Patient Information Form

Last Name: _____ First Name: _____ Middle Initial:_____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____Date of Birth: _____

Social Sec#: _____ Marital Status: _____ Email Address:_____

Preferred method of contact (circle one): Home Cell Work

Patient's Employer: _____Occupation: _____

Employer Address: _____

City: _____ State: _____ Zip Code: _____ Phone # _____

Primary Care Physician: _____ Phone# _____

Referring Physician: _____ Phone# _____

For treatment purposes your records will be sent to the physicians stated above unless you inform us otherwise.

_____

If you were not referred, how did you hear about us? ☐ Search Engine/Website ☐ Family/Friend ☐ Other

***Please provide us with your pharmacy information to expedite prescription pick up*.**

Pharmacy Name: _____Phone#_____

PHONE NUMBER OR STREET INTERSECTION REQUIRED

Guarantor Information: (Please list person responsible for bill-use full legal name)

Relationship of Guarantor to Patient: Self ____ Parent(**if under 18 only**)___ Guardian/Power of Attorney____

Last Name: _____ First name: _____ MI: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Date of Birth: _____ SS Number: _____

PLEASE GIVE ANY INSURANCE CARDS AND DRIVERS LICENSE OR OTHER FORM OF ID TO FRONT DESK

Primary Insurance Company: _____

Ins Phone# _____ Policy Holders Name: _____

Policy Holders Date of Birth: _____ Policy Holder SS# _____

Secondary Insurance Company: _____

Ins Phone # _____Policy Holders Name: _____

Policy Holders Date of Birth: _____ Policy Holders SS# _____

Relationship to Pt: _____ Policy Holders Employer: _____

HIGHLANDER SURGICAL ASSOCIATES

CONSENT FOR TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

*The consent you are about to read was written by the Texas Medical Association and require that all physicians have patient consent for general treatment. ***

"I, knowing that I am suffering from a condition requiring, diagnostic evaluation, medical or surgical treatment, or other form of necessary treatment, do hereby voluntarily consent to such procedures and care during my episode of care or other services under the general and specific instructions of the Physician(s), or their designee(s) as is necessary in their judgment. I also acknowledge that the practice of medicine is not an exact science and no guarantees have been made to me as to the result of treatments or examinations by Jason Harrison, MD, PA, Texas Laparoscopic Bariatrics, PA dba. Highlander Surgical Associates (collectively referred to herein as "HSA"). I further understand that all options will be discussed prior to the administration of such examinations and / or treatment."---Texas Medical Association.

I hereby consent to the use and disclosure of my protected health information necessary for my medical care to other providers assisting or consulting in my medical care and to any parties necessary to process medical claims and participation in workers compensation programs or applications for financial benefits or to conduct the health care operations of HSA. I understand that diagnosis or treatment of me by a physician or designee of this practice may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. HSA is not required to agree to the restrictions that I may request. However, if HSA agrees to a restriction that I request, the restriction is binding on HSA and its physician(s) and staff. I have the right to revoke this consent, in writing, at any time, except to the extent that HSA has taken action in reliance on this consent.

My "protected health information" (PHI) means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This PHI relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review HSA's Notice of Privacy Practices prior to signing this document. HSA's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of HSA. This Notice of Privacy Practices also describes my rights and HSA's duties with respect to my protected health information.

HSA reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

TREATMENT OF MINORS (persons 17 years of age and under): Pursuant to Texas law, Consent for Treatment of Minors must be completed.

Furthermore, I have read, understand, and agree to the statements that appear herein.

PRINTED NAME: _____ **RELATIONSHIP TO PATIENT:** _____

SIGNATURE: _____ **DATE:** _____

WITNESSES NAME: _____ **WITNESSES SIGNATURE:** _____ **DATE:** _____

HIGHLANDER SURGICAL ASSOCIATES

FINANCIAL POLICY

Please be assured that everyone in this practice is dedicated to providing medical care of the highest quality possible to all of our patients, in an atmosphere of caring, trust and mutual respect.

We thank you in advance for taking time to review this policy. Your complete understanding of your financial responsibilities is essential; it takes a team that includes patient participation, to succeed with insurance processing and reimbursement. Failure by the insurance company to pay, results in the balance being transferred to the patient for payment.

Our practice policy requires that prior to any services being rendered; all patients must sign the practice financial policy.

We ask that you please present to the office with a form of payment (cash, check or credit card) to meet your obligations to your insurance provider and to your healthcare provider.

Please feel free to discuss any concerns or questions you may have with anyone of our billing staff or our practice manager. We would welcome the opportunity to assist you in your understanding the complexities of health insurance today.

Things to bring with you to your visit:

- Health Insurance Card
- Drivers License or other form of government issued photo ID.
- Method of payment – for your convenience we accept checks, credit cards, debit cards and cash.
    - Please note a thirty dollar ($30.00) processing fee will be applied to any non-sufficient funds.
    - NSF may be referred to the Worthless Check Unit of the Tarrant County Office of the District Attorney, pursuant to Texas Penal Code Sec. 31.06

Assignment of Benefits:

- Jason Harrison, MD, PA, Texas Laparoscopic Bariatrics, PA dba. Highlander Surgical Associates (collectively referred to herein as "HSA") will bill contracted and non-contracted insurance plans as a courtesy to our patients provided if the patient has provided the required insurance information in a timely manner and has signed a current financial policy and Assignment of Benefits form.

Co-pay, co-insurance and deductibles:

- Payment is due at the time services are rendered. This includes in or out of network coverage.
- Co-pay: We are obligated to collect the co-pay at the time of your visit. We are required to do so by your insurance plan. The co-payment amount is determined by your individual insurance policy.
- Deductible: Some insurance plans require that patients pay a predetermined dollar amount prior to services being covered. The amount of money you must pay each year to cover your medical expenses before your health insurance policy starts paying.
- Co-insurance: In addition to the deductible, health insurance plans may have a coinsurance. This is the amount you are required to pay for medical care in a fee-for-service plan after you have met your deductible. Coinsurance rate is usually expressed as a percentage. For example; if the insurance company pays 80 percent of the claim, you are responsible for 20 percent. This portion is due at time of service.
- At no time will co-pay, coinsurance or deductibles be waived.
- Minor Patients: For all services rendered to minor patients, we will look to the accompanying adult or custodial parent or guardian, for payment.
- Ultimately it is your responsibility to call your insurance company to determine what your schedule of benefits allows, if a deductible applies and your potential financial responsibility.

Self "cash" Pay/Fee for Service

- We offer a reasonable discount for our cash pay/fee for service patients who have no health insurance coverage in any form. We are required to provide you with our office policy on this policy, please feel free to ask our front desk if you would like a copy.
- Prior to your visit, you will be provided the visit cost and will be required to pay in full at time of check in on the day of your appointment.
- Prior to any surgery, you will be provided an estimate of the surgery cost and will be required to pay in full prior to the surgery date.
- You will be asked to sign a waiver stating that you have no health insurance coverage and will not be filing with any health insurance carrier.

Collections- Referral for Outside collections

- In the event that a balance becomes past due, the account will be considered delinquent.
- Delinquent accounts may be subject to further collection action, including placement with a collection agency. Accounts that are placed with a collection agency now become the responsibility of the collection agency, Credit Systems International, Inc. In addition, all accounts placed with Credit Systems International, Inc will also be forwarded to three major credit bureaus in which will affect your credit report. The patient is responsible for the balance and any related fees.
- If you account has been forwarded to the collection agency, please contact the agency at: *Credit Systems International, Inc. 1227 Country Club Lane, Fort Worth, Texas 76112. Phone: 817/496-6500*
- Prior to providing additional services to you, payment in full of total outstanding balances will be required.

FMLA and other Disability Paperwork

- Special forms are sometimes necessary to provide documentation of medical conditions. Completing forms is time consuming and falls outside of the contractual relationship between you and your insurance company.
- We are happy to complete the form(s) for you. Each form must be accompanied with a filing fee of $25.00 prior to completion. Please allow 15 business days for completion.

Charges for copies of medical records- With Proper signed consent.

- You may request your medical records to be sent to another physician. There is no charge.
- You will be charged for copies of medical records as per Texas Medical Association guidelines, if medical records are released to the patient. This is a pre-pay of twenty five dollars ($25) for the first 20 pages and fifty cents ($0.50) per page thereafter. These charges cover the administrative costs of copying and mailing such records.
- Please allow 15 business days for processing from the time of consent submission.

Phone Appointments

- If you need to discuss a healthcare issue or abnormal test results, you will be asked to schedule an appointment to see your provider; they are longer able to do this by phone.

Professional Courtesy

- Professional courtesy will not be offered in any form to our colleagues in the health related fields.

Refunds:

- Refunds are issued to the appropriate party. Patient refunds will not be processed until all active or past due charges are paid in full. Refunds less than $10.01 will not be issued unless requested.

My signature below attest that I have read, understand and acknowledge the above information and have been given the opportunity to ask questions and have had any questions answered.

Patient Signature: _____ Date: _____

Witness Name :_____ Witness Signature: _____ Date: _____

HIGHLANDER SURGICAL ASSOCIATES

LEGAL IRREVOCABLE ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND SUMMARY PLAN DOCUMENTS

Patient Name: _____ Patient SS#: XXX-XX-_____ Date:_____

In considering the amount of expenses to be incurred, I _____, the undersigned, have insurance and/or employee health care benefits coverage with _____ (insurance company information) and hereby irrevocably assign and convey directly to Jason Harrison, MD, PA/Texas Laparoscopic Bariatrics, PA dba. Highlander Surgical Associates (hereafter "provider(s)") all right, title and interest in all medical benefits payable and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such provider(s) /practice. Said irrevocable assignment and transfer shall be for the purpose of granting the provider(s) and practice an independent right of recovery against such responsible parties, but shall not be construed to be an obligation of the provider(s) and practice to pursue any such right to recovery. I hereby authorize all responsible parties to pay directly to the provider(s) and practice all benefits and amounts due for services rendered.

I understand that if the provider(s) and practice is not paid in full by proceeds for any benefits, then this assignment does not release my obligation and liability to the provider(s) and practice for payment and all services and items provided to me or by my insurance company or employee health benefit plan, then I agree to pay provider(s) and practice for all charges in excess of the benefits paid. All payments will be made to provider(s) and practice at: 301 Highlander Blvd Ste 101 Arlington, Texas 76018.

I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the provider(s) to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such provider(s) and practice any and all summary plan documents, insurance policy and/or settlement information upon written request from such provider(s) and practice in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named provider(s) to the full extent permissible under the law and under any applicable insurance policies and/or employee health care plan any claim, chosen action, or the right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named provider(s) and practice and to the extent permissible under law to claim such benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such provider(s) and practice in any attempts by such provider(s) and practice to pursue such claim, chosen action or right against any insurers and/or employee health care plan, including, if necessary, bring suit with such provider(s) and practice against any insurers and/or employee health care plan in my name but at such provider(s) and practice's expense.

This lifetime assignment of benefits will remain in effect until revoked by me in writing. A photocopy of this assignment of benefits is to be considered as valid as the original.

The terms and consequences of these irrevocable assignments and financial responsibilities have been fully explained to me to my understanding and I have signed this document freely and without inducement other than the rendition of services by the provider(s).

_____	_____	_____
NAME of Insured / Responsible Party	**Signature of Insured / Responsible Party**	**Date**
_____	_____	_____
NAME of Patient or Guardian	**Signature of Patient or Guardian**	**Signature of WITNESS**

HIGHLANDER SURGICAL ASSOCIATES

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.

SUMMARY OF NOTICE OF PRIVACY PRACTICES

If you have any questions about this Notice please contact: our Privacy Officer.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or verbally, are kept confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, Highlander Surgical Associates prepared this summary explanation of how we are required to, and how this practice will maintain the privacy of your health information and how we may disclose your health information. A detailed explanation is available upon request from any of our office staff.

Highlander Surgical Associates may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

I. Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would be referring you to another physician for a second opinion.
II. Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be submitting a claim, on your behalf, for your visit to your insurance company for payment to our office.
III. Health Care Operations include the business aspects of running our practice, such as conducting quality assessment and improvement activity, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide you appointment reminders or information about treatment alternatives or other health-related benefits and services our practice offers that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization inwriting and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to our Privacy Officer, Highlander Surgical Associates, 301 Highlander Blvd Ste 101 Arlington, Texas 76018:

I. The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in wrtiting to remove it.
II. Right to request restriction - Individuals will have the right to request that a covered entity restrict the disclosure of their protected health information of the individual and the covered entity must comply with the requested restriction except if the disclosure is to a health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment).
III. The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
IV. The right to inspect and copy your protected health information.
V. The right to ammend your protected health information.
VI. The right to receive an accounting of disclosures of protected health information and electronic versions of protected health information.
VII. The right to obtain a paper copy of this summary version, or a detailed version of the notice from our office upon request.
VIII. Right to Provide an Authorization for Other Uses and Disclosures.
IX. Right to File a Complaint.

We are rquired by law to maintain the privacy of your protected health information and to provide you with the notice of our legal obligations, duties and privacy practices with respect to your protected health information.

This notice is effective as of June 13, 2011 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated.You have the right to file a formal, written complaint with our Privacy Officer or with the Department of Health & HumanServices, Office of Civil Rights, about violations of the provisions of this notice or the associated policies and procedures of this office. We will not retaliate against you for filing a complaint.

For more information or to file a complaint with our Privacy Officer:Tel: 817/419-9200 during regular business hours or in writing at:***Privacy Officer, Highlander Surgical Associates, 301 Highlander Blvd Ste 101 Arlington, Texas 76018.***

For complaints involving covered entities located in Arkansas, Louisiana, New Mexico, Oklahoma, or Texas:
Region VI: Office for Civil Rights
US Department of Health and Human Services
1301 Young Street, Suite 1169
Dallas, TX 75202
Voice Phone (214) 767-4056. FAX (214) 767-0432. TDD (214) 767-8940

HIGHLANDER SURGICAL ASSOCIATES

NOTICE OF PRIVACY PRACTICES:

Acknowledgement of Receipt

By signing this form, you acknowledge receipt of the *Notice of Privacy Practices of Highlander Surgical Associates.* Our *Notice of Privacy Practices* provides information about how we may use and disclose your protected health information and your rights related to the Use and Disclosure of your protected health information. We encourage you to read it in full. The most current version was updated September 23, 2013.

Our *Notice of Privacy Practices* is subject to change. If we change our notice, you may obtain a copy of the revised notice by: *Requesting a copy from our office at Highlander Surgical Associates, 301 Highlander Blvd Ste 101 Arlington, Texas 76018, or calling 817/419-9200.*

If you have any questions about our *Notice of Privacy Practices,* please contact:

Privacy Officer, Highlander Surgical Associates, 301 Highlander Blvd Ste 101, Arlington, Texas 76018,

or calling 817/419-9200

I acknowledge receipt of the *Notice of Privacy Practices of Jason Harrison, MD, PA, Texas Laparoscopic Bariatrics, PA dba. Highlander Surgical Associates.*

Name: _____ Relation to Patient: _____

Signature: _____ Date: _____

Witness Name: _____ Date: _____

Witness Signature: _____

INABILITY TO OBTAIN ACKNOWLEDGEMENT

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgement was not obtained:

☐ Notice of Privacy Practices Given - Patient Declined to Sign

☐ Notice of Privacy Practices Given - Patient unable to sign:

- ☐ Unconscious
- ☐ Communication / Language Barrier
- ☐ Other reason patient / legal representative unable to sign: _____

Name of Privacy Officer: _____

Signature of Privacy Officer: _____ Date: _____

Acknowledgment of Additional Information

Sharing Information:

I hereby give Jason Harrison, MD, PA, Texas Laparoscopic Bariatrics, PA dba. Highlander Surgical Associates (collectively referred to herein as "HSA") office permission to disclose and discuss any medical/billing information, appointments/scheduling to/with the following family member(s), other relative(s) and/or close friend(s):

1. _____ Relationship: _____ DOB _____

2. _____ Relationship: _____ DOB _____

____ I do not wish to give permission for any family members, relatives or close friends to have any access to any information regarding my medical condition or treatment.

How to be contacted:

Please print the telephone number where you want to receive calls about appointments, lab and test results, billing and insurance inquiries, or other health care information. _____

May confidential messages (appointment reminders, lab and test results, billing and insurance inquiries) be left on the answering machine/voicemail at the number given above? **YES** **NO** **please circle one**

Who may we contact in case of emergency? _____ Phone number _____

Updates of Information

If any changes in address, phone number or insurance occur, it is the responsibility of the responsible party to inform HSA of this change.

Work Related Injury

Please indicate if you believe this injury/illness is work related.

NO this is not a work related injury/illness _____ (Signature Required)

YES this IS a work related injury/illness _____ (Signature Required)

Our office **does not** accept or file Texas Workers Compensation claims. If you believe your injury is work related, please see someone at the front desk so your situation can be addressed.

Patient Signature

By signing below I am verifying that I have read and understand each of the six sections on this page. I also agree that the names listed in section 1 were assigned by me.

_____ _____ _____

(Patient/Legal Representative Signature) (Legal Representatives Relationship to Patient) (Date)

_____ _____ _____

(Patient's Printed Name) (Witness Signature) (Date)

Social History

EXERCISE: Do you currently exercise? Never ☐ Daily ☐ Weekly ☐ Type: _____

ALCOHOL:

Do you drink alcohol: Never ☐ Rarely ☐ Regularly ☐

How many standard glasses do you drink per day? _____

How many days do you drink per week? _____ Beer ☐ Wine ☐ Spirits ☐

SMOKING: cigarettes ☐ pipe ☐ cigars ☐

Do you smoke? ☐Yes ☐ No ☐Never If yes: how many per day?_____

Have you smoked in the past? ☐Yes ☐ No If so, how many per day? _____

For how many years _____ When did you stop smoking? _____

Allergies: Drug and Food

IF NO ALLERGIES, PLEASE WRITE NONE

Drug/Food/Dressings	Reaction

Are you allergic to LATEX? YES NO Reaction: _____

Current Medications

Include all Herbal Medication, Vitamins and Blood Thinners:

Name	Dose	Frequency	Reason

If you wish, a copy of your medications can be scanned into your chart.

Please circle 'Y' for YES to the following symptoms you are currently experiencing and 'N' for NO to the symptoms you are not feeling today or within the past week.

GENERAL:

Y N Fever

Y N Chills

Y N Weight Loss

Y N Weight Gain

EYES/EARS/NOSE/THROAT

Y N glasses or contacts

Y N discoloration of eyes

Y N thyroid mass

Y N hearing aids

Y N dentures

Y N nasal congestion/discharge

BREASTS:

Y N lumps

Y N tenderness

Y N nipple discharge

Y N mammogram

Year_____

HEART:

Y N chest pain

Y N irregular heart beats

Y N high blood pressure

Y N heart disease

Y N pacemaker/surgery

Cardiologist: _____

RESPIRATORY:

Y N cough

Y N sleep apnea

Y N asthma

Y N COPD

Y N emphysema

GASTROINTESTINAL:

Y N abdominal pain

Y N heart burn/GERD

Y N bloating

Y N nausea

Y N vomiting

Y N difficulty swallowing

Y N diarrhea

Y N constipation

Y N blood in stools

Y N hemorrhoids

Y N rectal pain/pressure

Y N ulcers

Y N last colonoscopy _____

Y N upper scope (EGD) _____

Performing Physician: _____

Y N Barrett's esophagus

Y N Crohn's Disease

Y N Ulcerative Colitis

GENITOURINARY

Y N kidney problems

Y N poor bladder control

Y N blood in urine

Y N scrotal mass

Y N scrotal pain

Y N pregnancy

Y N PAP YR _____

Y N Prostate Exam Yr_____

SKIN:

Y N rash

Y N itching

Y N new skin lesion

MUSCULOSKELETAL

Y N joint pain

Y N back pain

Y N arthritis

HEMATOLOGY:

Y N blood thinning meds

Y N easy bleeding

Y N easy bruising

Y N hepatitis

Y N AIDS/HIV

NEUROLOGIC:

Y N tingling/numbness

Y N muscular weakness

Y N seizures

ENDOCRINE:

Y N diabetes

Y N thyroid disorder

Y N high cholesterol

PHYCHOLOGICAL:

Y N depression

Y N anxiety

ALLERGY:

Y N sinus allergy

Y N skin allergy

Cancer_____

Please list any other medical conditions we have not included:_____

_____

Family Medical History

List any known illnesses or conditions.

Example:High blood pressure, High cholesterol, Heart disease, Diabetes, Stroke, Asthma, Any type of cancer

Please list any other condition(s) not listed.

Mother: _____ ___ No Illnesses

Father: _____ ___No illnesses

Siblings: _____ ___No illnesses

Maternal GM: _____ ___No illnesses

Maternal GF: _____ ___No illnesses

Paternal GM: _____ ___No illnesses

Paternal GF: _____ ___No illnesses

Hospitalizations and Surgical History

Date	Surgery/Illness	Reason	Length of Stay	Complications

Have you ever had any problems with anesthesia? **Yes** **No**

The information on the forms I have completed is accurate and complete to the best of my knowledge. I understand that withholding any information regarding my health may cause harm to possible treatments.

_____ _____ _____

(Patient/Legal Representative Signature) (Legal Representatives Relationship to Patient) (Date)

_____

(Patient's Printed Name)