PATIENT'S PERSONAL HISTORY & HEALTH ASSESSMENT **Date: _____**

PATIENT'S NAME: _____ SSN#: _____ DOB: _____ SEX: _____

PATIENT'S STREET ADDRESS: _____ CITY: _____

STATE: _____ ZIP CODE: _____ HOME PHONE#:_____ CELL PHONE#: _____

EMPLOYER: _____ EMPLOYER PHONE# _____

NEAREST RELATIVE/KIN: _____ RELATIONSHIP: _____

ADDRESS: _____ CITY: _____

STATE: _____ ZIP CODE: _____ PHONE#:_____ WORK PHONE#: _____

DATE OF LAST PHYSICAL EXAM: _____ PHYSICIAN: _____

MEDICAL EQUIPMENT: Do you use a Cane ___ Oxygen ___ Catheter ___ Wheelchair ___ Nebulizer ___
Do you use Glasses? ___ Hearing Aid ___

SOCIAL HISTORY: Alcohol ___ Smoking ___ Drugs ___ Other _____

RELIGION: _____ **ETHNICITY:** □ Hispanic or Latino □ Not Hispanic or Latino □ Prefer not to Disclose

RACE: (Please check below)

□ American Indian or Alaska Native □ Asian □ Black or African □ White
□ Native Hawaiian or Other Pacific Islander □ Hispanic □ Other Race □ Prefer not to Disclose

MARITAL STATUS: Married ___ Widowed ___ Single ___ Divorced ___ Separated ___ Live Alone ___

IMMUNIZATIONS: Pneumococcal ___ Rubella ___ Tetanus ___ Influenza ___ Diphtheria ___ Other _____

FAMILY HISTORY:

	Alive	Dead	Age	Cause of Death
Mother				
Father				
Brother				
Sister				

Check if you have/had any of the following illnesses. If unsure, leave blank:

	Self	No	Relative		Self	No	Relative		Self	No	Relative
Alcohol Overuse	□	□	□	Epilepsy	□	□	□	Mumps	□	□	□
Allergies (other than medications)	□	□	□	Frequent Kidney/Bladder Infections	□	□	□	Nervous Breakdown	□	□	□
Anemia	□	□	□	Frequent Lung Infections	□	□	□	Radiation Treatments	□	□	□
Arthritis	□	□	□	Gallbladder Disease	□	□	□	Rheumatic Fever	□	□	□
Asthma	□	□	□	Goiter	□	□	□	Sexually Transmitted Diseases	□	□	□
Bleeding Tendency	□	□	□	Gout	□	□	□	Sickle Cell Anemia	□	□	□
Cancer	□	□	□	Hay Fever	□	□	□	Stomach Ulcers	□	□	□
Chicken Pox	□	□	□	Heart Attack	□	□	□	Stroke	□	□	□
Colitis	□	□	□	Hepatitis	□	□	□	Suicide Attempt	□	□	□
Congenital Heart Disease	□	□	□	High Blood Pressure	□	□	□	Thyroid	□	□	□
Depression	□	□	□	Intestinal Polyps	□	□	□	Tuberculosis	□	□	□
Diabetes	□	□	□	Jaundice	□	□	□	Whooping Cough	□	□	□
Dialysis	□	□	□	Leukemia	□	□	□	Other	□	□	□
Emphysema	□	□	□	Measles	□	□	□				
				Migraine	□	□	□				

PATIENT NAME: _____ DATE: _____

OPERATIONS: List and indicate approximate year.

_____

_____

_____

SERIOUS INJURIES: (Other than the above) List injuries and give approximate dates

_____

_____

_____

HOSPITALIZATIONS: (Other than operations, **especially in the last year**)

_____

_____

_____

_____

MEDICATIONS: - INDICATE IF YOU TAKE ANY OFTHE FOLLOWING ADMINISTRATION.	**MEDICATION NAME** INDICATE THE DOSE AND FREQUENCY OF DRUGS	**DOSAGE**	**FREQUENCY**
□ ASTHMA WHEEZING MEDICINE	_____	_____	_____
□ ASPIRIN, BUFFERIN, ANACIN, TYLENOL OR SIMILAR PRODUCTS	_____	_____	_____
□ BLOOD PRESSURE PILLS	_____	_____	_____
□ CORTISONE, PREDNISONE	_____	_____	_____
□ COUGH MEDICINE	_____	_____	_____
□ DIGITALIS OR HEART MEDICINE	_____	_____	_____
□ HORMONES	_____	_____	_____
□ INSULIN OR DIABETIC PILLS	_____	_____	_____
□ ANEMIA MEDICINE	_____	_____	_____
□ LAXATIVES	_____	_____	_____
□ MOTRIN, ADVIL	_____	_____	_____
□ SLEEPING PILLS/TRANQUILIZERS	_____	_____	_____
□ THYROID MEDICINE	_____	_____	_____
□ STOMACH/DIGESTIVE MEDCINE	_____	_____	_____
□ WEIGH-REDUCING PILLS	_____	_____	_____
□ DILANTIN	_____	_____	_____
□ WATER PILLS, DIURETICS	_____	_____	_____
□ ANTIBIOTICS	_____	_____	_____
□ PHENOBARBITAL/BARBITUATES	_____	_____	_____
□ VITAMINS	_____	_____	_____
□ OTHER PRESCRIPTION OR OVER THE COUNTER DRUGS	_____	_____	_____

ARE YOU ALLERGIC TO ANY MEDICATIONS? YES □ NO □

IF YES, PLEASE LIST MEDICATIONS AND THE REACTION YOU HAD WITH THEM.

_____

_____

_____

_____

PLEASE BRING ALL MEDICINES YOU ARE TAKING TO EVERY VISIT!

PATIENT NAME: _____ DATE: _____

REVIEW OF SYSTEMS: Please check ***YES*** to the following question ***ONLY*** if the problem is of significant concern in the recent past (1 month) or unless the question specifically states "**EVER**."

1. GENERAL:
   - Do you usually feel persistently tired or worn out? **Yes** □ **No** □
   - Have you recently been drinking more waters or fluids? **Yes** □ **No** □
   - Has there been any unusual weight gain or loss recently? **Yes** □ **No** □

2. CARDIOVASCULAR:
   - Do you have pain, tightness or pressure in the front or back of your chest? **Yes** □ **No** □
   - Have you been told your electrocardiogram was abnormal? **Yes** □ **No** □
   - Do you have any swelling of your feet or ankles? **Yes** □ **No** □
   - Does your heart ever beat fast or irregularly? **Yes** □ **No** □
   - Do you have cramps in the calf muscles when you walk? **Yes** □ **No** □
   - Do your fingers or toes ever get cold, become numb, get very white or bluish? **Yes** □ **No** □

3. CENTRAL NERVOUS SYSTEM:
   - Do you have frequent or severe headaches? **Yes** □ **No** □
   - Do you often have spells of dizziness, faintness or lightheadedness? **Yes** □ **No** □
   - Do you have sometimes lose the ability to speak? **Yes** □ **No** □
   - Have you recently fainted, blacked out, lost consciousness? **Yes** □ **No** □
   - Do you have trouble remembering recent events? **Yes** □ **No** □
   - Do you ever have convulsions or fits? **Yes** □ **No** □
   - Have you ever wanted to commit suicide? **Yes** □ **No** □
   - Do you ever hear voices or see people when no one is around? **Yes** □ **No** □

4. EYES:
   - Have you had:
     - Any pain in your eyes? **Yes** □ **No** □
     - Glaucoma? **Yes** □ **No** □
     - Blurry vision? **Yes** □ **No** □
     - Halo around lights? **Yes** □ **No** □
     - Change in vision? **Yes** □ **No** □
     - Cataracts or implants? **Yes** □ **No** □
     - Do you wear glasses? **Yes** □ **No** □
   - When did you last see an eye doctor? _____

5. ENT:
   - Do you have:
     - Any trouble hearing? **Yes** □ **No** □
     - Ringing or buzzing in your ears? **Yes** □ **No** □
     - Earaches or discharge from Your ears? **Yes** □ **No** □
     - Drainage down the back of your throat? **Yes** □ **No** □
     - Frequent or severe nosebleeds? **Yes** □ **No** □
     - Persistent hoarseness? **Yes** □ **No** □
     - Bleeding gums? **Yes** □ **No** □
     - Do you use a hearing aid? **Yes** □ **No** □

6. GASTROINTESTINAL:
   - Have you recently had any change in your eating habits? **Yes** □ **No** □
   - Have you recently noted any trouble in swallowing? **Yes** □ **No** □
   - Do you have a lot of indigestion or heartburn? **Yes** □ **No** □
   - Have you ever vomited blood? **Yes** □ **No** □
   - Are you bothered with constipation? **Yes** □ **No** □
   - Do you have frequent loose stools or diarrhea? **Yes** □ **No** □

7. SKIN:
   - Do you have:
     - Any change in the color of your skin? **Yes** □ **No** □
     - Any rashes or itching? **Yes** □ **No** □
     - Any growths or lumps on your skin? **Yes** □ **No** □
     - Any sores or wounds that do not heal? **Yes** □ **No** □
     - Any changes in the color or size of warts or moles? **Yes** □ **No** □

8. GENITOURINARY:
   - Do you have:
     - Burning or pain when you urinate? **Yes** □ **No** □
     - To pass water frequently to get up at night? **Yes** □ **No** □
   - Trouble with losing urine when you cough or sneeze? **Yes** □ **No** □
   - A problem with dribbling urine? **Yes** □ **No** □

Have you ever passed blood in your urine? **Yes** □ **No** □
Have you ever had an operation to prevent pregnancy? **Yes** □ **No** □
MEN: Do you have prostate gland trouble? **Yes** □ **No** □
Have you had herpes? **Yes** □ **No** □

9. MUSCULOSKELETAL:
Do you ever have a problem with back pain? **Yes** □ **No** □
Does back pain interfere with your work or activities? **Yes** □ **No** □
Do you have joint pain or stiffness (arthritis)? **Yes** □ **No** □
Do you have trouble walking or using your hip, knee joints? **Yes** □ **No** □

10. RESPIRATORY:
Do you have:
Frequent chest colds **Yes** □ **No** □
Pneumonia? **Yes** □ **No** □
A constant or bothersome cough? **Yes** □ **No** □
Coughing or blood? **Yes** □ **No** □
Difficulty breathing? **Yes** □ **No** □
Wheezing or whistling in your chest? **Yes** □ **No** □

11. WOMEN ONLY:
Did you have any pregnancies? **Yes** □ **No** □
How many? _____
Have you had any lumps in your breast? **Yes** □ **No** □
Have you had any abnormal bleeding from the vagina in the past year? **Yes** □ **No** □
Have you passed the menopause or change? **Yes** □ **No** □
Do you have any prolapsed (*falling out*) of the vagina or uterus? **Yes** □ **No** □
Have you had a hysterectomy? **Yes** □ **No** □
Do you have any vaginal drainage? **Yes** □ **No** □
Have you had herpes? **Yes** □ **No** □

12. LIVING ARRANGEMENTS:
Do you own your home? **Yes** □ **No** □
Do you rent your home? **Yes** □ **No** □
Do you live alone? **Yes** □ **No** □
Do you have a Will? **Yes** □ **No** □
Do you have a Living Will? **Yes** □ **No** □
Do you need other legal assistance? **Yes** □ **No** □

13. OCCUPATIONAL:
Are you presently employed? **Yes** □ **No** □
Does or did your work involve unusual work, exposure to dust, noise, radioactivity, etc.? **Yes** □ **No** □
Are you limited at work because of disability? **Yes** □ **No** □
Are you retired? **Yes** □ **No** □
Types of work you have done:
_____
_____

14. SOCIAL HISTORY:
Have you recently lived or traveled outside the U.S.? **Yes** □ **No** □
Do you eat less than three meals a day? **Yes** □ **No** □
Do you have special food customs or restrictions? **Yes** □ **No** □
Do you use any community services now? **Yes** □ **No** □

PERSONAL HABITS:
Have you ever smoked tobacco?
Are you a regular smoker now?
Number of cigarettes per day _____ Cigars □ Pipe □
How long have you been smoking? _____ Years.
Check if you regularly drink:
Hard liquor 1-3 oz. per day □ over 3 oz. per day □
Beer 1 bottle per day □ 2 bottles □ 3 or more □
Wine 1 glass per day □ 2glasses □ 3 or more □

Do you drink coffee? □ Yes □ No □ 3 or more cups
Do you exercise? _____ Regularly □ Occasionally □ Rarely □
Have you used any of the following:
Marijuana □ LSD □ Heroin □ Cocaine □
Speed □ other similar substances □

HERSHMAN
MEDICAL CENTER

RELEASE AUTHORIZATION

I, _____, authorize Dr. Hershman to release my medical information (lab results, x-ray reports, health status, etc.) to the following persons.

1. _____relationship _____
2. _____relationship _____
3. _____relationship _____
4. _____relationship _____

Patient's signature _____ Date _____

Witness _____

11479 S.W. 40th Street, Miami, FL 33165
Tel: 305-221-7235, Fax: 305-220-1847

NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT OF RECEIPT

Dated April 14, 2003

I, _____, acknowledge and agree that I have received a copy of **Hershman Medical Center**'s Notice of Privacy Practices.

_____ _____

Patient Signature Date

_____ _____

Patient Legal Representative (if applicable) Date

_____ _____

Print Name of Legal Representative Date

FOR CLINIC USE ONLY:

Drs. Hershman made the following good faith efforts to obtain the above-reference individual's written acknowledge of receipt of the Notice Privacy Practices:

The patient received a written description of their rights regarding their medical information in an effort to educate them to the new policy and procedures as set forth by HIPAA Privacy Regulation. The Patient's signature on this notice of acknowledgement form indicates the patient has received full disclosure from Hershman Medical Center, PA.

11479 S.W. 40th Street, Miami, FL 33165
Tel: 305-221-7235, Fax: 305-220-1847

HERSHMAN
MEDICAL CENTER

NOTICE OF PRIVACY PRACTICES

Effective April 14, 2003

This notice describes how health information about you or your child (herein after referred to as "you" or "your") may be used and disclosed and how you can access this information. Please review it carefully.

If you have any questions about this notice, please contact our

Privacy Officer at
11479 SW 40th St.,
Miami, FL. 33165
(305) 221-7235

OUR COMMITMENT TO YOUR PRIVACY

We understand that the information about you and your health is very personal and we are committed to protecting the privacy of this information. Each time you visit Drs. Hershman & Hershman we create a record of the care and services you receive. This record is necessary to provide you with high quality care and to ensure we are in compliance with certain legal requirements. The notice applies to all of your health information in our custody.

This notice will describe the ways in whi9ch we may use and disclose your medical information. We reserve the right to change the terms of this notice at any time. Any revisions to this notice will be applicable to all the medical information we already have about you. As well as any of your medical information that we may receive, create or maintain in the future. We will post a copy of our current notice in prominent locations in your practice location. A copy of the current notice in effect will be available from the practice receptionist.

HOW WE MAY USE AND DICLOSE HEALTH INFORMATION ABOUT YOU

The following categories describe different ways that we use your health information within Drs. Hershman & Hershman and disclose your health information to persons and entities outside of Drs. Hershman & Hershman. Each description is of a category of uses or disclosures. We have not listed every use or disclosure within the categories, but all permitted uses and disclosures will fall within one of the following categories.

Treatment: We may use health information about you to provide you with medical treatment and services. We may disclose health information about you to doctors, nurses, technicians, medical students, interns, or other personnel who are involved in taking care of you during your visit with us.

Payment: We may use or disclose health information about you so the treatment and services you receive at Drs. Hershman & Hershman may be billed to and payment collected from you, an insurance company or a third party. This may also include the disclosure of health information to obtain prior authorization for procedures from your insurance plan.

Healthcare Operations: We may use and disclose health information about you for healthcare operations, including quality assurance activities, granting medical staff credentials to physicians, administrative activities, including Drs. Hershman & Hershman financial and business planning and development, customer service activities, including investigation of complaints, your health insurance plan and certain marketing activities, etc. These uses and disclosures are necessary for Drs. Hershman & Hershman to ensure all of our patients receive quality care.

Appointment Reminders: We may use your health information to contact you as a reminder that you have an appointment for treatment or medical care.

Health Related Products or Services: We may notify you of health-related products and services that may be of interest to you.

Family Members and Friends: We may disclose your health information to individuals, such as family members and friends, who are involved in your care of who help pay for your care. We may make such disclosures when: (a) we have your verbal agreement to do so, (b) we make such disclosures and you do not object, or (c) we can infer from the circumstances that you would not object to such disclosures. For example, if family members are in the exam room with you, we will assume that you agree to our disclosure of your information in their presence.

We may also disclose your health information to family members or friends in instances when you are unable to agree or object to such disclosures, provided that we feel it is in your best interests to make such disclosures and the disclosures relate to that family member or friend's involvement in your care. For example, if you present to our clinic with an emergency medical condition we may share information with a family member or friend who calls us to request a prescription refill for you.

SPECIAL SITUATIONS THAT DO NOT REQUIRE YOUR AUTHORIZATION

The following disclosures of your health information are permitted by law without any oral or written permission from you:

Organ and Tissue Donation: If you are an organ donor, we may release health information to organizations that handle organ procedurement or organ, eye or tissue transplantation, or to an organ donation bank as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans: If you are a member of the armed forces, we may release health information about you as required by military command authorities.

Worker's Compensation: We may release health information about you for worker's compensation or similar programs if you have a work related injury. These programs provide benefits for your work-related injuries.

Averting a Serious Threat to Health or Safety: We may use and/or disclose health information about you when necessary to prevent a serious threat to your health and/or safety and/or safety of another person or the public. These disclosures would be made only to someone able to help prevent the threat.

Public Health Activities: We may disclose health information about you for public health activities. These generally include the following:

- To prevent or control disease, injury or disability
- To report births and deaths
- To report child abuse or neglect
- To report reactions to medications, problems with products or other adverse events
- 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.
- To notify the appropriate government authority if we believe a patient has been the victim of abuse (including child abuse), neglect or domestic violence. We will only make this disclosure if you agree or when required as authorized by law.

Health Oversight Activities: We may disclose health information to a health oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections and licensure. These activities are necessary for the government to monitor the healthcare system, government programs and compliance with civil rights law.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a course or administrative order. We may disclose health information about you in response to a subpoena, discovery request or other lawful process by someone else involved in the dispute.

Law Enforcement: We may disclose health information if asked to do so by law enforcement officials for the following reasons:

- In response to a court order, subpoena, warrant, summons or similar process.
- To identify or locate a suspect, fugitive, material witness or missing person.
- About the victim of a crime if, under certain circumstances, we are unable to obtain
- About a death we believe may be the result of a criminal conduct.
- About criminal conduct at our facility
- In emergency circumstances to report a crime, the location of the crime or victims, or the identity description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Home Directors: We may disclose health information to a coroner or medical examiner. This may be necessary to identify a decreased person or determine the cause of death of a person. We may also release health information about patients at our facility to funeral home directions as necessary to carry out of their duties.

National Security and Intelligence Activities: We may disclose health information about you to authorized federal officials for intelligence, counterintelligence and other national security activities authorized by law.

Inmates: If you are an inmate of a correctional institution or under custody of a law enforcement official, we may disclose health information about you to the correctional institution or the law enforcement official. This is necessary for the correctional institution to provide you with healthcare, to protect your health and safety of others, or for the safety and security of the correctional institution.

Legal Requirements: We will disclose health information about you without your permission when required to do so by federal, state or local law.

WITH YOUR SPECIFIC WRITTEN "AUTHORIZATION"

Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission (called "authorization"). If you authorize us to use or disclose health information about your authorization, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provide to you.

YOUR HEALTH INFORMATION RIGHTS

Although your health record is the physical property of Drs. Hershman & Hershman entity that created it, the information belongs to you. You have certain rights with respect to your information as described below. If you wish to exercise your rights, you may complete preprinted forms at registration or you may write directly to the Privacy Officer.

1. **Right to request a restriction on certain uses and disclosures of your information.** You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the health information we disclose about you to someone, such as family member or friend who is involved in your care or in the payment of your care. For example, you could ask that we not disclose information regarding a particular treatment that you received. We are not required to agree with your request. If we do not agree, that agreement must be in writing and signed by you and us.

2. **Right to request confidential communications.** You have the right to request that we communicate with you about medical matters in a certain manner or a certain location. For example, you may request that we limit our communications with you to contact work or home. Your request must be in writing, as described above, and must specify the manner in which or the location at which you wish to be contacted. All reasonable requests will be accommodated.

3. **Right to inspect and/or request a copy of your health record**. You have the right to inspect and/or receive a copy of any medical information maintained about your care. Typically, this will include your medical and billing records but does not include psychotherapy notes.

   In order to inspect and/or receive a copy of your medical information, you must submit your request in writing to your Privacy Officer, and we may charge a reasonable fee for this service based on our cost of complying.

   In very limited circumstances, we may deny your request to inspect and/or receive a copy of your information. However, if you request is denied, in some cases you may request that the denial be reviewed. Such reviews are performed by an independent licensed healthcare professional chosen by the Privacy Officer. We will comply with the outcome of the review.

4. **Right to request an amendment to your health record.** If you believe the information we maintain about you is incorrect or incomplete, you may request that we amend the information. In order to request an amendment, you must submit a written request, as described above, indicating the specific information you wish to be amended and providing the reason supporting the request. Failure to put your request in writing or provide supporting reasoning is likely to result in a denial of your request.

   We may also deny your request if you ask us to amend information that:
   - Is accurate and complete.
   - Is not part of information which you would be permitted to inspect or receive a copy
   - Is not part of the medical information maintained by (Physicians or Practice)
   - Was not created by us, unless the individual organizations that created the information are no longer available to make the amendment

5. **Right to obtain an accounting of disclosures of your health information**. You have the right to request an accounting or disclosures which is a list of certain disclosures of your medical information made by Drs. Hershman & Hershman other than disclosures allowed or required by law or authorized by you. The request for this accounting must be submitted in writing as described above. Your request must include the time period for which you are requesting an accounting, which may not exceed six years and not include dates prior to April 14, 2003. Fees may be imposed as allowed by law.

6. **Right to obtain a copy of Notices of Privacy Practices upon request.** We will post a copy of the current notice in our facility. A copy of the current notice in effect will be available at the reception area of each facility.

COMPLAINTS OR CONCERNS

You may contact the Privacy Officer if you have a question about this privacy notice or your privacy rights. You should also contact the Privacy Officer if you have a complaint or concern that your rights have been violated.

DRS. HERSHMAN & HERSHMAN
11479 SW 40th ST.
MIAMI, FL. 33165

You may also write to the Security of Health and Human Services

Date: _____

Patient Financial Responsibility Disclosure Statement

Your signature below forms a binding agreement between Hershman Medical Center (HMC – the provider of medical services) and yourself, the patient, who is receiving medical services, or for a minor, under 18 years old. You acknowledge that you are financially responsible for the payment(s) of all medical bills incurred on today's visit.

All charges for services rendered are due and payable at the time of service.
MEDICAL INSURANCE: We have contracts with many insurance companies, and we will bill them as a service to you. As the responsible party, you are responsible if your insurance company declines to pay for any reason.

The person signing on behalf of the Patient as the Responsible Party must:

- Inform HMC of the current address and phone number for the patient and the responsible party.
- Present all current insurance card(s).
- Verify that the information is current by signing our data sheet.
- Pay any required co-pay at the time of the visit.

Returned Check Policy
If a payment is made on an account by check, and the check is returned as Non-Sufficient Funds (NSF), Account Closed (AC), or Refer to Maker (RTM), the patient or the Patient's Responsible Party will be responsible for the original check amount in addition to a $35.00 Service Charge. Once notice is received of the returned check, HMC will send out a letter to notify the Responsible Party of the returned check.

Non-Payment on Account
Should collection proceedings or other legal action become necessary to collect an overdue account, the patient or the patient's Responsible Party, understands that HMC has the right to disclose to an outside collection agency all relevant personal and account information necessary to collect payment for services rendered. The patient, or the patient's Responsible Party, understands that they are responsible for all costs of collection including, but not limited to, interest due at 18% APR, all court costs and Attorney fees, and a collection fee will be added to the outstanding balance.

By signing below, you agree to accept full financial responsibility as a patient who is receiving medical services or as the Responsible Party for a minor patient(s). Your signature verifies that you have read the above disclosure statement, understand your responsibilities, and agree to these terms.

Patient Name (Please Print) _____
Patient Signature _____ Date _____
Responsible Party Name (Please Print) _____
Responsible Party Signature _____ Date _____