APPLICATION FOR TREATMENT/ CONFIDENTIAL PATIENT INFORMATION

(PLEASE PRINT)
Cash_____Insurance_____Medicare_____PI/PIP_____Worker's Comp _____Other_____
IS YOUR VISIT DUE TO AN ACCIDENT? ☐YES ☐ NO (IF YES, PLEASE COMPLETE BOTH SIDES)

PATIENT DATA

LAST NAME_____ FIRST NAME _____ MDDLE NAME_____
AGE_____ MALE☐ FEMALE☐ BIRTHDATE_ _ _ _____
SOCIAL SECURITY #_____
MARITAL STATUS_____ # OF CHILDREN_____
ADDRESS_____
CITY_____ STATE_____ ZIP_____
HOME PHONE _____
CELL PHONE _____
WORK PHONE _____
OCCUPATION_____
EMPLOYED BY_____
EMAIL _____

EMERGENCY CONTACT DATA
NAME_____
RELATIONSHIP_____
HOME PHONE_____
CELL PHONE_____
EMAIL _____

INSURED INFORMATION
NAME _____
RELATIONSHIP _____
SOCIAL SECURITY #_____DOB_____
INSURANCE COMPANY _____

PRESENT COMPLAINT
(If any of the following are relevant to your medical complaint, please check the accompanying box)

☐ NECK PAIN	☐ DIGESTIVE DISORDERS	☐ LOSS OF MEMORY	☐ PALPITATION
☐ SHOULDER PAIN	☐ EXCESS PERSPIRATION	☐ ANXIETY	☐ DEPRESSION
☐ CHEST PAIN	☐ SHORTNESS OF BREATH	☐ TENSION	☐ DOUBLE VISION
☐ UPPER BACK PAIN	☐ EYE STRAIN	☐ NEURITIS	☐ SINUS TROUBLE
☐ MID BACK PAIN	☐ PAIN BEHIND EYES	☐ FAINTING	☐ FATIGUE
☐ LOW BACK PAIN	☐ EYES LOSS OF FOCUS	☐ INSOMNIA	☐ MENTAL DULLNESS
☐ PINS & NEEDLES IN ARM/KNEE/ LEG	☐ EYES SENSITIVE TO LIGHT	☐ TREMORS	☐ BLURRY VISION
☐ NUMBNESS IN FINGER, ARM & LEG	☐ EARS BUZZING/RINGING	☐ DIZZINESS	☐ HEAD SEEMS TOO HEAVY
☐ CONSTIPATION	☐ FEET/HANDS COLD	☐ HEADACHE	☐ EXTREME NERVOUSNESS
☐ DIARRHEA	☐ LOSS OF TASTE	☐ FACE PALE	☐ SHOULDER TIRED/HEAVY
☐ NAUSEA, VOMITING	☐ LOSS OF SMELL	☐ IRRITABILITY	

☐ DIFFICULTY IN EXCESSIVE ☐ STANDING ☐ WALKING ☐ SITTING ☐ BENDING _____
☐ NECK ☐ BACK STIFFNESS UPON RISING
☐ PAIN RADIATING INTO ☐ ARM ☐ RIGHT ☐ LEFT ☐ BOTH ☐ LEG ☐ RIGHT ☐ LEFT
☐ DIFFICULTY IN EXCESSIVE LIFTING ☐ LIGHT ☐ MODERATE ☐ HEAVY ☐ REPETITIVE
☐ PAIN RADIATING INTO ☐ NECK ☐ BACK ☐ BASE OF SKULL ☐ SHOULDER ☐ HIPS
SYMPTOMS OTHER THAN ABOVE_____
DID YOU REQUIRE POST-ACCIDENT HOSPITALIZATION? ☐ YES ☐ NO IF YES, WHERE? _____
HAVE YOU HAD SIMILAR ACCIDENTS OR INJURIES BEFORE? ☐ YES ☐ NO YEAR _____

MEDICAL HISTORY
(If any of the following are relevant to your medical history, please check the accompanying box.)

☐POLIO	☐DIABETES	☐RHEUMATISM	☐ DIGESTIVE DISORDER	☐ HEART TROUBLE
☐ANEMIA	☐HEPATITIS	☐CONCUSSION	☐ CONVULSIONS	☐ PACEMAKER
☐ASTHMA	☐ARTHRITIS	☐GERMAN MEASLES	☐ MUSCULAR DYSTROPHY	☐ PREGNANT/ DUE DATE: _____
☐CANCER	☐DIZZINESS	☐NERVOUSNESS	☐ VENERREAL DISEASE	☐HIGH CHOLESTEROL
☐NEURITIS	☐NUMBNESS	☐TUBERCULOSIS	☐ SINUS TROUBLE	☐HIGH BLOOD PRESSURE
☐EPILEPSY	☐BACKACHES	☐OTHER:_____	☐ SURGERY _____	☐RHEUMATIC FEVER
				☐MULTIPLE SCLEROSIS

PATIENT AGREEMENT
I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees professional services rendered me will be immediately due and payable. This is also an **Assignment of Benefits** authorizing direct payment to the doctor/facility.

PATIENT'S SIGNATURE_____ DATE_____

SPOUSE'S OR GUARDIAN'S SIGNATURE_____ DATE_____

⇒Turn and Complete reverse page if accidental injury occurred⇐

ACCIDENTAL INJURY REPORT

(PLEASE FILL OUT COMPLETELY AS POSSIBLE)

DATE OF ACCIDENT_____ HOUR OF ACCIDENT_____AM / PM LOCATION _____
TYPE OF ACCIDENT □ WORK RELATED □ TRAFFIC □ SLIP/FALL □OTHER _____
NUMBER OF DAYS MISSED FROM WORK DUE TO ACCIDENT_____ DAY(S)

TRAFFIC ACCIDENT

WHAT KIND OF VEHICLE WERE YOU IN: MAKE/MODEL/YEAR _____
WERE YOU A □ DRIVER □ PASSENGER □ PEDESTRIAN ESTIMATED VEHICLE DAMAGE $_____
IF A PASSENGER PLEASE INDICATE YOUR LOCATION IN THE CAR: _____# OF PEOPLE IN THE VEHICLE _____
DID YOU GO TO THE HOSPITAL? □ YES □ NO IF YES, WHERE? _____
WAS YOUR VEHICLE MOVING WHEN THE ACCIDENT OCCURRED? □ YES □ NO MPH? _____
DID YOUR VEHICLE HIT OTHER VEHICLE(S)? □ YES □ NO WHERE? _____
DID OTHER VEHICLE(S) HIT YOUR VEHICLE? □ YES □ NO WHERE? _____
DID THE FOLLOWING OCCURRED: □ AIRBAG DEPLOYED □ TOWED AWAY □ VEHICLE FLIP/SPIN
WAS THE ACCIDENT REPORTED TO POLICE DEPARTMENT? □ YES □ NO INCIDENT#: _____
WERE TRAFFIC TICKET ISSUED? □ YES □ NO TO WHOM: _____

PATIENT'S INSURANCE INFORMATION

DO YOU OR THE VEHICLE YOU WERE IN HAVE CAR INSURANCE □ NO □ YES (If YES please fill out the rest of section)
INSURANCE COMPANY _____ PHONE # _____EXPIRATION DATE _____
POLICY HOLDER'S NAME _____ POLICY # _____ DATE OF BIRTH _____

DO YOU HAVE HEALTH INSURANCE □ NO □ YES (If YES please fill out the rest of section)
INSURANCE COMPANY _____ PHONE # _____EXPIRATION DATE _____
POLICY HOLDER'S NAME _____ MEMBER ID # _____ GROUP # _____

OTHER INSURANCE INFORMATION _____

DESCRIBE ACCIDENT INCLUDING CAUSE(S) AND SURROUNDING CIRCUMSTANCES

_____

_____

_____

_____

_____

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Developed for Texas Health & Safety Code § 181.154(d)
effective June 2013

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information. Covered entities as that term is defined by HIPAA and Texas Health & Safety Code § 181.001 must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. **Covered entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.** Individuals cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits.

NAME OF PATIENT OR INDIVIDUAL

_____
Last First Middle

OTHER NAME(S) USED _____

DATE OF BIRTH Month _____ Day _____ Year _____

ADDRESS _____

_____

CITY _____ **STATE** _____ **ZIP** _____

PHONE (_____)_____ **ALT. PHONE** (_____)_____

EMAIL ADDRESS (Optional): _____

I AUTHORIZE THE FOLLOWING TO DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION:

Person/Organization Name _____
Address _____
City _____ State _____ Zip Code _____
Phone (_____)_____ Fax (_____)_____

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?

Person/Organization Name _____
Address _____
City _____ State _____ Zip Code _____
Phone (_____)_____ Fax (_____)_____

REASON FOR DISCLOSURE
(Choose only one option below)

- ☐ Treatment/Continuing Medical Care
- ☐ Personal Use
- ☐ Billing or Claims
- ☐ Insurance
- ☐ Legal Purposes
- ☐ Disability Determination
- ☐ School
- ☐ Employment
- ☐ Other _____

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only the first box.

- ☐ **All health information**
- ☐ Physician's Orders
- ☐ Progress Notes
- ☐ Pathology Reports
- ☐ History/Physical Exam
- ☐ Patient Allergies
- ☐ Discharge Summary
- ☐ Billing Information
- ☐ Past/Present Medications
- ☐ Operation Reports
- ☐ Diagnostic Test Reports
- ☐ Radiology Reports & Images
- ☐ Lab Results
- ☐ Consultation Reports
- ☐ EKG/Cardiology Reports
- ☐ Other_____

Your initials are required to release the following information:

_____Mental Health Records (excluding psychotherapy notes)
_____Drug, Alcohol, or Substance Abuse Records
_____Genetic Information (including Genetic Test Results)
_____ HIV/AIDS Test Results/Treatment

EFFECTIVE TIME PERIOD. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): Month _____ Day _____ Year _____

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURE X_____ _____
Signature of Individual or Individual's Legally Authorized Representative **DATE**

Printed Name of Legally Authorized Representative (if applicable): _____
If representative, specify relationship to the individual: ☐ Parent of minor ☐ Guardian ☐ Other _____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See, e.g., Tex. Fam. Code § 32.003).

SIGNATURE X_____ _____
Signature of Minor Individual **DATE**

IMPORTANT INFORMATION ABOUT THE AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Developed for Texas Health & Safety Code § 181.154(d)
effective June 2013

The Attorney General of Texas has adopted a standard Authorization to Disclose Protected Health Information in accordance with Texas Health & Safety Code § 181.154(d). This form is intended for use in complying with the requirements of the Health Insurance Portability and Accountability Act and Privacy Standards (HIPAA) and the Texas Medical Privacy Act (Texas Health & Safety Code, Chapter 181). **Covered Entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.**

Covered entities, as that term is defined by HIPAA and Texas Health & Safety Code § 181.001, must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. (Tex. Health & Safety Code §§ 181.154(b),(c), § 241.153; 45 C.F.R. §§ 164.502(a)(1); 164.506, and 164.508).

The authorization provided by use of the form means that the organization, entity or person authorized can disclose, communicate, or send the named individual's protected health information to the organization, entity or person identified on the form, including through the use of any electronic means.

Definitions - In the form, the terms "treatment," "healthcare operations," "psychotherapy notes," and "protected health information" are as defined in HIPAA (45 CFR 164.501). "Legally authorized representative" as used in the form includes any person authorized to act on behalf of another individual. (Tex. Occ. Code § 151.002(6); Tex. Health & Safety Code §§ 166.164, 241.151; and Tex. Probate Code § 3(aa)).

Health Information to be Released - If "All Health Information" is selected for release, health information includes, but is not limited to, all records and other information regarding health history, treatment, hospitalization, tests, and outpatient care, and also educational records that may contain health information. As indicated on the form, specific authorization is required for the release of information about certain sensitive conditions, including:

- Mental health records (excluding "psychotherapy notes" as defined in HIPAA at 45 CFR 164.501).
- Drug, alcohol, or substance abuse records.
- Records or tests relating to HIV/AIDS.
- Genetic (inherited) diseases or tests (except as may be prohibited by 45 C.F.R. § 164.502).

Note on Release of Health Records - This form is not required for the permissible disclosure of an individual's protected health information to the individual or the individual's legally authorized representative. (45 C.F.R. §§ 164.502(a)(1)(i), 164.524; Tex. Health & Safety Code § 181.102). If requesting a copy of the individual's health records with this form, state and federal law allows such access, unless such access is determined by the physician or mental health provider to be harmful to the individual's physical, mental or emotional health. (Tex. Health & Safety Code §§ 181.102, 611.0045(b); Tex. Occ. Code § 159.006(a); 45 C.F.R. § 164.502(a)(1)). If a healthcare provider is specified in the "Who Can Receive and Use The Health Information" section of this form, then permission to receive protected health information also includes physicians, other health care providers (such as nurses and medical staff) who are involved in the individual's medical care at that entity's facility or that person's office, and health care providers who are covering or on call for the specified person or organization, and staff members or agents (such as business associates or qualified services organizations) who carry out activities and purposes permitted by law for that specified covered entity or person. If a covered entity other than a healthcare provider is specified, then permission to receive protected health information also includes that organization's staff or agents and subcontractors who carry out activities and purposes permitted by this form for that organization. Individuals may be entitled to restrict certain disclosures of protected health information related to services paid for in full by the individual (45 C.F.R. § 164.522(a)(1)(vi)).

Authorizations for Sale or Marketing Purposes - If this authorization is being made for sale or marketing purposes and the covered entity will receive direct or indirect remuneration from a third party in connection with the use or disclosure of the individual's information for marketing, the authorization must clearly indicate to the individual that such remuneration is involved. (Tex. Health & Safety Code §181.152, .153; 45 C.F.R. § 164.508(a)(3), (4)).

Limitations of this form - This authorization form shall not be used for the disclosure of any health information as it relates to: (1) health benefits plan enrollment and/or related enrollment determinations (45 C.F.R. § 164.508(b)(4)(ii), .508(c)(2)(ii); (2) psychotherapy notes (45 C.F.R. § 164.508(b)(3)(ii); or for research purposes (45 C.F.R. § 164.508(b)(3)(i)). **Use of this form does not exempt any entity from compliance with applicable federal or state laws or regulations regarding access, use or disclosure of health information or other sensitive personal information (e.g., 42 CFR Part 2, restricting use of information pertaining to drug/alcohol abuse and treatment), and does not entitle an entity or its employees, agents or assigns to any limitation of liability for acts or omissions in connection with the access, use, or disclosure of health information obtained through use of the form.**

Charges - Some covered entities may charge a retrieval/processing fee and for copies of medical records. (Tex. Health & Safety Code § 241.154).

Right to Receive Copy - The individual and/or the individual's legally authorized representative has a right to receive a copy of this authorization.

Complete Injury Centers

Assignment of Benefits and Cause of Action | Designation of Authorized Representative

I, the undersigned patient and/or responsible party, in addition to my continuing personal financial responsibility, and in consideration of services, treatments, therapies, and/or medications rendered or to be rendered assign to **Complete Injury Centers ("Clinic")**, the following rights, power and authority:

RELEASE OF INFORMATION: I hereby authorize Clinic to release information concerning my condition and treatment to any insurance company, attorney or insurance adjuster for purposes of processing a claim for benefits and payment of services, treatments, therapies, and/or medications provided to me by Clinic.

IRREVOCABLE ASSIGNMENT OF BENEFITS AND CAUSE OF ACTION: I hereby irrevocably assign and convey directly to Clinic, as my designated authorized representative, all insurance benefits, if any, otherwise payable to me for services, treatments, therapies, and/or medications rendered or provided by Clinic. I also irrevocably assign to Clinic all rights, title, and interest in benefits payable out of any third party action or claim against any other person, entity, or insurance company, and out of any recovery under the Uninsured Motorist/Under-Insured Motorist (UM/UIM), medical payments or Personal Injury Protection (PIP) provisions of any auto insurance policy(ies) or any other insurance policy(ies) under which I may be entitled to recover. I also irrevocably assign to Clinic the exclusive right to any claim or cause of action that exists in my favor against any person, entity, insurance company for the terms of the policy, including the exclusive right to receive payment for services, make demand in my name for payment, and prosecute any claim or cause of action to which my treatment at Clinic is related. I further pledge to cooperate, provide information as needed, appear as needed, and to assist in the prosecution of such claims for benefits upon request.

I intend by this assignment and designation of authorized representative to convey to Clinic all of my rights to claim the benefits related to the services, treatments, therapies, and/or durable medical equipment provided by Clinic, including rights to any settlement, insurance or applicable legal or administrative remedies. The assignee and/or designated representative of Clinic is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or causes of action or right against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator, as my assignee and my designated authorized representative may bring suit against any such person, entity, or insurance company in its own name with derivative standing at Clinic's expense.

I hereby authorize Clinic to establish a PIP or UM/UIM claim on my behalf. I also instruct my insurance carrier to provide Clinic with any written rejections of PIP or UM/UIM coverage. If my carrier is unable to provide said rejections in a timely manner, I irrevocably assign to Clinic my right to recover minimum levels of coverage pursuant to Texas Insurance Code §§ 1952.101 and 1952.152, and I further instruct my carrier to pay up to the available limits directly to Clinic and to send any and all checks or financial instruments to 1 East Erie St, Suite 525 PMB 4567, Chicago, IL 60611.

If my injuries are the result of the negligence or fault of a third party, then I instruct the liability insurance carrier to issue a separate draft to pay in full for all services, treatments, therapies, and/or medications rendered to me by Clinic, payable directly to Complete Injury Centers, LLC, and to send payment to 1 East Erie St, Suite 525 PMB 4567, Chicago, IL 60611.

LIMITED POWER OF ATTORNEY: I hereby grant to Clinic the power to endorse my name upon any checks, drafts, or other negotiable instruments representing payment from any insurance company for services, treatments, therapies, and/or medications rendered to me by Clinic. I agree that any such insurance payment in excess of the charges for services, treatments, therapies, and/or medications rendered to me by Clinic will be credited to my account or forwarded to my address upon request in writing to Clinic.

TERMINATION OF CARE: I hereby acknowledge and understand that if I do not keep appointments as recommended to me by Clinic, then clinic may terminate responsibility for my care within a reasonable period of time.

A photocopy of this assignment is to be considered valid, the same as if it was the original.

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

Sign: _____ **Print:** _____ **Date:** _____

Complete Injury Centers

Attestation

By my signature below, I hereby attest and certify that the personal injury claim that I am pursuing was the result of the legitimate accident that occurred on _____.

I hereby acknowledge that I have been informed by Complete Injury Centers and Complete Injury Centers that it is a violation of federal and State Law to falsely claim that I was injured or involved in an accident that is in any way staged or set up for the purpose of filing a fraudulent claim.

Further by my signature below, I acknowledge that nobody has come to my residence or otherwise contacted to inform me that I should or must come to this clinic for therapy due to the accident on _____ that caused my injury.

Patient Sign In/Out Responsibility

I hereby acknowledge that I am responsible for signing in and signing out. During signing out I will review the treatment modalities that I had received at this office and instruct this office to update today's bill to reflect my current balance. If I fail to sign out, I have agree to the treatment modalities and instruct this office to update today's bill to reflect my current balance.

Disclaimer

During my course of treatment, if medically necessary my doctor may refer me to other medical provider/facility/diagnostic center to further evaluate, update, and continue my treatment. I understand I have the right to choose any medical provider/facility/diagnostic center at my choosing. If I do not want to go to the medical provider/facility/diagnostic center that my doctor refer me to I will instruct my doctor to send it to a location at my choosing. I understand by going to the medical provider/facility/diagnostic center my referring doctor or the treating facility is not responsible for my bill.

Complete Injury Centers, LLC has a business agreement with your treating facility. Complete Injury Centers, LLC does not treat, diagnosis, give medical advice, order diagnostic study, or charge you for your treatment. At the instruction of your treating facility, Complete Injury Centers will provide ancillary services such as: billing support, collection, maintain records and whatever the treating facility deem necessary.

Sign: _____ Print: _____ Date: _____

Complete Injury Centers

CONSENT TO TREATMENT

Health care providers are required to advise patients of the nature of the treatment to be provided, the risks and benefits of the treatment, and any alternatives to the treatment.

There are some risks that may be associated with treatment, in particular you should note:

a. “While rare, some patients have experienced rib fractures or muscle and ligament sprains or strains following treatment; b. There have been rare reported cases of disc injuries following cervical and lumbar spinal adjustment although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal or soft tissue manipulation or treatment. c. There have been reported cases of injury to a vertebral artery following osseous spinal manipulation. Vertebral artery injuries have been known to cause a stroke, sometimes with serious neurological impairment, and may be, on rare occasion, result in paralysis or death. The possibility of such injuries resulting from cervical manipulation is extremely remote;

Osseous and soft tissue manipulation has been the subject of government reports and multi-disciplinary studies conducted over many years and have demonstrated it to be highly effective treatment of spinal conditions including general pain and loss of mobility, headaches and other related symptoms. Musculoskeletal care contributes to your overall well being. **The risk of injuries or complications from treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.**

I acknowledge I have discussed the following with my healthcare provider:

a. The condition that the treatment is to address; b. The nature of the treatment c. The risks and benefits of that treatment; and d. Any alternatives to that treatment.

I have had the opportunity to ask questions and receive answers regarding the treatment.

I consent to the treatments offered or recommended to me by my healthcare provider, including osseous and soft tissue manipulation. I intend this consent to apply to all my present and future care with _____ (health care providers name).

Dated this _____ day of _____20_____

_____

Patient signature (or Legal Guardian) Signature of witness

_____

Print Name