AZALEA ORTHOPEDICS

A DIVISION OF OrthoLoneStar

| Today's Date: | Today's Appointment Scheduled with: |
|---|---|

**PATIENT INFORMATION**

| Patient's Last Name: | First: | Middle: | Marital status: |
|---|---|---|---|
| Previous Name: | Sex: | DOB: | SSN: |
| Address: [P.O Box, City, ST ZIP Code] | | | |
| Home Phone: | Mobile Phone: | Consent to Text: ◯ Yes ◯ No | |
| Work Phone: | Patient Email: | Contact Preference: | |
| Employer Name: | Occupation: | Pharmacy: | |
| Language: | Race: | Ethnicity: | |

**INSURANCE INFORMATION**

(Please give your insurance card to the receptionist.)

Primary Insurance:

| Subscriber's name: | Subscriber's SSN: | Birth date: | Policy Number: | Group Number: | Co-payment: |
|---|---|---|---|---|---|
| Patient's relationship to subscriber: | | | | | |

| Secondary Insurance (if applicable): | Subscriber's name: | Policy Number: | Group Number: |
|---|---|---|---|
| Patient's relationship to subscriber: | | | |

**EMERGENCY CONTACT**

| Name: | Relationship to patient: | Home phone: | Work phone: |
|---|---|---|---|

**REFERRING INFORMATION**

| Primary Care Provider (PCP): | Referring Provider: | How did you hear about us?<br>Family or Friend/Referring or PCP/Online Search (Internet)/Social Media<br>Other: _____ |
|---|---|---|

**GUARANTOR INFORMATION (NAME TO WHOM STATEMENTS ARE SENT)**

| Name:<br><br>Address: [P.O Box, City, ST ZIP Code] | Relationship to patient: | Home phone: | Work phone: |
|---|---|---|---|

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian signature Date

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# FINANCIAL POLICY

The physicians and employees of OrthoLoneStar are dedicated to providing the best possible care to you at the best possible value; therefore, we regard your understanding of our financial policies an essential element of your treatment. Our intent is to be fair, transparent, caring and accessible. If you have any questions, please discuss them with one of our staff members.

Your signature below authorizes the following:

- I/we assign to OrthoLoneStar, PLLC ("OLS") all insurance benefits or Medicare benefits to which it may be entitled for services rendered by its providers and authorize direct payment to the practice. This assignment includes without limitation major medical and disability insurance proceeds and benefits accruing under any settlement, structured or otherwise, or awarded in judgement for personal injury caused by a third party. I/we agree to pay practice for all charges not paid pursuant to this assignment.
- For ERISA, out-of-network, and self-funded plans, I assign and convey directly to OLS, as my designated authorized representative, all insurance reimbursement for services rendered by OLS regardless of network participation status. I authorize OLS and its authorized agents to negotiate, discuss, appeal and, in any other way, communicate with my insurance company to determine final payment for services I received. OLS has full authorization to accept or reject any proposed reimbursement proposal, and to act as necessary to accomplish the final adjudication of any claims. The results of that determination are binding upon me/us.
- Release of pertinent medical information to your insurance carrier(s).
- Administrative charges for completion of forms such as disability and FMLA forms, medical records copies, CDs of images, printed films, or similar items. Please consult with a staff member for these charges.
- If, after all your claims have been paid, the resulting balance is a credit of $5.00 or less, you will authorize us to write off this balance. Amounts greater than $5.00 will be refunded to you.
- I/we understand that insurance coverage and verification is not a guarantee of payment. I/we agree that I/we am/are ultimately responsible for any balance due after my insurance has paid or denied my claim(s). I/WE UNDERSTAND THAT I/WE AM/ARE RESPONSIBLE FOR ANY CHARGES IF THE INSURANCE COMPANY DENIES A CLAIM FOR ANY REASON INCLUDING STATING THAT IT IS INVESTIGATIONAL, EXPERIMENTAL, A PRE-EXISTING CONDITION, AUTO RELATED OR ACCIDENT-RELATED WHERE LIABILITY INSURANCE IS INVOLVED, OR ANY OTHER NON-COVERED SERVICE(S).

Responsibilities and acknowledgement of financial policy specifics:

- Please present your insurance card and photo ID at each appointment. Please share address, telephone number and/or insurance information updates any time a change occurs.
- Payment is due at the time of service unless other arrangements have been made in advance. For your convenience, we accept cash, check, and most major credit cards. Other financing options may be available. Please ask our staff about these programs.
- Payment of your deductible and coinsurance will be required for your calculated portion of our fees, based on your insurance contract, in advance of any scheduled surgical procedures and diagnostic testing. Any balance remaining after your health plan pays its portion is your responsibility and payment for balance is due upon notification from our office. Any overpayment will be refunded directly to you.
- You may be asked to put a credit card on file, which will only be charged according to the terms you agree to when placing such card on file. By processing your insurance first, we will only charge you for your exact out-of-pocket responsibility. You will receive notification containing a summary of charges and an estimate of what we believe you will owe. After your insurance has processed your claim, you will receive a second notification informing you of the actual amount you owe and notifying you that your card will be charged. Contact the practice if you have questions once you receive this notification.
- Your insurance is an agreement between you and your insurance company. As a courtesy to you, we will file your insurance claims for you if you assign benefits to the practice. If your insurance does not pay, we will look to you for payment of your balance in full.



OrthoLoneStar

- All health plans are not the same and do not cover the same services. If your health plan determines a service to be “not covered”, you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office. You are responsible for knowing and understanding your insurance benefits.
- You will be responsible for promptly responding to your insurance company to provide additional information they may request regarding your treatment, pre-existing conditions, accidents or other insurance coverage. Failure to respond in a timely manner may result in your account becoming due and payable, in full, by you.
- Responsibility for payment for patients who are minors whose parents are divorced rests with the parent who seeks the treatment or the adult accompanying the minor for all services rendered to the minor patients regardless of any court order responsibility judgement.
- Appointment Cancellations within 24 hours of scheduled time may result in a charge.
- Failure to notify us 48 hours before canceling a surgery may result in a charge.
- Returned checks for any reason will result in a charge.
- Some orthopedic supplies are not covered by your insurance, in which case we will require payment at time of service. A deposit will be collected upon receipt of certain Durable Medical Equipment items.
- All HMOs and some PPOs require prior authorization or referral from your primary care physician for each visit. This is your responsibility. IF YOU DO NOT HAVE THIS REFERRAL NUMBER AT THE TIME OF YOUR APPOINTMENT, YOUR BENEFITS MAY BE PAID AT A REDUCED RATE OR NOT PAID AT ALL AND YOU WILL BE RESPONSIBLE FOR THE CHARGES.
- When you are charged a “global” fee for surgery or office care of a fracture, laceration repair, excision of an ingrown toenail, or other medical procedure, that fee includes the service on the day it is performed and routine follow up care as well. The global period ranges from 10 to 90 days depending on the procedure and your health plan. Injections, X-rays, and supplies (such as casting or dressing materials, splints, braces, etc.) are not included in the “global” fee and a charge will be made for these items. Services related to complications are not included in the global fee.
- Please note there are no refunds or returns on all braces/soft goods.
- If you do not pay your balance and we are required to use a third party to collect your balance, an administrative charge of up to 25% of the balance may be added to the amount you owe.

I have read and understand the financial policy outlined above, and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by OLS.

**Patient Signature**: _____ **Date**: _____

If a patient is a minor (under the age of 18) or incapacitated:

**Responsible Party Name**: _____ **Relationship to Patient**: _____

**Responsible Party Signature**: _____ **Date**: _____

Patient Name: _____ Patient ID: _____

## Consent for Care and Treatment

I hereby agree and consent for OrthoLoneStar, PLLC and its subsidiaries and affiliates (collectively "Azalea" as used throughout this form) to furnish medical care and treatment to the patient listed above considered necessary and proper in diagnosing or treating her or her physical condition. I acknowledge that I have received no warranties or guarantees with respect to the benefits to be realized or consequences of the procedures or treatments. I understand that, should I leave the facility without written consent of my attending physician, I hereby relieve the physician and the facility of all responsibility of my action.

## Physician's Assistant and Certified/Nurse Practitioner Consent

Azalea and its affiliates utilize Physician's Assistants and Nurse Practitioners (collectively known as "Non-Physician Practitioners") to assist in the delivery of orthopedic medical care. I acknowledge a Non-Physician Practitioner is not a physician. Texas licenses Non-Physician Practitioners. Non-Physician Practitioner can, under the supervision of a physician, diagnose, treat, and monitor common acute and chronic diseases as well as provide health maintenance care and assist at surgery. Supervision does not require the constant physical presence of the supervising physician, but rather overseeing and accepting responsibility for the medical services provided. Azalea, its employees, and affiliates, may bill your insurer or plan administrator fiduciary separately to obtain payment for the services of Non-Physician Providers. I acknowledge this information and consent to the services of Non-Physician Practitioners for my health care needs. I understand that, at any given time, I can request to see the physician instead of a Non-Physician Practitioner.

## Patient Referral

I understand that, in some cases, my physician or Non-Physician Practitioner may refer me to an out-of-network provider and that I may have more out-of-pocket costs from such out-of-network provider. It is the patient's responsibility to ensure that any provider from whom the patient seeks treatment is in or out-of-network.

## Disclosure of Physicians' Ownership Interests

Our providers are committed to helping facilitate exceptional care at various healthcare facilities and through other health care providers. By maintaining ownership in other facilities and health care providers, our providers are able to have a voice in administrative and operational direction, resulting in a higher overall quality of care. Pursuant to the requirements of section §105.002 of the Texas Occupations Code and of Federal Law, this is to inform you that one or more of our physicians may have ownership in the facilities listed below and may, indirectly, receive compensation for services you receive. You, as the patient, have the option of using an alternative if you so desire. Upon request, we will provide a list of physician owners/immediate family members.

Baylor Scott & White Texas Spine & Joint Hospital, Christus Mother Frances Hospital, and UT Health East Texas. You may receive separate billing from each entity.

## Telephone Consumer Protections Act (TCPA) Notice

I agree that Azalea, or any other collection or servicing agency or agencies retained by Azalea (together referred to hereafter as "collectors") to collect any money that I owe to the facility may contact me by telephone or text message at any number given by me or otherwise associated with my account, including but not limited to, cellular/wireless telephone numbers that may result in my incurring fees for the call or text message. I am consenting to communication by email as required by 15 U.S.C. §7001and related state regulations and statutes.

I understand, acknowledge and agree that the collectors may contact me by automatic dialing devices and through pre- recorded messages, artificial voice messages or voice mail messages. I further agree that the collectors may contact me using e-mail at any e-mail address that I provide to the facility or is otherwise associated with my account.

## Email and Text Message Communications

I consent and state my preference to have Azalea communicate with me by email or standard SMS (text) messaging regarding various aspects of my medical care, which may include, but shall not be limited to, test results, prescriptions, appointments, and

billing. I understand that email and standard SMS messaging are not confidential methods of communication and may be insecure. I further understand that, because of this, there is a risk that email and standard SMS messaging regarding my medical care might be intercepted and read by a third party. ☐ ou do not want to be contacted via email or text message, please indicated your preference by checking this box:

## Telephone Communication Preferences

I wish to be contacted in the following manner (check all that apply):

**Home Phone:**

___ Leave message with detailed information ___ Leave message with call back number only

**Cell Phone:**

___ Leave message with detailed information ___ Leave message with call back number only

**Work Phone:**

___ Leave message with detailed information ___ Leave message with call back number only

**Patient Signature**: _____ **Date**: _____

If a patient is a minor (under the age of 18) or incapacitated:

**Responsible Party Name**: _____ **Relationship to Patient**: _____

**Responsible Party Signature**: _____ **Date**: _____

Patient Name: _____ Patient ID: _____

## Release of Photos/Radiographs/Videos for Website Publication

☐ I give permission to OrthoLoneStar, PLLC and its wholly owned subsidiaries and affiliates to photograph, televise, or otherwise illustrate as deemed advisable for diagnostic, educational, or research purposes and to enhance the medical record. I further authorize the use of such audio-visual material (video tape, audio tape, photographs, motion pictures, and other resulting records) for teaching purposes or to illustrate scientific papers or lectures at any time hereafter without inspection or approval, on my part, of the finished product or the specific use to which this material may be applied. I understand that no personally-identifying information will be used.

☐ I DO NOT consent to the use of any pictures/videos/radiographs obtained during my treatment.

## Acknowledgement of Receipt of Notice of Privacy Practices

The federal government requires all medical offices to make patients aware that they have rights regarding the use of their personal health information. Our Notice of Privacy Practices is available for review on our website and our front desk.

☐ I acknowledge that I was provided access to a copy of the Notice of Privacy Practices that I have read (or had the opportunity to read if I so choose) and understand the Notice.

☐ I refuse to sign this acknowledgement.

**Patient Signature**: _____ **Date**: _____

If a patient is a minor (under the age of 18) or incapacitated:

**Responsible Party Name**: _____ **Relationship to Patient**: _____

**Responsible Party Signature**: _____ **Date**: _____

# Friends and Family Information Disclosure

Patient Name: _____ Patient ID: _____

☐ I authorize the release and discussion of medical information (by telephone, mail or otherwise) by physicians and staff of OrthoLoneStar, PLLC and its wholly owned subsidiaries and affiliates to:

| Name and Relationship | Address/Phone Number |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

☐ I DO NOT authorize the release of medical information to my family members.

**Patient Signature**: _____ **Date**: _____

If a patient is a minor (under the age of 18) or incapacitated:

**Responsible Party Name**: _____ **Relationship to Patient**: _____

**Responsible Party Signature**: _____ **Date**: _____

# Workers' Compensation Disclosure

Patient Name: _____ Patient ID: _____

## IMPORTANT NOTICE

The following physicians are non-participating physicians in the Texas Workers' Compensation Program. Therefore, they are not listed as part of the ADL (Approved Doctor List) of the TDI-DWC (Texas Department of Insurance –Division of Workers' Compensation) and are not authorized in any capacity to treat patients for any work-related injury under the TWCC system.

The following physicians do not accept Texas Workers' Compensation related patients and/or listed are Non-ADL Physicians:

- Dr. Gary Goodfried
- Dr. Robert Dennis
- Dr. Kenneth Kaminski

***According to Texas Labor Code § 413.042, the patient is responsible for ALL healthcare expenses incurred if he or she violates Texas Labor Code § 408.022 relating to the selection of a doctor and receives medical treatment from a physician NOT chosen from a list of doctors approved by TDI-DWC. Furthermore, many insurance carriers have a healthcare network as allowed by the Insurance Code Chapter 1305. If you seek treatment outside of the carrier's healthcare network without prior approval you may be liable for ALL healthcare expenses incurred pursuant the Texas Insurance Code § 1305.451(b)(6).***

- ***You can access the ADL list through TDI-DWC's website at the following link:***

  https://www.tdi.texas.gov/wc/employee/iefaqe.html#q6

- ***To access your workers' compensation insurance carrier's healthcare network website, please contact your insurance carrier.***

**Patient Certification**: I hereby certify that the information provided by me is truthful, accurate and correct. I fully understand the above-referenced state law as well as any related regulations.

I have read and understand the above statement regarding WORKERS' COMPENSATION BENEFITS coverage.

☐ This is a work-related condition, injury, or symptom.

☐ This is NOT a work-related condition, injury or symptom.

I am scheduled to see Doctor: _____

If this is a work related condition, injury, or symptom, have you received any plain language notice regarding medical benefits?

☐ Yes I have received a plain language notice from my insurance carrier.

☐ No I have not received a plain language notice from my insurance carrier

If you have further concerns regarding whether or not your treatment is covered under workers' compensation benefits we recommend you contact your employer and/or your workers' compensation insurance carrier to determine if you have coverage prior to medical services being rendered. You can also contact the Texas Department of Insurance Division of Workers' Compensation at 800-252-7301 prior to medical services being rendered.

**Financial Obligation**: I understand if the information that I provide is inaccurate, OrthoLoneStar, PLLC and its wholly owned subsidiaries and affiliates (collectively, "Azalea") may not be able to collect payment from the insurance company. I also understand and acknowledge that providing false information on the completed forms will result in serious legal consequences for myself.

I hereby affirm that I am responsible to pay Azalea on demand for my medical services if I violated Texas law and knowingly selected a physician not chosen from a list of doctors approved by TDI-DWC or an approved doctor for my insurance carrier's healthcare network. Further, I understand that I will be financially liable if my insurance company declares the service to be work-related resulting in a request for refund, if I do not dispute the issue to declare otherwise.

**Patient Signature**: _____ **Date**: _____

If a patient is a minor (under the age of 18) or incapacitated:

**Responsible Party Name**: _____ **Relationship to Patient**: _____

**Responsible Party Signature**: _____ **Date**: _____

# Opioid (Narcotic) Prescription Policy

Patient Name: _____ Patient ID: _____

We understand that physical pain is interpreted differently among all of us and we are sensitive to the fact that many of our patients present to us with physically painful conditions. However, it is also our duty as physicians to minimize harm to patients. Narcotic addiction is a national epidemic. Physicians have been placed on the front line of managing this epidemic and are held accountable. In order to protect our patients and maintain our professional standing, OrthoLoneStar, PLLC and its wholly owned subsidiaries and affiliates have an established policy for prescribing narcotics.

- Narcotics will not be prescribed for chronic pain conditions; however, they can be prescribed for acute conditions at the discretion of the treating physician.
- If you are under the care of a pain management physician, we expect you to disclose this information on your first visit. Failure to do so would violate your contract with your pain management physician.
- Narcotics will be prescribed post-operatively for a maximum of six to eight weeks depending on the type of surgical procedure performed.
- Prescriptions for narcotics will be dispensed in accordance with the Texas Prescription Monitoring Program. They may not be “called in” to your pharmacy.
- Your prescription history will be reviewed prior to the prescribing of any narcotic medication, pursuant to the Texas Prescription Monitoring Program.
- If you are taking narcotics prescribed by a pain management physician, you will need to receive your post-operative pain medicine from that physician.
- Long-term pain medication needs will require a referral to another physician, such as a pain management physician or primary care provider.
- Refills may take up to three days to process, so you must call well in advance. No refills will be authorized after hours or on weekends. NO EXCEPTIONS. On-call physicians are not authorized to refill narcotic pain medication. You may be asked to come to the office to be reevaluated prior to receiving a refill.
- Lost, damaged or stolen prescriptions will NOT be replaced.
- All medications are to be used as prescribed. Adjustments or increases in the amount of medication should not be done without discussion with the prescribing provider.
- Adverse reactions are to be reported to the physician’s office immediately.
- Combining narcotic pain medications may have unrecognized or unpredictable interactions with other pain medications.
- Operating heavy equipment or driving is not permitted when using narcotic pain medications.

We have created this policy to ensure the health and safety of our patients. We appreciate your cooperation.

**Patient Signature**: _____ **Date**: _____

If a patient is a minor (under the age of 18) or incapacitated:

**Responsible Party Name**: _____ **Relationship to Patient**: _____

**Responsible Party Signature**: _____ **Date**: _____

# NOTICE OF PRIVACY PRACTICES

*Dear Patient,*

*Thank you for choosing OrthoLoneStar to provide your musculoskeletal care. In compliance with HIPAA, we would like to make you aware of your rights and our uses and disclosures as it pertains to your Personal Health Information.*

**YOUR CHOICE.**

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

- In these cases, you have both the right and choice to tell us to:
  - Share information with your family, close friends, or others involved in your care.
  - Share information in a disaster relief situation.
    **If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.**
- In these cases, we never share your information unless you give us written permission
  - Marketing purposes
  - Sale of your information
  - Sharing of psychotherapy notes
- In the case of Fundraising:
  - If we contact you for any community relief efforts, you can tell us not to contact you again.

**YOUR RIGHTS.**

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

- Get an electronic or paper copy of your record.
  - We will provide a copy of your health information, usually within 15 days of your request. We may charge a reasonable, cost-based fee. We may contract with a third party to perform this service.
- Ask us to correct your medical record.
  - You can ask us to correct information that you think is incorrect or incomplete.
  - We may say “no” to your request, but we’ll tell you why in writing within 60 days.
- Request confidential communications.
  - You can ask us to contact you in a specific way (for example, cell, home or office phone) or to send mail to a different address.
  - We will say “yes” to all reasonable requests.
- Ask us to limit what we use or share.
  - You can ask us NOT to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it would affect your care.
  - If you pay for a service or healthcare item in full, out-of-pocket, you can ask us not to share that information with your health insurer. We will say “yes” unless a law requires us to share that information.
- Get a copy of this privacy notice.
  - You can ask for a paper copy of this notice at any time. It is also available on our website
- Choose someone to act for you
  - If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. Please provide us with a copy of this documentation.
- File a complaint if you feel your rights are violated.
  - Please let us know if you have any questions, concerns or grievances. You may contact the OrthoLoneStar Privacy Officer, 7401 Main Street, Houston, TX 77030, 713-794-3352 or privacy@ortholonestar.com. We also have a manager at each location available for you to speak with.
  - You can file a complaint with the Region VI, Office for Civil Rights, U.S. Department of Health & Human Services at to 1301 Young Street, Suite 1169, Dallas, TX 75202
  - We will not retaliate against you for filing a complaint
- Get a list of those with whom we’ve shared information.
  - You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
  - We will include all the disclosures except for those about treatment, payment and health care operations, and certain other disclosures (such as any you asked us to make).

**OUR USES & DISCLOSURES.**

We typically use or share your health information in the following ways:

- Treat you.
  - We can use your health information and share it with other professionals who are treating you.
  - To access your pharmacy benefits data for; formulary check, prescriptive history and electronic prescribing.
- Run our organization.
  - We can use and share your health information to run our practice, improve your care, and contact you when necessary.
  - We use email and text (SMS) technology for appointment reminders and form completion. You have the option to opt out of these messages.
  - We may contact you with relevant health information, research, initiatives, or opportunities. You have the option to opt out of these notifications.
- Bill for your services
  - We can use and share your health information to bill and get payment from health plans or other entities.

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index/html

- Help with public health and safety issues
  - Preventing disease
  - Helping with product recalls
  - Reporting adverse reactions to medications
  - Reporting suspected abuse, neglect, or domestic violence
  - Preventing or reducing a serious threat to anyone's health or safety
- Do research
  - We can use or share your anonymized information for health research.
- Comply with the law, address workers' compensation, law enforcement, and other gov't requests
  - We will share information about you if state or federal laws require it, including in compliance with the Department of Health and Human Services.
  - For workers' compensation claims
  - For law enforcement purposes or with a law enforcement official
  - With health oversight agencies for activities authorized by law
  - For special government functions such as military, national security, and presidential protective services
- Respond to organ and tissue donation requests
  - We can share health information about you with organ procurement organizations.
- Work with a medical examiner or funeral director
  - We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
- Respond to lawsuits and legal actions
  - We can share health information about you in response to a court or administrative order, or in response to a subpoena.

**OUR RESPONSIBILITIES.**

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it upon request.
- We will not use or share your information other than as described here unless you tell us we can in writing. You may change your mind at any time, by notifying us in writing.

**CHANGES TO THE TERMS OF THIS NOTICE**

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.

**Patient Signature**: _____ **Date**: _____

If a patient is a minor (under the age of 18) or incapacitated:

**Responsible Party Name**: _____ **Relationship to Patient**: _____

**Responsible Party Signature**: _____ **Date**: _____