2023/2024 School Year
REGISTRATION PACKET INSTRUCTIONS

Parents/Guardians of students receiving School-Based Services must complete
ALL HIGHLIGHTED SECTIONS
on every page of the attached packet.

Please note the following:

Page 1 ∗Both Parents/Legal Guardians Information must be recorded on form and documentation submitted if a parent's legal rights have been terminated.

Page 3 ∗Initial as indicated **3** times
∗Sign and date

Page 4 ∗Complete Applicable Insurance Information Section
∗Include copy of your card if possible
∗If the student has no insurance, provide your contact details and we will contact you to assist with applying for our Sliding Fee Scale Discount Program.

Page 5 ∗Sign and date

Page 6 ∗Initial as indicated **1** time
∗Sign and date

Page 8 ∗Sign and date

Page 10 *Only Complete if student is receiving **School-Based Medical Services***
∗Initial as indicated **2** times
∗Sign and date

Page 11 *Only Complete if student is receiving **School-Based Dental Services***
∗Initial as indicated **2** times
∗Sign and date

Upon completion, if the student is receiving:

Medical Services, submit Pages 1-10 completed with **6** areas Initialed and **5** Signatures

Dental Services, submit Pages 1-9 & 11 completed with **6** areas Initialed and **5** Signatures

Medical & Dental Services, submit Pages 1-11 completed with **8** areas Initialed and **6** Signatures

PATIENT REGISTRATION FORM

(Please Print)

Grade: ______________

Teacher: ______________

School: ______________

PATIENT DEMOGRAPHIC INFORMATION

Patient's Legal Name (First, Middle Initial, Last):		Social Security Number:	Birth Date: / /
Preferred First Name:	Maiden Name:		Gender at Birth: ☐ Male ☐ Female
Physical Street Address:	City:	State:	Zip Code:
Mailing Address: ☐ Same as Above		Martial Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed	
Email Address: ☐@gmail.com ☐@hotmail.com ☐@yahoo.com ☐@live.com	Primary Phone Number where messages can be left: ( ) ☐ Home Phone ☐ Cell Phone ☐ Other	Secondary Phone Number where messages can be left: ( ) ☐ Home Phone ☐ Cell Phone ☐ Other	
Preferred Pharmacy:	Preferred Pharmacy Street & City:		
Does the patient have any problems with: ☐ Vision ☐ Hearing ☐ Reading ☐ Speaking Explain for any boxes checked:			

PARENT/LEGAL GUARDIAN INFORMATION

Person(s) listed must be both legal parent(s) and/or legal guardian(s).

*Legal documentation is required if person(s) listed are not the custodial parent(s) or if a parent's legal rights have been terminated.

Name:		Phone Number: ( )	Birth Date: / /
Relationship Type: ☐ Mother ☐ Father ☐ Legal Guardian* *Attach legal documentation	Address: ☐ Same as Child		
Name:		Phone Number: ( )	Birth Date: / /
Relationship Type: ☐ Mother ☐ Father ☐ Legal Guardian* *Attach legal documentation	Address: ☐ Same as Child		

PERSON(S) WHO MAY BE NOTIFIED IN CASES OF EMERGENCY OTHER THAN PARENT/LEGAL GUARDIAN

This does not give the individual(s) listed, authority to accompany minor to appointment or access medical records.

Name:	Phone Number:	Relationship to Patient:
Name:	Phone Number:	Relationship to Patient:
Name:	Phone Number:	Relationship to Patient:

Katy Trail Community Health

All questions must be answered

Katy Trail Community Health (KTCH) is required to ask the following information from all patients served to help us obtain Federal funding to support our community.

RACE:

Please check all that apply

- ☐ White
- ☐ Black/African American
- ☐ American Indian/Alaskan Native
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian
- ☐ Native Hawaiian
- ☐ Other Pacific Islander
- ☐ Guamanian or Chamorro
- ☐ Samoan
- ☐ Choose not to disclose

ETHNICITY:

- ☐ Latino/a or Hispanic
- ☐ Not Hispanic, Latino/a or Spanish Origin
- ☐ Another Hispanic Latino/a or Spanish Origin
- ☐ Mexican, Mexican American, Chicano/a
- ☐ Puerto Rican
- ☐ Cuban
- ☐ Choose not to disclose

PRIMARY LANGUAGE:

- ☐ English
- ☐ Spanish
- ☐ Russian
- ☐ Ukrainian
- ☐ Other: ____________________

GENDER IDENTITY:

- ☐ Male
- ☐ Female
- ☐ Transgender Male (Female-to-Male)
- ☐ Transgender Female (Male-to-Female)
- ☐ Gender Neutral
- ☐ Choose not to disclose

SEX BY ORIENTATION:

- ☐ Straight or heterosexual
- ☐ Lesbian, gay or homosexual
- ☐ Bisexual
- ☐ Something else
- ☐ Don't know
- ☐ Choose not to disclose

HIGHEST LEVEL OF EDUCATION:

- ☐ Not yet in school
- ☐ Pre-School/Kindergarten
- ☐ Grade School
- ☐ Middle School
- ☐ High School (Currently)
- ☐ High School Grad/GED
- ☐ Did Not Complete High School
- ☐ Technical/Trade School
- ☐ Some College
- ☐ College Graduate

HOUSING:

- ☐ Own
- ☐ Rent
- ☐ Public Housing (Income-Based)
- ☐ Homeless
  - Homeless Status:
    - ☐ Doubling Up (staying with others)
    - ☐ Street
    - ☐ Shelter
    - ☐ Transitional Housing

ARE YOU A VETERAN?

- ☐ Yes
- ☐ No

EMPLOYMENT STATUS:

- ☐ Full Time
- ☐ Part Time
- ☐ Seasonal
- ☐ N/A

INCOME STATUS:

Number of Persons in Household: ____________________

Estimated Annual Household Income:

- ☐ $10,000 or below
- ☐ $10,001-$20,000
- ☐ $20,001-$30,000
- ☐ $30,001-$40,000
- ☐ $40,001-$50,000
- ☐ $50,001-$60,000
- ☐ $60,001-$70,000
- ☐ $70,001-$80,000
- ☐ $80,001-$90,000
- ☐ $90,001-$100,000
- ☐ over $100,000

Katy Trail Community Health

CONSENTS & AGREEMENTS

Consent to Treat
By signing below I am giving consent for myself/my ward to receive any treatment as deemed necessary by the attending health care provider. KTCH provides services without regard to religion, race, color, national origin, handicapping condition, age, sex, number of pregnancies, or marital status. By signing below I also consent to treatment for myself/my ward by KTCH dental providers and/or students from UMKC school of dentistry and SFCC when or if dental services are provided. Additionally, title X services are provided solely on a voluntary basis and acceptance of a family planning service is not a prerequisite to eligibility or receipt of any other service.

Initial: ___________________

Receipt to Obtain External Prescription History:
By signing below, I am giving consent for KTCH to view my external presription history via our electronic medical record system (eClinical Works). This will allow my provider to have information regarding medications i'm taking in order to minimize adverse drug reactions. By accepting this, you understand that prescription history from multiple unaffiliated medical providers, insurance companies, and pharmacies may be viewed by your provider and authorized staff. This consent will remain in effect until the day you revoke your consent in writing. If you choose to revoke this consent, it will not have an effect on your treatment.

Initial: ___________________

Consent & Agreement for Patient Portal:
We are committed to protecting your personal health information in compliance with the law. By signing below you are requesting that we register your email for our patient portal (Healow). By signing below, you are also acknowledging that you have read, fully understand, agree and aware of the risks and benefits associated with online communication via patient portal. You agree to adhere to the policies set forth by KTCH as well as any other instructions or guidelines that may be imposed for online communications.

Initial: ___________________

By signing below I am acknowledging that I have completed the information in this packet to the best of my knowledge. By signing below and initialing on the above lines, I am acknowledging that I have read and understand the above information.

SIGNATURE: ____ **DATE:** ______________________

PRINTED NAME: ________________________________ **Relationship to Patient:** ______________________

Katy Trail Community Health

INSURANCE INFORMATION

Please provide a copy of ALL insurance cards

MEDICAL INSURANCE INFORMATION				
PRIMARY MEDICAL INSURANCE	Insurance Name: ☐ Medicare ☐ Medicaid ☐ BCBS/Anthem ☐ Tricare ☐ Other Commercial: ________			
	Subscriber Name:		Subscriber Phone Number: ( )	Subscriber Birth Date: / /
	Subscriber SSN:	Subscriber Address:	Subscriber Relationship to Patient: ☐ Mother ☐ Father ☐ Legal Guardian	
SECONDARY MEDICAL INSURANCE (If Applicable)	Insurance Name: ☐ Medicare ☐ Medicaid ☐ BCBS/Anthem ☐ Tricare ☐ Other Commercial: ________			
	Subscriber Name:		Subscriber Phone Number: ( )	Subscriber Birth Date: / /
	Subscriber SSN:	Subscriber Address:	Subscriber Relationship to Patient: ☐ Mother ☐ Father ☐ Legal Guardian	

DENTAL INSURANCE INFORMATION				
PRIMARY DENTAL INSURANCE	Insurance Name:			
	Subscriber Name:		Subscriber Phone Number: ( )	Subscriber Birth Date: / /
	Subscriber SSN:	Subscriber Address:	Subscriber Relationship to Patient: ☐ Mother ☐ Father ☐ Legal Guardian	
SECONDARY DENTAL INSURANCE (If Applicable)	Insurance Name:			
	Subscriber Name:		Subscriber Phone Number: ( )	Subscriber Birth Date: / /
	Subscriber SSN:	Subscriber Address:	Subscriber Relationship to Patient: ☐ Mother ☐ Father ☐ Legal Guardian	

****This is NOT a free service. If you are uninsured, a Community Health Worker (CHW) will be reaching out to you to discuss our Sliding Fee Scale (SFS) options and options for obtaining insurance for your family. Please provide the best contact number & time of day:**

CONTACT NUMBER: ______________________________ **DAY/TIME:** ______________

HIPAA Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose Protected Health Information (PHI).

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your PHI is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. 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 PHI and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- PHI may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

Below, please list the individuals you consent for KTCH to share your medical and dental records:

Name:	Relationship:	Phone #:

SIGNATURE: ______________________________ **DATE:** ______________

PRINTED NAME: ______________________ **Relationship to Patient:** ______________

Katy Trail Community Health
Patient Financial Information

IMPORTANT NOTICE TO OUR PATIENTS-PLEASE READ CAREFULLY

- Our Sliding Fee Discount Program is designed to help you pay for medical, dental, and behavioral health services provided by KTCH. If you would like to apply for our sliding fee discount program, please ask the front desk for a sliding fee program application or request an appointment with our Sliding Fee Discount Program Coordinator. You must complete the application and provide proof of income to be certified for the sliding fee discount prior to any appointment that you would like the sliding fee to apply.

- Your child may be eligible for a Medicaid program so please ask for an appointment with one of our Care Coordinators to explore this option.

- Your payment today may be by cash, check, or credit / debit card. Your minimum co-pay is due at the time of check-in or your appointment will be rescheduled. The only exception will be when your medical/dental condition is considered an emergency which will be determined by our triage nurse/dental coordinator using guidelines established by our Chief Medical /Dental Officer.

- If you participate in a health insurance network, Katy Trail will be happy to file the insurance claim on your behalf. It is your responsibility to pay the balance of any fees for services not covered under your insurance plan upon receipt of the bill or as agreed upon in your payment plan. Should you foresee needing financial assistance to pay this balance; you must complete the sliding fee application and provide proof of income before the time of service to be certified for the slide at that time.

- If you do not participate in a health insurance network & have income over 200% of the poverty level, a deposit of $130 will be required for services you are receiving today. **You will also receive a bill for any fees in excess of your deposit.** Should the fees for medical service be less than your deposit, the difference will be refunded to you. It is your responsibility to pay the balance of any fees for services upon receipt of the bill or as agreed upon in your payment plan.
  Initial: ___________________________

Katy Trail firmly believes that a good provider/patient relationship is based upon understanding and good communications. The above information was provided to avoid any misunderstandings. Questions about financial arrangements should be directed to our billing office at 1-877-733-5824 ext. 1156. By signing below as the patient or other patient representative, you acknowledge that you have read this Patient Financial Information sheet and agree to the terms stated.

Signature of Patient or Responsible Party ____________________ Date ____________

Katy Trail Community Health

Patient Rights

At Katy Trail Community Health, we are committed to providing you a **patient center medical home (PCMH)**. A patient centered medical home is not a place of residence and does not change where you live. Instead a medical home is where you get healthcare and see your primary care provider (PCP). A PCP can be a doctor, nurse practitioner or a dentist. Your PCP leads a team of individuals within the organization who, as a care team, will take responsibility for the ongoing care of each patient. You and your family are an essential part of the care team. As a patient, you have certain rights. Understanding those rights will help you to get the best possible care. You have the right to:

- ☑ Receive compassionate and respectful care regardless of age, sex, race, national origin, religion, disability, or communicable disease.
- ☑ Personal Provider – each patient has an ongoing relationship with a primary care provider (PCP) who will give complete and continuous care.
- ☑ Comprehensive Medical Care – the PCMH is responsible for meeting the majority of each patient's physical and mental health care needs, including prevention and wellness, acute care, and chronic care. You have the right to be well informed about your diagnosis, treatment, and chances for recovery in words you can understand. This information should include the specific treatment, medical risks, benefits, side effects.
- ☑ Comprehensive Dental Care - the PCMH is responsible for meeting the majority of each patient's oral health care needs, including prevention and wellness and acute care. You have the right to be well informed about your diagnosis, treatment, and chances for recovery in words you can understand. This information should include the specific treatment, medical risks, benefits, side effects.
- ☑ Provider Directed Medical Practice – the PCP leads a team of individuals within the organization who, as care team, will take responsibility for the ongoing care of each patient. **Your care team includes your medical PCP, medical assistant, LPN, behavioral health consultant, care coordinator, and a case manager.** The care team will support the patient for self-management of their health and health care goals.
- ☑ Provider Directed Dental Practice - the PCP leads a team of individuals within the organization who, as care team, will take responsibility for the ongoing care of each patient. **Your care team includes your dental PCP, hygienist, dental assistant, expanded functions dental assistant, behavioral health consultant, and care coordinator.** The care team will support the patient for self-management of their oral health and oral health care goals.
- ☑ Whole Person Orientation – the PCP is responsible for providing for the entire patient's healthcare needs and takes responsibility for appropriately arranging care with other qualified professionals as needed.
- ☑ Behavioral Health Needs- The PCMH employs or contracts for BH Consultants and Psychiatrists. Your PCP may refer you to behavioral health for either chronic disease management or mental health services.
- ☑ Care is Coordinated – the PCMH coordinates care across all areas of the health care system, including specialty care, hospitals, home health care, and community services and supports. Such coordination is particularly critical during transitions between sites of care, such as when patients are being discharged from the hospital.
- ☑ Accessible Services – a PCMH delivers services that are easy to get and with shorter waiting times for urgent needs, better in-person hours, and around-the-clock telephone access to a member of the care team. **The after-hours phone number is 660-851-7765**
- ☑ Quality and Safety – PCMH's are dedicated to improving quality of care by using evidence-based medicine and clinical decision-making tools to help providers, patients and families make decisions. Patients will always have the right to refuse recommended treatment to the extent permitted by law, and to be told what will happen to you medically if that is your choice. Express verbally or by letter, any complaints or recommendations concerning our services. You may communicate a complaint or grievance in writing at our main site at 821 Westwood, Sedalia, MO 65301, or by calling our main site at 877-733-5824.
- ☑ Privacy – You have the right to the privacy and confidentiality of all your records pertaining to your treatment, except as required by law or third party payment. Your medical and dental record can be read only by individuals directly involved in or supervising your treatment, monitoring the quality of your treatment, or authorized by law or regulation. You have the right to access the information contained in your medical record, within the limit of the law and facility policy. Please refer to the KTCH Notice of Privacy for additional information on your privacy rights.

Katy Trail Community Health

Patient Responsibilities

The care you receive is partially dependent upon your acting in a cooperative manner with your health care providers, including communicating openly and honestly, following treatment plans, and respecting the facility standards of conduct. As a patient at Katy Trail Community Health, you are responsible for:

1. Following all facility rules as posted inside and/or outside the clinical facility. Respecting and considering other people, employees, the property of others, and property of Katy Trail Community Health.
2. Advising us of any changes in the following:
   Name, Address, Phone Number(s), Insurance Information, Income, and Family Size
3. Providing accurate and complete information about current symptoms, medical history, hospitalizations, medications, care obtained outside the practice, self care information, advance directives, and any other matters related to care.
4. Following instructions that you and your care team have agreed upon. Follow through on goals for self-management of your health.
5. Asking questions about your care that you may not understand or have questions about, including risks of procedures, outcomes, and costs of treatment.
6. Knowing what medications or drugs you are taking, why you are taking them, and the proper way to take them according to your PCP's instructions.
7. Keeping scheduled appointments, arriving on time for scheduled appointments, and calling at least 4 hours in advance to cancel when you cannot keep a scheduled appointment. KTCH reserves the right to terminate service to patients who do not show for appointments more than three times in a 12 month period.
   a. **MEDICAL**: New patients are required to arrive 30 minutes in advance of their appointment. Please notify us at least 4 hours in advance of appointment cancellations. After missing four medical/behavioral health appointments within a calendar year the patient will be required to make all future appointments through the triage nurse. Patients may be removed from the list after writing a letter stating what steps they will take to ensure future appointments are not missed.
   b. **DENTAL:** New patients are required to arrive 30 minutes in advance of their appointment. If you are more than **10 minutes late for your dental appointment**, your appointment will be rescheduled. Please notify us at least 24 hours in advance of appointment cancellations. After missing two dental appointments the patient will be required to meet one of the following criteria, Wait six (6) months to schedule an appointment, write the provider a letter asking for the privilege to be seen again, meet with a care coordinator to discuss barriers to care.
8. Attending and supervising your children while in the facility.
9. Calling your pharmacy to request a refill 1 week before you run out of your prescription. If authorized by a KTCH provider, your request will be filled within 72 business hours.
10. Paying bills and fees promptly as defined in the financial policies.

I have read and understand the Katy Trail Community Health **Patient Rights and Responsibilities** and have been given an opportunity to obtain a copy for my personal records.

Signature of Patient or Responsible Party ______________________ Date ____________

**7. Not applicable to onsite school visits.

Katy Trail Community Health

REQUIRED HEALTH HISTORY INFORMATION FOR SERVICES

PATIENT NAME: ______________________ ***DOB:*** ____________ ***Today's Date:*** ____________

Primary Medical Provider: ______________________ Last Visit Date: ____________

Tobacco Usage: (smoke or smokeless): ☐ Never used tobacco ☐ Daily tobacco user ☐ Ex-tobacco user

Have you ever been diagnosed with, or treated for any of the following? (Check all that apply):

- ☐ Abnormal bleeding
- ☐ Acid Reflux
- ☐ ADHD
- ☐ Alcohol Abuse
- ☐ Anemia
- ☐ Anxiety
- ☐ Artificial Bones/Joints
- ☐ Artificial Heart Valves
- ☐ Asthma
- ☐ Autism - Mild
- ☐ Autism – Severe
- ☐ Behavioral Issues
- ☐ Cancer
- ☐ Congenital Heart Defects
- ☐ Congestive Heart Failure
- ☐ COPD
- ☐ Coronary Artery Disease (CAD)
- ☐ Other ____________
- ☐ Diabetes Type I
- ☐ Diabetes Type II
- ☐ Drug Abuse
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting Spells
- ☐ Gestational Diabetes
- ☐ Glaucoma
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hemophilia
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ HIV/AIDS
- ☐ Hyperlipidemia (High Cholesterol)
- ☐ Hypertension (High Blood Pressure)
- ☐ Hypotension (Low Blood Pressure)
- ☐ Joint Replacement
  Type: ____________
- ☐ Kidney Disease
- ☐ Lupus
- ☐ Mitral Valve Prolapse
- ☐ Non-Epileptic Seizures
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Psychiatric Problems
- ☐ PTSD
- ☐ Rheumatic Fever
- ☐ Rheumatoid Arthritis
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Tuberculosis

☐ Currently Pregnant, Due Date: ______________________ ☐ Currently Nursing

List any medications that you are currently taking: ☐ *No Current Medications*

____

____

____

Are you allergic to LATEX? ☐ Yes ☐ No If yes, what kind of reaction? ____________

Office Use Only: If yes, Enter in tooth chart under allergies AND create "pop-up" note

List any Drug / Food Allergies	***Reaction***
☐ No known Drug/Food Allergies	

Have you had any recent surgery and/or hospitalizations? ☐ No ☐ Yes – Date of hospitalization: ____________

If yes, please explain: ____

Consent to Treat Patient without Parent/Legal Guardian Present for Medical Services

❖ **Authorization:**

I have the legal right to preauthorize Katy Trail Community Health and its personnel to deliver the below indiciated services to my child. These services may include, but are not limited to a routine annual wellness medical services, age appropriate immunizations and any other treatment plan as recommended.

I, ______________________________ , request and authorize Katy Trail Community Health and its personnel to deliver the indicated services to the child named below as may be deemed necessary or advisable in the diagnosis and treatment of the minor child.

Parent/Legal Guardian Name

______________________________ ____________________

Child's Name Child's Birth Date

❖ **Services that may be delivered:**

I agree to my child receiving the below school based services while they are in school without me present:

________ **Medical Services**
(Initial)

❖ **Limitations:**

Identify any specific limitations on the types of services/treatment for which this authorization is given:

____

____

❖ **Communication:**

________ By initialing here, I give permission for the KTCH dental/medical provider providing services to my
(Initial) child, to communicate with the school personnel regarding the treatment or services relevant to their needs, if necessary. This communication consent will expire one year from the date of signature below unless indiciated otherwise. You understand that you can contact the clinic at any time to revoke this acknowledgement prior to that date.

SIGNATURE: ______________________________ **DATE:** ______________

PRINTED NAME: ______________________ **Relationship to Patient:** ______________

Consent to Treat Patient without Parent/Legal Guardian Present for Dental Services

❖ **Authorization:**

I have the legal right to preauthorize Katy Trail Community Health and its personnel to deliver the below indiciated services to my child. These services may include, but are not limited to dental examination, prophylaxis (cleaning), flouride application, oral x-rays and treatment planning as recommended.

I, ______________________________ , request and authorize Katy Trail Community Health and its personnel to deliver the indicated services to the child named below as may be deemed necessary or advisable in the diagnosis and treatment of the minor child.

Parent/Legal Guardian Name

______________________________ ____________________

Child's Name Child's Birth Date

❖ **Services that may be delivered:**

I agree to my child receiving the below school based services while they are in school without me present:

________ **Dental Services**

(Initial)

❖ **Limitations:**

Identify any specific limitations on the types of services/treatment for which this authorization is given:

____

____

❖ **Communication:**

________ By initialing here, I give permission for the KTCH dental/medical provider providing services to my child, to communicate with the school personnel regarding the treatment or services relevant to their needs, if necessary. This communication consent will expire one year from the date of signature below unless indiciated otherwise. You understand that you can contact the clinic at any time to revoke this acknowledgement prior to that date.

(Initial)

SIGNATURE: ______________________________ **DATE:** ____________________

PRINTED NAME: ______________________________ **Relationship to Patient:** ____________________