4. If you have treatment with another provider, such as a dentist , orthopedist, hospitalization, ER, etc., we EXPECT that the provider will write additional medication to cover the pain that you may have from that procedure. Again that is expected, and does not violate this contract. If you use the medication that we are prescribing to cover other treatment, you are going to run out early and be without medication. If there is any question about this, show this agreement to your other provider and they are welcome to call Palmetto Pain Management to confirm.
5. I understand these medications are for me only, and I will not share, sell or trade my medication with anyone.
6. If medication does not work for me, or if i have side effects I know to NOT "flush pills", but instead bring original bottle with me to next visit.
7. I understand there is a possible 48 hour wait period for refill request.
8. I will not expect or request early refills or additional doses in addition to the number of tablets agreed to for any chronic condition
9. If an adjustment in the amount of medication is needed, I will schedule an office vis it to discuss this with my provider.
10. I am responsible for safeguarding my pain medications from loss of theft. Unfortunately we can no longer replace lost, stole or misplaced medication.
11. Random urine testing will be requested to verify what substances are in my system. Failure to comply with testing may result in denial of prescriptions.
12. Using street drugs and/or abusing alcohol while taking the medication that we are prescribing f or you can create a dangerous situation, which may result in criminal charges, such as DUI, and may require changing the medication we prescribe.
13. Tobacco users, the provider may at his/her discretion require that I show effort to reduce/stop using tobacco. Bone loss can occur with combination of alcohol, tobacco and opioid medications. Failure to comply with these recommendations may result in discharge.
14. I agree to follow up with my provider as requested regarding pain control and to keep all scheduled appointments regarding my chronic pain.
15. I understand that not following the above, which has been fully explained to me, may result in discontinuation of all narcotic or controlled substance prescriptions from this office and could potentially result in termination of care at Palmetto Pain Management.

I have read and understand the above guidelines.

____________________________	____________________________	____________________________
Patient	Patient Signature	Date
____________________________	____________________________	
PPM Physician	Date	

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Late Arrival & Cancellation Policy

Late Arrival Policy

Our doctors, medical assistants and staff aim to make your visit a pleasurable one. In our efforts to make your visit more comfortable and to minimize your wait time, our office has implemented a late arrival policy.
If a patient is more than 15 minutes late for an appointment, the appointment may need to be rescheduled. This is to ensure that the patients who arrive on time do not wait longer than necessary to see the provider. You may be given the option to wait for another appointment time on the same day if one is available. We will try to accommodate late-comers as best as possible, but cannot compromise on the quality and timely care provided to our other patients.
New patients are encouraged to fill out new patient paperwork prior to coming in. Otherwise, new patients need to arrive at the office at least 30 minutes prior to the scheduled appointment to complete the paperwork. If a new patient's paperwork is not completed in a timely fashion upon arrival, we may need to accommodate other patients who arrive on time.
The doctors and staff at Palmetto Pain Management truly appreciate your compliance and understanding of this policy so that we can continue to provide excellent medical care as well as excellent customer service.

Cancellation Policy

Palmetto Pain Management has instituted an appointment cancellation policy. A cancellation made with less than a 24 hour notice significantly limits our ability to make the appointment available for another patient in need.
To remain consistent with our mission, we have instituted the following policy:
1.Please provide our office a 24-hour notice in the event that you need to reschedule your appointment. This will allow us the opportunity to provide care to another patient. A message can always be left with the answering service to avoid a cancellation fee being charged.
2.A "No-Show", "No-Call" or missed appointment, without proper 24-hour notification, WILL be assessed a $25 fee.
3.This fee is not billable to your insurance.
4.If you are 15 or more minutes late for your appointment, the appointment may be cancelled and rescheduled.
5.As a courtesy, we send out reminder text, and emails for appointments, one to two days in advance. Please note, if a reminder text or message is not received, the cancellation policy remains in effect.
6.Repeated missed appointments may result in termination of the physician/patient relationship
I have read and understand the **Late Arrival Policy** and the **Appointment Cancellation Policy** of Palmetto Pain Management and I agree to the terms. I also understand and agree that such terms may be amended from time to time by the practice.
If you have any questions regarding these policies, please let our staff know and we will be glad to clarify any questions you have. A copy of this policy will be provided to you, at your request. Please sign and date below your acknowledgement.
I, ____________________ (print name) have read and understood policies of Palmetto Pain Management.

______________________________ ______________________________
Patient Signature Date

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Financial Policy

Thank you for choosing Palmetto Pain Management! We are committed to the success of your medical treatment, and we strive to offer excellent care in a patient friendly environment. We recognize that healthcare is expensive, insurance requirements are frustration, and discussing payment arrangements when you don't feel well may be unpleasant. As your healthcare provider, our relationship is with you, our patient – not with your insurance company. Your insurance plan is a contract between you, your insurance, and/or your employer. Our office is not a party to that contract, or any possible restrictions imposed by it. while we will make every effort to obtain appropriate payment from your insurance carrier, payment for services rendered is ultimately your responsibility.

Payment for Services

Copay's, deductible, and coinsurance percentage portions will be collected at check-in, as well as any outstanding balance due on the account. We participate with many health care plans and file charges with those plans as a curtesy. Most health plans required us to collect charges they deem to be patient responsibility in the form of copays, deductibles, and coinsurance. We must also collect payment directly from the patient for services the plan does not cover. If Palmetto Pain Management does not participate with your insurance plan, payment in full is required at the time of service.

Our charges are usually customary for our area. If tour insurance ultimately denies responsibility for services you receive, you are responsible for payment. If you have a Health Savings Account (HSA), Health Reimbursement Account (HRA), or a Flexible Spending Account, we will provider all documentation necessary for you to received appropriate reimbursement, however, payment is still required at the time of service.

Prepayments for Procedures

When scheduling for procedures our office will verify benefits with your insurance carrier and estimate portion of charges your carrier deems you responsible for. Prior or at the time of scheduling of your procedure you will be given estimated amount that will need to be paid either on and/or before the scheduled procedure date. Typically, 50% of your responsibility will be required as deposit, and will go towards full estimated amount owed. If unable to pay 50% a $100.00 deposit will be required to be paid at the time of scheduling. Payment plans may also be available for larger estimates. Please keep in mind that no procedures will be scheduled if there is a past due balance of more than $150.00 and no payment plan is on file.

Insurance

You will be required to update your insurance information at least once a year, but we may ask you to provide your insurance card more frequently. Please notify our office immediately if you change carriers, drop coverage, received new insurance card, assigned a new ID number, or in any way experience a change to your coverage. Failure to do so may result in insurance claim denials that cause all charges to become your full responsibility. Please know the benefits, limitations, and responsibilities of your insurance plan.

Referrals and Authorizations

If your plan(s) require a referral from your primary care physician (family or regular doctor), please make sure one has been provided prior to your appointment. We must have a current referral to prevent your insurance carrier from denying payment for services you received with us.

Uninsured Patients

Payment is due at the time of service

Past Due Balances

Balances that re not paid within 30 days from the date of service are considered past-due. If your insurance company has not responded to our request for payment within 30 days, we will ask for your assistance in obtaining payment from the carrier and/or to make a payment on the balance. Patient with past due balances will be required to make payment arrangements before additional services will be scheduled.
I acknowledge receipt and understanding of the Palmetto Pain Management Financial Policy outlined above.

______________________________________ ______________________________________

Patient Signature Date Patient Printed Name

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MEDICAL HISTORY CHECKLIST

NAME: ______________ DATE OF BIRTH: ______________ DATE: ______________

SYMPTOMS: Check ☐ symptoms you currently have or have had:

GENERAL ☐ Sinus Problems
- ☐ Fever
- ☐ Night Sweats
- ☐ Significant Weight Gain
- ☐ Significant Weight Loss
- ☐ exercise Intolerance
- ☐ Chills
- ☐ Malaise
- ☐ Fever

NEUROLOGIC
- ☐ Loss of Consiousness
- ☐ Weakness
- ☐ Numbness
- ☐ Tingling
- ☐ Burning Sensation
- ☐ Dizziness
- ☐ Headaches
- ☐ Migraines
- ☐ Restless Legs
- ☐ Seizures
- ☐ Tremor
- ☐ Gait Dysfunction
- ☐ Paralysis

EYE, EAR, NOSE, THROAT
- ☐ Dry Eyes
- ☐ Eye Irritation
- ☐ Vision Changes
- ☐ Eye Disease/Injury
- ☐ Contacts/Glasses
- ☐ Ear Discharge
- ☐ Difficulty Hearing
- ☐ Ear Pain
- ☐ Frequent Nose Bleeds
- ☐ Nose Problems
- ☐ Sore Throat
- ☐ Bleeding Gums
- ☐ Snoring
- ☐ Dry Mouth
- ☐ Oral Abnormalities
- ☐ Mouth Ulcer
- ☐ Teeth Abnormalities
- ☐ Mouth Breathing
- ☐ Ringing in Ears
- ☐ Sinusitis

CARDIOVASCULAR
- ☐ Chest Pain on Exertion
- ☐ Arm Pain on Exertion
- ☐ Shortness of Breath when Walking
- ☐ Shortness of Breath when Lying Down
- ☐ Palpitations
- ☐ Known Heart Murmur
- ☐ Light-headed on standing
- ☐ Ankle Swelling

GASTROINTESTINAL
- ☐ Normal Appetite
- ☐ Abdominal Pain
- ☐ Nausea
- ☐ Vomiting
- ☐ Constipation
- ☐ Change in Appetite
- ☐ Black or Tarry Stools
- ☐ Frequent Diarrhea
- ☐ Vomiting Blood
- ☐ Dyspepsia
- ☐ GERD

GENITO-URINARY
- ☐ Urinary Loss of Control
- ☐ Difficulty Urinating
- ☐ Increase Urinary Frequency
- ☐ Hematuria
- ☐ Incomplete Emptying

RESPIRATORY
- ☐ Cough
- ☐ Wheezing
- ☐ Shortness of Breath
- ☐ Coughing up Blood
- ☐ Sleep Apnea

MUSCULOSKELETAL
- ☐ Muscle Aches
- ☐ Muscle Weakness
- ☐ Arthralgias/Joint Pain
- ☐ Back Pain
- ☐ Swelling in the Extremities
- ☐ Neck Pain
- ☐ Difficulty Walking
- ☐ Cramps
- ☐ Osteoporosis
- ☐ Fractures

INTEGUMENTARY
- ☐ Abnormal Mole
- ☐ Jaundice
- ☐ Rash
- ☐ Itching
- ☐ Dry Skin
- ☐ Growths/Lesions
- ☐ Laceration
- ☐ Non-Helaing areas
- ☐ Changes in Hair/Nails
- ☐ Psoriasis
- ☐ Change in kin color
- ☐ Breast Lump

PSYCHIATRIC
- ☐ Anxiety
- ☐ Depression
- ☐ Sleep Disturbances
- ☐ Feeling Unsafe in Relationship
- ☐ Restless Sleep
- ☐ Alcohol Abuse
- ☐ Hallucinations
- ☐ Suicidal Thoughts
- ☐ Mood Swings
- ☐ Memory Loss
- ☐ Agitation
- ☐ Dementia
- ☐ Delirium

ENDOCRINE
- ☐ Fatigue
- ☐ Increase Thirst
- ☐ Hair Loss
- ☐ Increased Hair Growth
- ☐ Cold Intolerance

HEMATOLOGIC/LYMPHATIC
- ☐ Swollen Glands
- ☐ Easy Bruising
- ☐ Excessive Bleeding
- ☐ Anemia
- ☐ Phlebitis

ALLERGIES/IMMUNOLOGIC
- ☐ Runny Nose
- ☐ Sinus Pressure
- ☐ Itching
- ☐ Hives
- ☐ Frequent Sneezing

CONDITIONS: Check ☐ symptoms you currently have or have had:

- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Cancer ______________
- ☐ Cataracts
- ☐ Illicit Drug Use
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Hypertension
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes/Gonorrhea
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriages
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Rheumatoid Arthritis
- ☐ Rheumatic Fever OR Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections

PALMETTO PAINMANAGEMENT

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MEDICATIONS AND ALLERGIES

MEDICATIONS: Please list all medications you are currently taking:

Medication	Dose	How often do you take it?

ALLERGIES: Please list all allergies you have:

1) ___________**2)** ___________**3)** ___________**4)** ___________

For patients over the age of 66: Have you received a Pneumococcal vaccine on or after your 60th birthday? YES NO
If so, what was the date of administration?: ______________________
Have you had an adverse reaction to the vaccine before? YES NO

Please add any additional comments you feel would be helpful in treating your condition:______________________

Patient Signature:______________________ **Date:**______________________

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FAMILY HISTORY AND SURGERIES

FAMILY HISTORY: Fill in health information about your family	
Blood relative had/have any of the following:	
Disease	**Relationship to you (MATERNAL/PATERNAL)**
Arthritis, Gout	
Asthma, Hay Fever	
Cancer	
Chemical Dependency	
Diabetes	
Heart Disease, Stroke	
High Blood Pressure	
Kidney Disease	
Tuberculosis	
Other	

HOSPITALIZATIONS/SERIOUS ILLNESS/INJURIES				
Year	**Hospital**	**Reason for Hospitalization and Outcome**	**# of Births**	**Complications, if any:**

SURGERIES		
SURGERY NAME	**DATE**	**OUTCOME**

Have you ever had a blood transfusion? Y ☐ N ☐
If yes, please give approximate date:______________________

CANCER SCREENINGS

Date of last Breast Cancer Screening/Mammogram: ______________________

Name of OB/GYN: ______________________Tel: ______________________

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form

Signature: _________________________________**Date:** _________________________________

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PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: ______________________ **DATE:** ______________ **DATE:** ______________

Over the **last 2 weeks,** how often have you been bothered by any Not at all Several More than Nearly of the following problems?	Not at all	Several days	More than half the days	Nearly every day
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. Moving or speaking so slowly 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
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING:_________ + _________ + _________ + _________
=TOTAL SCORE: _________

If you marked 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**
☐	☐	☐	☐

Currently Treated By:_______________________________________(For Office Use)

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OTHER HEALTH INFORMATION

Patient Name: _______ D.O.B: __________

1. Are you or any dependents on currently listed insurance policy covered by another health care plan, HMO, or Medicare? ___ Yes ___ No

If YES, please complete the following. If NO, sign at the bottom and return this form

2. Is your other health insurance coverage Medicare Part B? ____ Yes ____ No

If NO, go to question 3

Subscriber Medicare Number: ________________________________

Subscriber Medicare Eligibility Date: Part B________________________________

Dependent Medicare Number: ________________________________

Dependent Medicare Eligibility Date: Part B ________________________________

Subscriber's Working Status: ____Active ____ Retired Date Retired:________________________________

3. If your other health insurance coverage is not Medicare, please complete the following:

Name of Other Insurance Company: ________________________________

Full Address of Other Insurance Company (on the back of the insurance card): ________________________________

Policy Holder's Name: ________________________ Policy Number: ____________ Group Number:____ ____ __

Telephone Number of Other Insurance Company:______2

Name of Employer Providing Coverage:

4. This policy provides the following benefits (check all that apply):

____Medical ____Pharmacy ____Dental ____Vision ____Mental health ____Durable medical equipmen

5. Please list who is covered by your other insurance company policy:

Name	Date of Birth	Gender	Relationship to Policyholder

Patient Signature: ________________________________

Date:____________________Daytime Phone:________________________________

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HIPAA PRIVACY AUTHORIZATION FORM

1. I hereby authorize Palmetto Pain Management to use and/or disclose the protected health information described below to: ____
(Name of Individual, Address and Telephone Number)

2. Authorization for Release of Information:
a. Covering the period of health care from:
☐ ___________to ___________Or ☐ all past , present and future periods.
b. Covering the following protected health information:
☐ I hereby authorize the release of my complete health record.
OR
☐ I hereby authorize the release of my complete health record with the exception of the following information: _________________________________

3. This authorization shall be in force and effect until______________________, at which time this authorization expires.
(Date of Event)

4 . I understand that I have the right to revoke this authorization, in writing, at any time . I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

5. I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned upon signing this authorization.

6. I understanding that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

____ ______________________
Signature of Patient or Personal Representative Date

____ ______________________
Print Name of Patient or Personal Representative Relationship to Patient

Palmetto Pain Management, LLC
2611 Forest Drive, Suite 200
Columbia, South Carolina 29204
Tel: (803) 779-3263 Fax: (803) 779-3207

Effective Date: 10/01/2023

Patient Notice of Privacy Practices

At Palmetto Pain Management, we are committed to maintaining the privacy and confidentiality of your medical information. This notice explains how your medical information may be used and disclosed and how you can access this information. Please read it carefully.

1. Uses and Disclosures of Medical Information
We may use and disclose your medical information for various purposes, including but not limited to:
a. Treatment: We may use and disclose your medical information to provide, coordinate, or manage your healthcare and related services.
b. Payment: We may use and disclose your medical information to bill and collect payment for the services we provide to you.
c. Healthcare Operations: We may use and disclose your medical information for activities such as quality improvement, training, and compliance with legal requirements.
d. Patient Rights: You have the right to access, amend, and request an accounting of your medical information. For more details, contact our Privacy Officer.

2. Authorization for Other Uses and Disclosures
We will obtain your written authorization before using or disclosing your medical information for purposes other than those listed in this notice. You may revoke such authorizations at any time, in writing.

3. Uses and Disclosures Without Authorization
Under certain circumstances, we may use or disclose your medical information without your authorization. These include:
a. To public health agencies for disease control and prevention.
b. To law enforcement agencies for legal investigations.
c. For health oversight activities by government agencies.
d. In response to court orders, subpoenas, or other legal processes.
e. For workers' Compensation claims.

4. Patient Rights
You have the right to:
a. Access your medical information (electronic or paper copy).
b. Request amendments to your medical information.
c. Request an accounting of disclosures.
d. Request restrictions on how your information is used and disclosed.
e. Receive confidential communications regarding your health information.

f. Choose someone to act for you such as a legal guardian or power of attorney that can exercise your rights and make choices about your health.
g. File a complaint if you feel your rights are violated.

5. Complaints
If you believe your privacy rights have been violated, you can file a complaint with our Privacy Officer or with the Secretary of the Department of Health and Human Services by calling 877-696-6775.

6. Changes to this Notice
We reserve the right to amend this notice at any time. You may obtain a copy of the most current notice from our office.

7. Access to Health Information via AthenaOne Patient Portal
Palmetto Pain Management, LLC provides access to your health information via AthenaOne secure patient portal. You must have an email address to set up a Patient Portal Account. The use of email helps ensure that the patient receives proper notification from the practice. Practice users can register patients via:

- Practice computer
- Using patients registered email address by sending an invitation to Patient Portal
- Using patient's smartphone (iPhone or Android devices)

8. Contact Information

If you have questions about this notice or need further information, please contact:

Jennifer Hodge, Security Officer/COO
2611 Forest Drive, Suite 200
Columbia, South Carolina 29204
Tel: (803) 779-3263 Fax: (803) 779-3207

By signing this document, you acknowledge that you have received and understand our Patient Notice of Privacy Practices.

Patient's Name: ____

Patient's Signature: ______________________________________ Date: ____________________
(or legal guardian)