Parkhill Clinic for Women

Confidential Patient Information

Today's Date:			
Patient Information			
Patient Name: Full Legal Name		**Name you go by:**	
Mailing Address:		**Date of Birth/Age:**	
City, State, Zip:		**Social Security No:**	
Primary Phone:	( )	**Cell Telephone:**	( )
Preferred Method of Communication		**Email Address**	
Employer Information			
Employer Information:		**Employer Telephone:**	( )
Employer Address: Include City, State, Zip			
Insurance Information			
Insurance Information			
Primary Insurance Carrier:		**Policy Holder:**	
Policy Number:		**Group Number:**	
Pharmacy Information			
Preferred Pharmacy Name		**Pharmacy address**	
Guardian/Spouse Information			
Name:		**Social Security No:**	
Employer:			
Emergency Contact (not living with you)			
Contact Name:			
Relationship to Patient:			
Street Address			
City, State, Zip:			
Telephone:			

_____ _____

Date **Patient Name**

Parkhill
The Clinic for Women

Confidential Health History

Today's Date:			
Patient Name:		Date of Birth:	
Full Legal Name:		Age:	
Reason for appointment:	Yearly Check-up ☐	Problem ☐	

What problems or concerns do you have?

Allergies and Medications

Allergies to Medications:	
Other Allergies:	
Current Prescribed Medications: List all with DOSAGE	
Over the Counter Medications and vitamins:	

Medical History

Describe any Serious Illnesses as a child or adult:

Surgeries

Surgery	When and Where	Complications

List Other Hospitalizations:

Age at your first menstrual period:		Date of last period:	
Days between menstrual periods:		Date of last pap smear:	
How long does menstrual period last?		Last Pap smear results?	
Is the amount light, moderate or heavy?		Any History of abnormal pap smears?	
Spotting or bleeding between periods?		Bone Density Scan and Date?	
What are you using for contraception?		Colonoscopy and Date?	
Date of Last Mammogram:		Normal results Abnormal results	

Number of Pregnancies:		Number of Miscarriages or abortions:		Number of Living Children:	

Pregnancies

Date of Birth mm/dd/yy	Place Delivered	Weeks Gestation	Duration of Labor	Type of Delivery	Baby Weight	Maternal Complications	Infant Complications

Health Habits

Do you exercise regularly?	Describe
Do you smoke?	How much per day and for how many years?
Do you drink alcohol?	How much per day or week?
Do you use recreational drugs?	Which drugs and how often?

REVIEW OF SYSTEMS **Patient Name:**

Reason for Today's Visit:

PLEASE CHECK ALL SYMPTOMS YOU ARE EXPERIENCING:

CONSTITUTIONAL

Fatigue	☐	Fever	☐	Chills	☐
Weight Loss	☐	Weight Gain	☐	Night Sweats	☐
Easy Bruising	☐	TB exposure	☐	Loss of appetite	☐
Headaches	☐	Blurred vision	☐		

Additional symptoms:

BREAST

Lumps	☐	Tenderness	☐	Swelling	☐
Redness	☐	Nipple discharge	☐	Abnormal change in breast size	☐

Additional symptoms:

CARDIOVASCULAR

Chest pain	☐	Irregular heartbeats	☐	Rapid heart rate	☐
Syncope	☐	Varicositus	☐	Cyanosis	☐
Lower extremity edema	☐				

Additional symptoms:

GASTROINTESTINAL

Nausea/vomiting	☐	Diarrhea	☐	Blood in stool	☐
Constipaton	☐	Heartburn	☐	Hemorrhoids	☐
Dsyphagia	☐	Abdominal pain	☐		

Additional symptoms:

GENITOURINARY

Urgency/Frequency	☐	Foul odor	☐	Pain with urination	☐
Hematuria	☐	Vaginal dryness	☐	Incontinence	☐
Urinary retention	☐	Decrease libido	☐	Dyspareunia(pain-Intercourse)	☐
Genital sores	☐	Irregular menses	☐	Painful periods	☐
Heavy periods	☐	Vaginal discharge	☐	Amenorrhea	☐
Possible pregnancy	☐	Significant PMS	☐	Vaginal itching	☐
Stress Incontinence	☐				

Additional symptoms:

INTEGUMENT

Rash	☐	Itching	☐		
Hair growth change	☐	New skin lesions	☐		
Acne	☐				

Additional symptoms:

NEUROLOGIC

Muscular weakness	☐	Memory Difficulties	☐	Seizures	☐
Tingling or numbness	☐	Difficulty concentrating	☐	Speech difficulties	☐

Additional symptoms:

ENDOCRINE

Loss of Hair	☐	Cold intolerance	☐		
Hirsutism	☐				
Hot Flashes	☐				

Additional symptoms:

PSYCHIATRIC

Anxiety	☐	Depression	☐	Mood swings	☐
Difficulty sleeping	☐	Suicidal ideations	☐		

Additional symptoms:

REVIEW OF SYSTEMS **Patient Name:**

EYES, EAR, NOSE AND THROAT

Vision Problems	☐	Nosebleeds	☐	Tooth problems	☐
Hearing Problems	☐	Sore throat	☐		
Sinus Trouble	☐	Hoarseness	☐		
Hay fever	☐	Lumps in neck	☐		

Additional symptoms:

RESPIRATORY

Cough	☐	Emphysema	☐	
Coughing blood	☐	Bronchitis	☐	
Wheezing	☐	TB exposure	☐	
Asthma/COPD	☐	Shortness of breath	☐	

Additional symptoms:

PAST Personal Medical (P) AND Family (F) HISTORY (Please list family member)

	P	F		P	F		P	F
Abnormal pap smears	☐	☐	Fibroids	☐	☐	Sudden Death	☐	☐
Vaginal prolapse	☐	☐	PMS	☐	☐	Alzheimer's Disease	☐	☐
Genital Herpes	☐	☐	Fibrocystic changes-breast	☐	☐	High Cholesterol	☐	☐
Infertility	☐	☐	Diabetes (Type 1 or 2)	☐	☐		☐	☐
Uterine prolapse	☐	☐	Bleeding Disorder	☐	☐	Cancer - List type below	☐	☐
Endometriosis	☐	☐	Stroke	☐	☐	Type of cancer:	☐	☐
Rectal/bladder prolapse	☐	☐	Hypothyroid	☐	☐		☐	☐
Ovarian Cancer	☐	☐	Hyperthyroid	☐	☐		☐	☐
Breast Cancer	☐	☐	Blood clot	☐	☐		☐	☐
Pelvic inflammatory disease	☐	☐	TB	☐	☐		☐	☐
Hx of Miscarriage	☐	☐	Depression	☐	☐		☐	☐
Menopausal syndrome	☐	☐	Osteopenia	☐	☐		☐	☐
Anemia	☐	☐	High blood pressure	☐	☐		☐	☐
Carcinoma in situ of cervix	☐	☐	Heart Disease	☐	☐		☐	☐
	☐	☐		☐	☐		☐	☐

Other:

Parkhill Clinic for Women
Notice of Privacy Practices

Your Information. Your Rights. Our Responsibilities.

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

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

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 medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- 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, 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 health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

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). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

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.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

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
- Include your information in a hospital directory

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
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

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.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

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

We can share health information about you for certain situations such as:

- 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 information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

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.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- 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 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.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

- **NOT WITHSTANDING ANY OTHER NOTICE OR INFORMATION CONTAINED HEREIN, BY YOUR BECOME A PATIENT OF PARKHILL, THE CLINIC FOR WOMEN, YOU AGREE THAT YOU HAVE BECOME THE PATIENT OF EACH OF OUR PHYSICIANS ANY ONE OF WHOM MAY BE CALLED UPON TO PROVIDE MEDICAL CARE AND TREATMENT TO YOU. YOU FURTHER AGREE THAT BY YOUR BECOMING A PATIENT OF PARKHI, YOUR PROTECTED HEALTHCARE INFORMATION SHALL BE AVAILABLE TO AND ACCESSIBLE BY ANY AND ALL OF PARKHILL'S PHYSICIANS AS WELL AS NON-PHYSICIAN STAFF MEMBERS WHO ARE OR WHO MAY BECOME INVOLVED IN YOUR CARE AS A PATIENT OF PARKHILL, THE CLINIC FOR WOMEN.**
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For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Mutual Rights

Mutual trust and respect between you as a patient, and our staff is absolutely necessary in order to maintain a healthy and successful doctor-patient relationship. A breakdown of this mutual trust and respect adversely affects every aspect of this relationship. Therefore, it is important that you be aware of our mutual rights and obligations.

As a patient, you have the right to terminate treatment with Parkhill Clinic for Women for any reason. If you do so, we request that payment be made for all unpaid services previously rendered by our staff. We also request that if you choose to terminate treatment, that you do so before any previously scheduled office visit or hospital admission so that other patients may be scheduled and seen during your previously scheduled time. You are not required to so; however, we request that you provide us the reason(s) for your termination so that we may take corrective action in the event you believe that you did not receive appropriate care and treatment or were treated unprofessionally by any Parkhill staff member.

Parkhill Clinic for Women reserves the right to terminate our doctor-patient relationship for good cause, including, but not limited to, your failure to keep regularly scheduled appointments; non-compliance with instructions, recommendations and orders from your physician which we consider vital for your safety and well-being as well as the safety and well-being of your unborn child; abusive language in oral or written communications to any staff member, including receptionists, technicians, nurses and physicians; threats of physical violence made by you or by a member of your family and for the failure to pay the reasonable charges for our services after you have been given options for payment and a reasonable time within which to do so.

Parkhill Clinic for Women will not intimidate, threaten, coerce, discriminate against, or take other retaliatory action against you or any family member for the exercise of any right established, or for the participation in any process provided for by these privacy rules, including the filing of a complaint or acting on the rights granted by Parkhill's privacy rule or any federally defined privacy rule.

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 web site.

Effective September 2013 – rev. Sept 2017

Administrator- Parkhill Clinic for Women Privacy Officer
479-521-4433

Parkhill Clinic for Women
3215 N. North Hills Blvd Ste 3
Fayetteville, Arkansas

Parkhill Clinic for Women
901 SE Plaza, Suite 1
Bentonville, AR

Parkhill

The Clinic for Women

PATIENT CONSENT AND ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I understand that as part of the provision of healthcare services, Parkhill Clinic for Women creates and maintains health records and other information describing among other things, my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care of treatment.

I have been provided with a Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their Notice of Privacy Practices and will provide a revised copy upon request. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations (quality assessment and improvement activities, underwriting, premium rating, conducting or arranging for medical review, legal services, and auditing functions, etc.) and that the organization is not required to agree to the restrictions requested.

By signing this form, I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment and health care operations. I have the right to revoke this consent, in writing, except where disclosures have already made in reliance on my prior consent.

I also consent to allow Parkhill physicians/prescribers to obtain any critical patient drug information about me through their EMR system if needed.

I also consent to Parkhill providing my Summary of Care to another physician or physician office if I should be referred to that physician or transitioned to another setting of care.

This consent is given freely with the understanding that:

*Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or health care operations without my prior written authorization, except as otherwise provided by law.

*A photocopy or fax of this consent is as valid as this original.

*I have the right to request that the use of my Protect Health Information, which is used or disclosed for the purposes of treatment, payment or health care operations, be restricted. I also understand that the Practice and I must: agree to any restriction in writing that I request on the use and disclosure of my Protected Health Information; and agree to terminate any restrictions in writing on the use and disclosure of my Protected Health Information which have been previously agreed upon.

_____ _____

Patient's Printed Name Social Security Number

_____ _____

Patient's Signature Date

Rev. 9/14

Parkhill
The Clinic for Women

Authorization To Release Personal Protected Health Information to an Individual

Patient Full Name: _____

***Patient* Date of Birth:** _____

(Please check one of the following.)

☐ I ***do not authorize*** the release of any medical information to *any individual* except for treatment, payment and health care operations as specified in ***Parkhill Clinic for Women's*** *Notice of Privacy Practices.*

☐ I hereby authorize the release and disclosure of my medical information to the following individuals. My authorization extends to all protected health information for general information purposes. The information that may be discussed includes but is not limited to: statements of charges or payments, records of all visits, records of visits for any and all dates, copies of records or reports provided to hospitals, laboratories, clinics or other physicians, progress notes, discharge summaries, history and physical examination reports, and consultation reports. I understand this authorization does not expire unless otherwise noted below.

(Please list the name of the individuals with whom we may discuss your protected health information.)

Name	Relationship to Patient

This authorization is given freely with the understanding that: 1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law. 2. A photocopy of fax of this authorization is as valid as this original. 3. I may revoke this authorization at any time, except where information has already been released. The revocation must be in writing. A revocation form is available from the receptionist. 4. Parkhill Clinic for Women, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. 5. Treatment, payment, enrollment or eligibility for benefits may not be conditioned upon obtaining this Authorization. 6. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected.

_____ **Patient's Printed Name**

_____ **Date**

_____ **Patient's Signature**

_____ **Expiration Date**

_____ **Social Security Number (For identification purposes only)**

_____ **Patient's Personal Representative**

_____ **Date**

_____ **Patient's Personal Representative's Authority to Act**

_____ **Witness**

Parkhill

The Clinic for Women

No Show/Cancellation Policy

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment you provide more than 24 hours' notice. This will enable another person who is waiting for an appointment to be scheduled in that appointment slot.

We reserve the right to charge patients a fee and/or terminate our relationship with a patient who fails to keep their appointments without notifying our office in advance. Patients who no show three consecutive times may be dismissed from the practice thus they will be denied any future appointments.

Parkhill believes that good physician/patient relationship is based upon understanding and communication. Questions about cancellation and no show fees should be directed to the Business office.

Please sign that you have read, understand and agree to this No Show/Cancellation policy

_____ _____

Patient/Patient Representative Signature Date

_____ _____

Patient Name – PLEASE PRINT Patient - Date of Birth

Parkhill

The Clinic for Women

Contact Authorization

Patient Name: _____

Address:_____City_____St_____Zip_____

DOB:_____ Social Security Number _____

PHONE MESSAGES:

___ **YES**, it is OK to leave a phone message on my answering machine (may include personal health information).

___ **NO**, Please DO NOT leave a phone message on my answering machine

PREFERRED PHONE NUMBER - <u>PLEASE CHOOSE ONE</u>

___ Cell Number: _____

___ Home Number: _____

___ Work Number: _____

APPOINTMENT NOTIFICATIONS: <u>PLEASE CHOOSE ONE</u> (includes referral information to other physicians)

___ Phone

___ Text (Cell Phone #) _____

___ Email (List Address) _____

___ Mail (List Address) _____

LAB RESULTS: <u>PLEASE CHOOSE ONE</u> (includes pap smear results)

___ Prime Patient Portal – ask for details

___ Phone #: _____

___ Mail Address: _____

_____ _____

Patient Signature Date

Parkhill
The Clinic for Women

Authorization To Release Medical Records

Patient Full Name: _____ **Date of Birth:** _____
Patient Street Address: _____
Patient City, State, Zip: _____
Patient Telephone: _____

I hereby authorize the release and disclosure of the following specific medical information. I understand there may be fees, based on volume, associated with the reproduction of the requested medical records. My authorization extends only to those data elements/documents initialed below:

Initial any or all that apply:
_____ Statements of charges or payments
_____ Records of *all* visits
_____ Record of visit for a specific date or dates. Specific dates include or are limited to: _____
_____ Copies of records or reports provided to the above named (i.e., hospital, lab, clinic etc.)
_____ Progress Notes
_____ Discharge Summary
_____ History and Physical Examination
_____ Consultation Reports
_____ ***All of the above***
_____ Other (Must be specific) _____
_____ AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Information
_____ Hepatitis Information

These records are released for the purpose of: _____

Release Records:

___ To ___ From

Parkhill Clinic for Women
PO Box 8850
Fayetteville, AR 72703

Telephone: 479.521.4433
Facsimile: 479.521-0444

___To ___ From ___ Patient will Pickup

Name: _____
Address: _____
City, State, Zip: _____

Telephone: _____
Facsimile: _____

This authorization is given freely with the understanding that: 1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law. 2. A photocopy or fax of this authorization is as valid as this original. 3. I may revoke this authorization at any time, except where information has already been released. This authorization is valid for a one year period from the date it is signed, or sooner if noted below. The revocation must be in writing. A revocation form is available from the receptionist. 4. Parkhill Clinic for Women, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. 5. Treatment, payment, enrollment or eligibility for benefits may not be conditioned upon obtaining this Authorization. 6. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected.

_____ **Patient's Printed Name**

_____ **Date**

_____ **Patient's Signature**

_____ **Expiration Date**
(If other than one year from date above)

_____ **Social Security Number**
(For identification purposes only)

_____ **Patient's Personal Representative**

_____ **Date**

_____ **Patient's Personal Representative's Authority to Act**

_____ **Witness**

Form ARMR 9/7/06

PARKHILL CLINIC FOR WOMEN

PATIENT AUTHORIZATION FOR STUDENT OBSERVATION

Parkhill Clinic for Women participates in clinical education programs with area colleges and universities to give students engaged in a course study related to a medical career, including nursing students, medical students, interns, and residents (students) experience in clinical practice. Your physician has agreed to permit such students to observe and participate in her patient care activities, including, where appropriate, providing medical care to patients under the physician's direct supervision.

By signing below, you agree to permit the students working in our office to observe and participate in your medical care during your appointment today, including, where appropriate, providing direct medical care to you under your physician's direct supervision. You agree that you have been given the opportunity to refuse to give such consent and that you may withdraw your consent at any time during your appointment.

_____ _____

Patient Name Patient Signature

Date:_____ Time:_____

_____

Witness Signature

IF PATIENT IS UNABLE TO CONSENT OR IS A MINOR, COMPLETE THE FOLLOWING:

This patient, whose name is written about, is a minor, _____ years of age or is otherwise unable to consent to and execute this document for the following reason:

_____

I hereby execute this document on the patient's behalf. I have read and fully understand each part of this document. I represent and verify that I am authorized to execute this document on behalf of the patient named above. I understand that I am entitled to receive a signed copy of this document.

_____ _____

Signature of parent of minor patient, Custodial parent, guardian, or legal Representative

Relationship to patient

Date: _____ Time:_____

_____

Witness Signature