Albert Chung, MD., MBA, Inc. / CRSurgeryOC

Consent for Treatment

I hereby consent to and authorized the administration of all treatments that may be considered advisable or necessary in the judgment of the physician.

Patient name printed (or parent, legal guardian, or representative): _____

Relationship (if appropriate) : _____

Signature: _____ Date: _____

801 North Tustin Avenue, Suite 203, Santa Ana, CA 92705
Tel: (714) 988-8690 Fax: (714) 988-2235

Albert Chung, MD., MBA, Inc. / CRSurgeryOC

Notice of Financial Responsibility

1. It is your (the patient, or patient representative's) responsibility to verify if Dr. Albert Chung is a provider in your insurance network. For patients who require a referral or authorization to see the specialist (e.g. HMO and other managed care network patients), it is the patient's (or patient representative's) responsibility to verify if there is a valid referral or authorization for the any or all of the following: office visit, planned surgery, or procedure.

2. It is your (the patient or patient representative's) responsibility to verify insurance coverage, eligibility, deductible, copayment, coinsurance, and other financial responsibility for the services provided by Dr. Albert Chung (including but not limited to: office visit, office procedures, anoscopy, sigmoidoscopy, colonoscopy, surgery and other procedures). You authorize and request that insurance payments the directly made to Albert Chung, MD., MBA, Inc. / CRSurgeryOC.

3. If you are referred to a facility (for example to a laboratory, radiology or imaging center, hospital, surgery center or any other facility), it is your responsibility to verify patient eligibility and financial responsibility and to verify if the facility (e.g. hospital or surgery center) is in the insurance network.

4. If you are referred for a diagnostic test or procedure or treatment (e.g. blood test, x-ray, CT scan, physical therapy, MRI, etc.), it is the your (or patient representative's) responsibility to verify the test procedure or treatment is covered by the insurance and verify the financial responsibility. Referrals to another physician is your (or patient representative's) responsibility to verify if that physician is in the patient's insurance network.

5. This office verifies the status of all deductibles with your insurance company. If you believe the status to be different than the information that we received, you will need to provide adequate documentation to avoid making a payment. This is necessary to avoid non-payment of services from your insurance company.

6. You understand that payment of charges incurred is due at time of service unless other definite arrangements have been made prior to treatment. Due to the high cost of repetitive statement billing, there will be a minimum charge of $50.00 for rebilling of unpaid deductible and/or copayments balances that are not paid in full at the time of service. Accounts that are 90 days old that reflect unpaid deductibles and/or copayments will be forwarded to a collection agency without further notice. You agree to pay all reasonable attorney fees and collection costs in the event of default of payment.

7. If your insurance claim is denied for any reason other than error in submission from this office, you will be responsible for payment of the balance in full.

8. If payment is not received from the insurance company within 35 days of the correct submission date, a charge of $5.00 will be applied for routine resubmission of insurance claims to cover the cost of postage and supplies.

9. This office will bill your insurance company as a courtesy to you. However, we are not responsible for following up with the insurance company to ensure that they provide reimbursement. This is your responsibility. Payments for all services bill the insurance companies do in full within 35 days from the

data service. To avoid finance charges in rebilling cost to you, please follow up with your insurance company and ensure that payment is made within the allotted time.

10. There is a service charge of $25.00 for any missed appointments without a minimum of 24 hours prior notice. Adequate notice enables us to schedule another payment that may need to be seen in your appointment time slot.

11. The cost for reproduction or transfer of patient records is $35.00 to cover the cost of labor and supplies used this fee will need to be paid in full prior to the release of records. You are ultimately responsible for fees charge for copies of your records being provided to insurance companies if they do not provide reimbursement.

12. In order to help you better understand the billing procedure, we want you to be aware that physician charges are separate from lab, pathology, and radiology charges. When receiving bills from the lab, pathology, or radiology group, please be aware that the charges are coming directly from them and not our clinic. Therefore, please direct any questions concerning those bills directly to the billing entity.

13. There is a minimum of $35.00 fee for having any forms filled out by the office.

I have read and understood the above information, and I agree to comply accordingly.

Patient name printed (or parent, legal guardian, or representative): _____

Relationship (if appropriate): _____

Signature: _____ Date: _____

801 North Tustin Avenue, Suite 203, Santa Ana, CA 92705
Tel: (714) 988-8690 Fax: (714) 988-2235

Notice of Privacy Practices

Albert Chung, MD., MBA, Inc. / CRSurgeryOC
801 North Tustin Avenue, Suite 203, Santa Ana, CA 92705
Tel: (714) 988-8690 Fax: (714) 988-2235

Privacy officer: Albert Chung
Email: service@CRSurgeryOC.com

Date: December 1, 2018

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.

We understand the importance of privacy and are committed to maintain the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other healthcare providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights in our legal obligations with respect to your medical information. If you have any questions about this notice, please contact our privacy officer listed above.

A. How this medical practice may use or disclose your health information.

This medical practice collects health information about you and stores it in a computer and computer server provided by the electronic health record. This is your medical record. The medical record the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. Treatment. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other healthcare providers who will provide services which we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured.
2. Payment. We use and disclose medical information about you to obtain payments for the services we provide. For example, we give your health plan the information he requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.
3. Health care operations. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorized services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and

management. We may also share your medical information with our business associates, such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them to protect the confidentiality and security of your medical information. Although Federal law does not protect health information which is disclosed to someone other than another healthcare provider, health plan, healthcare clearinghouse, or one of their business associates, California law prohibits all recipients of healthcare information from further disclosing it except as specifically required or permitted by law. We may also share your information with other healthcare providers, healthcare clearinghouses or health plans that we have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population-based efforts to improve health or reduce healthcare costs, protocol development, case management or care coordination activities, their review of competence, qualifications and performance of healthcare professionals, their training programs, their accreditation, certification or licensing activities, their activities related to contracts of health insurance or health benefits, or their health care fraud and abuse detection and compliance efforts.

4. Appointment reminders. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.
5. Sign in sheet. We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.
6. Notification and communication with family. We may disclose your health information to notify or assistant notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you have instructed us otherwise, in the events of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.
7. Marketing. Provided we do not receive any payment for making these communications, we may contact you to encourage you to purchase or use products or services related to treatment, case management or care coordination, or to direct or recommend other treatments, therapies, healthcare providers or settings of care that may be of interest to you. We may similarly describe products or services provided by this practice and tell you which health plans we participating. We may receive financial compensation to talk with you face-to-face, to provide you with small promotional gifts, or to cover our cost of reminding you to take and refill your medication or otherwise communicate about a drug or biologic that is currently prescribed for you, but only if you either: (1) have a chronic and seriously debilitating or life-threatening condition and the communication is made to educate or advise you about treatment options and otherwise maintain adherence to the prescribed course of treatment, or (2) you are a current health plan enrollee and the communication is limited to the availability of more cost-effective pharmaceuticals. If we make these communications while you have a chronic and seriously debilitating or life-threatening condition, we will provide notice of the following in at least 14 point type: (1) the fact and source of the renumeration; and (2) your right to opt out of future renumerated communications by calling the communicator’s toll-free number. We will not otherwise use or disclose your medical information for marketing purposes or accept any payment for other marketing communications without your prior written authorization. The authorization will disclose whether we receive any financial compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization.

8. Sale of health information. We will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your help information if you authorize us to sell it, and we will stop any future sales of your information to the extension that you revoke that authorization.
9. Required by law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial administrative proceedings, or to law enforcement officials, we will further comply with the requirements set forth below concerning those activities.
10. Public health. We may, and are sometimes required by law to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child, elder or dependent adult abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure. When reporting suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.
11. Health oversight activities. We may, and are sometimes required by law to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by federal and California law.
12. Judicial administrative proceedings. We may, and are sometimes required by law to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery requests or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.
13. Law enforcement. We may, and are sometimes required by law to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspects, fugitive, material witness or missing person, complying with a court order, warrants, grand jury subpoena and other law enforcement purposes.
14. Coroners. We may and are often required by law to disclose your health information to coroners in connection with their investigation of death.
15. Organ or tissue donation. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.
16. Public safety. We may, and are sometimes required by law to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.
17. Proof of immunization. We will disclose proof of immunization to a school where the law requires the school to have such information prior to admitting a student if you have agreed to the disclosure on behalf of yourself or your dependent.
18. Specialized government functions. We may disclose your health information for military or national security purposes or to correctional institutions or law-enforcement officers that have you in their lawful custody.
19. Worker's compensation. We may disclose your health information as necessary to comply with worker's compensation laws. For example, to the extent your care is covered by worker's compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or worker's compensation insurer.

20. Change of ownership. In the event that this medical practice is sold or merged with another organization, your health information and record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.
21. Breach notification. In the case of the breach or unsecured protective health information, we will notify you as required by law. If you have provided us with a current email address, we may use email to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate.
22. Psychotherapy notes. We will not use or disclose your psychotherapy notes without your prior written authorization except for the following: (1) your treatment, (2) for training our staff, students and other trainees, (3) to defend ourselves if you sue us or bring some other legal proceeding, (4) if the law requires us to disclose information to you or the Secretary of HHS or for some other reason, (5) in response to health oversight activities concerning your psychotherapist, (6) to avert a serious threat to health or safety, or (7) to the coroner or medical examiner after you die. To the extent you revoke an authorization to use or disclose your psychotherapy notes, we will stop using or disclosing these notes.
23. Research. We may disclose your health information to researchers conducting research with respect to which your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.
24. Fundraising. We will not use or disclose your information (including your demographic information, the dates that you have received treatment, the department of service, your treating physician, outcome information and health insurance status and other information) for any fundraising activities, without your prior written authorization.

B. When does practice may not use or disclose your health information.

Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your health information rights.

1. Right to request special privacy protections. You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning healthcare items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.
2. Right to request confidential communications. You have the right to request that you receive your health information a specific way or at a specific location. For example, you may ask that we send information to a particular email account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.
3. Right to inspect and copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want to copy, your preferred form and format. We will provide you copies in your requested form and formatted if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can’t agree and we maintain the record in electronic format, your choice of a

readable electronic or hard copy format. We will also send a copy to another person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary, as allowed by federal and California law. We may deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision.

4. Right to amend or supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and we'll provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. You also have the right to request that we add to your record a statement up to 250 words concerning anything in the record do you believed to be incomplete or incorrect. All information related to any request to amend or supplement will be maintained in disclosed in conjunction with any subsequent disclosure of the disputed information.
5. Right to an accounting of disclosures. You have the right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuance to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incidence to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.
6. You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by email. You may request a copy of our Notice of Privacy Practices from our receptionist or as part of your patient portal as part of your electronic health record.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more these rights, contact our privacy officer listed at the top of this Notice of Privacy Practices.

D. Changes to this notice of privacy practices

We reserve the right to amend our privacy practices in the terms of this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with this Notice. After an amendment is made, the revised Notice of Privacy Practices will apply to all protected health information that we maintain, regardless of when it was created or received.

E. Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our privacy officer List the top of this Notice of Privacy Practices. All complaints to be made in writing.

Albert Chung, MD., MBA, Inc. / CRSurgeryOC

HIPAA Compliance Patient Consent and Notice of Privacy Practices

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains and describes your rights under the law. You ascertain that by your signature you have reviewed our notice before signing this consent. The terms of the notice may change, and if so, you will be notified at your next visit to update your signature and date.

You have the right to restrict how your protected health information is use and disclose for treatment, payment, or healthcare operations. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations. By signing this form, you consent to our use and disclosure of your protected health care information.

By signing this form, you understand that:

1. Protected health information may be disclosed for use for treatment, payment, or healthcare operations.
2. The practice reserves the right to change the privacy policy as allowed by law and you may obtain any revised notices at the practice/clinic.
3. You understand that you have the right to request a restriction of how my protected health information is used. However, I also understand that the practice/clinic is not required to agree to the request. If the practice/clinic degrees tonight requested restriction, and they must follow the restrictions.
4. You also understand that you may revoke this consent at any time, by making a request in writing, except for the information already used or disclosed.

Patient name printed (or parent, legal guardian, or representative): _____

Relationship (if appropriate): _____

Signature: _____ Date: _____

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Albert Chung, MD., MBA, Inc. / CRSurgeryOC

Assignment of Benefits and Release of Information

1. I request that payment of authorized insurance benefits (including benefits from Medicare, Medicaid, Medicare and other insurances are health plans or health networks) being made on my behalf to "Albert Chung, MD., MBA, Inc." for any medical services furnished to me by this provider and its representatives. I understand that I am financially responsible for all charges not paid or not covered by my insurance or health plan). I authorize the release of my medical or personal or insurance information as necessary to determine my insurance benefits and other benefits able to this provider.

2. Medicare authorization: I request that payment of authorized Medicare benefits, and if applicable, Medigap benefits, be made on my behalf to "Albert Chung, MD., MBA, Inc." for any services furnished to me by this provider. To the extent permitted by law, I authorize any holder of medical or other information concerning myself to be released to the center of Medicare and Medicaid services, Medigap insurer, and their agents the information needed to determine the benefits for related services.

3. I authorize "Albert Chung, MD., MBA, Inc." to send a consultation reports, clinic notes, and personal or insurance or other information to the referring physician or primary care physician or other physicians and institutions involved in my care that may be required for purposes of registration, billing, medical, or other related purposes.

4. If my address, phone number, contact information, or medical insurance changes, I will notify the medical office of "Albert Chung, MD., MBA, Inc." as soon as possible.

Patient name printed (or parent, legal guardian, or representative): _____

Relationship (if appropriate) : _____

Signature: _____ Date: _____

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Albert Chung, MD., MBA, Inc. / CRSurgeryOC

Physician – Patient Arbitration Agreement

Article 1: **Agreement to arbitrate**

It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such disputes decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All claims must be arbitrated**

It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence given rise to any claim. In the case of any pregnant mother, the term "patient" herein shell mean both the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against the physician, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

Article 3: **Procedures and applicable law**

A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written consent to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not in limited to, Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05; however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: **General provisions**

All claims based on the same incident, transaction or related circumstances shall be arbitrated in one proceeding. Hey claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation**

This agreement may be revoked by written notice delivered to this physician within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: **Retroactive effect**

If patient intends this agreement to cover services rendered before the date is signed (including, but not limited to, emergency treatment) patient should initial below:

Effective as of the date of first medical services: _____

Patient's or patient representative's initials

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

Patient name printed (or parent, legal guardian, or representative): _____

Relationship (if appropriate): _____

Signature: _____ Date: _____

Physician's signature: _____

Print Name of Physician: _____