FLINT HILLS ORTHOPAEDICS

700 W. Central Ste 206 / El Dorado, KS 67042
822. N Andover Road / Andover, KS 67002
1301 W. 12th Ave Ste 201 / Emporia, KS 66801
100 W. 16th Street / Eureka, KS 67045
2600 Ottawa Road / Neodesha, KS 66757
Tel: (316) 452-5113 Fax: (316) 452-5171

Dr. Gerard Librodo, MD
Bridget Howard, APRN
Paula Foster, APRN
Ryan Prebble, DNP

PATIENT INFORMATION

Name: _____ Date of Birth: _____ Age: _____
Street Address: _____ City: _____ State: _____ Zip Code: _____
SSN: _____ Email: _____
Phone Number: _____ Cell Phone Home Work (circle one)
Phone Number: _____ Cell Phone Home Work (circle one)

Sex:
☐ Male ☐ Female

Marital Status:
☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Ethnicity:
☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Not specified

Who is Filling out This Form?
☐ Self ☐ Husband ☐ Wife ☐ Partner ☐ Child ☐ Parent ☐ Grandparent ☐ Other Relative ☐ Friend

Race
☐ Unreported or refused to report ☐ White ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American

Preferred Communication Method:
☐ US Mail ☐ Work Phone ☐ Secure Email ☐ Cell Phone ☐ Home Phone

Preferred Language:
☐ English ☐ Spanish ☐ Other ☐ Decline to Answer

EMERGENCY CONTACT INFORMATION

First Name: _____ **Last Name:** _____
Relation to You: ☐ Husband ☐ Wife ☐ Partner ☐ Child ☐ Parent ☐ Grandparent ☐ Other Relative ☐ Friend
Phone Number: _____ Cell Phone Home Work (circle one)
Phone Number: _____ Cell Phone Home Work (circle one)

HEALTH INSURANCE INFORMATION

I do not have health insurance; I will be self-paying. ☐
Name of Insurance Co. _____
Phone Number: _____
Claims Address: _____
Claims City: _____ Claims State: _____
Claims Zip Code: _____
Policy Holder Name: _____
Member ID of Patient: _____
Group Number of Patient: _____
Employer: _____
Date of Birth: _____
Phone #: _____ Address: _____
City: _____ State: _____ Zip Code: ____

SECONDARY HEALTH INSURANCE INFORMATION

Name of Insurance Co. _____
Phone Number: _____
Claim Address: _____
Claims City: _____ Claims State: _____
Claims Zip Code: _____
Policy Holder Name: _____
Member ID of Patient: _____
Group Number of Patient: _____
Employer: _____
Date of Birth: _____
Phone #: _____ Address: _____
City: _____ State: _____ Zip Code: _____

GUARANTOR INFORMATION (for minors only)

First Name: _____ Last Name: _____
Date of Birth: _____ Street Address: _____ City: _____
State: _____ Zip Code: _____ Phone Number: _____

I ACCEPT PERSONAL RESPONSIBILITY FOR PAYMENT OF CHARGES FOR SERVICES RENDERED TO ME. I AUTHORIZE PAYMENTS OF MEDICAL INSURANCE BENEFITS TO FLINT HILLS ORTHOPAEDICS, P.A. I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM.

Signature of Patient/Insured: _____ Date: _____
Insured Signature (If other than patient): _____ Date: _____

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PATIENT NAME (LAST)	(FIRST)	(MIDDLE)	DATE

HISTORY OF PRESENT ILLNESS

REASON for **this** Visit: _____ Date of First Symptoms: _____
Is this an injury or an accident? ☐ Yes ☐ No
When were you injured? _____ Where were you injured? _____
How were you injured? _____
Is there an attorney involved? ☐ Yes ☐ No If Yes, Attorney's Name and Phone #: _____
Auto related? ☐ Yes ☐ No Work Comp Related? ☐ Yes ☐ No Name of Work Comp Adjuster: _____
Work Comp Claim #: _____ Phone #: _____ Fax #: _____
Work Comp Claim Address: _____

WORK STATUS

Employer: _____ Occupation: _____
Please Indicate Your Current Work Status:
☐ Working Full Time ☐ Working Part Time ☐ Seeking Employment
☐ Not Working by Choice (Retired, Homemaker, Students, Etc.)
☐ Physically Unable to Work Due to Musculoskeletal Problem
☐ Physically Unable to Work Not Due to Musculoskeletal Problem
☐ How long have you been out of work? _____

OTHERS DOCTORS YOU'VE SEEN

I have not seen any doctors in the past year. ☐
Primary Care Doctor's Name: _____
(First) (Last)
Information on Other Doctors, Specialists, or Other Providers You Have Seen:
Name of Doctor and Specialty:
First Name: _____ Last Name: _____
Specialty: _____

OUTSIDE TESTS

Have you had any imaging studies done? ☐ Yes ☐ No

X-Rays? ☐ Yes ☐ No If so, Where? _____
MRI? ☐ Yes ☐ No If so, Where? _____
CT Scan? ☐ Yes ☐ No If so, Where? _____
EMG/NCT? ☐ Yes ☐ No If so, Where? _____
Bone Scan? ☐ Yes ☐ No If so, Where? _____
CT/Myelogram? ☐ Yes ☐ No If so, Where? _____
Discogram? ☐ Yes ☐ No If so, Where? _____
Dexa Scan? ☐ Yes ☐ No If so, Where? _____

FLINT HILLS ORTHOPAEDICS

FINANCIAL POLICY

Thank you for choosing *Flint Hills Orthopaedics, P.A.* as your healthcare provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treamtment. The following is a statement of our Financial Policy. We required you to read and sign this policy before any treatment can be rendered.

MISSED APPOINTMENT: We reserve the right to charge a fee of $25 for all missed appointments that are not cancelled with a 24-hour advance notice. This fee will be billed to the patient. This fee is not covered by insurance and must be paid prior to your next appointment. Patients that have **3 "NO SHOWS"** for appointments, without calling prior to the appointment to reschedule may receive notification of termination from the practice and will no longer be scheduled for appointments.

COPAYS: You will be expected to pay your copay prior to seeing your physician. If you are unable to pay, you will be required to reschedule your appointment.

Uninsured Patient: A deposit of $230.00 will be collected at the time of the patient's first visit.
Additionally, patient will be asked to **pay additional deposit of $80.00 for each subsequent visit plus other possible procedure expenses (i.e., Casting/Splinting Supplies, Braces, Injections, etc....)**. You may be asked to reschedule your appointment if your deposit is not received at this time of service.

PAYMENT FOR SERVICES: All patients must complete a patient information form and provide insurance information, if appropriate, or make payment arrangements prior to leaving the clinic.

- Payment in full: Payment in full is expected and can be made by cash, check, or credit card. Please remember we accept *Visa, Master Card, Discover or Care Credit.*
- Payment Plan: If you are unable to pay the account in full, financial arrangements will be established based on the following guideline. When establishing a payment plan, the patient (or their guarantor) will sign a contract agreement with the 1st payment due upon signing the contract. This approach requires a minimum payment of $25. The contract will specify the dollar amount of subsequent payments and the day of the month the payments will be made. When you set up a payment plan, you will continue to receive a monthly statement. If you miss one payment and fail to bring the account current by the due date of the following payment, the account will be referred to the clinic's collection agency.
    - Patient Due Balances of $500 or less will be set up on a 90-day payment plan.
    - Patient Due Balances of $501-$1,000 will be set up on a 180-day payment plan.
    - Patient Due Balances of $1,000+ will be set up on a 1-year payment plan.

If at any time you are unable to make payment in full, please contact **Penny Nielsen** at **316-252-8668** to make reasonable payment arrangements.

COMPLETTION OF FORMS: (Disability, FMLA, Physician Statements, Etc.) A $25 charge will be assessed per form. Prepayment is required before the form(s) will be completed.

MINOR PATIENTS: If you are a minor, your parents and/or guardian need to accompany you to our office before treatment can be rendered. You need to make prior arrangements before being seen with your parent and/or guardian for payment to be made at the time of treatment.

LAB: In the event we need to have a lab drawn, our office uses an outside laboratory service. You will receive a separate bill for the lab services.

UNIFORM APPLICATION OF PLOICY: This policy will apply to all patients, employees, or others who present themselves for services (at any time, including any future visits).

It is always your responsibility to see that your account is paid, regardless of insurance or any other circumstances (such as litigation). The patient is responsible for costs associated with collecting said owed balances, including but not limited to collection agency fees, attorney fees and court costs.
I have read, understand and agree to adhere to the above Financial Policy.

_____ _____

Signature of Patient or Responsible Party Date

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PERMISSION TO GIVE OUT INFORMATION

Please list below only the names of the person and/or persons that you wish to give permission for our staff to speak with regarding your medical and/or financial information.

I, _____, hereby grant the physicians and staff of Flint Hill Orthopaedics, P.A. my permission to speak with the following people about my health and well-being.

Effective Date: _____

Name: _____ Relationship: _____

Telephone Number: _____ _____ _____
Home Work Cell

The following information may be given to the above individual:

- ☐ Appointment Time
- ☐ Financial Information
- ☐ Test/Lab Results
- ☐ Medications
- ☐ Procedures
- ☐ Other Information Regarding My Health

Name: _____ Relationship: _____

Telephone Number: _____ _____ _____
Home Work Cell

The following information may be given to the above individual:

- ☐ Appointment Time
- ☐ Financial Information
- ☐ Test/Lab Results
- ☐ Medications
- ☐ Procedures
- ☐ Other Information Regarding My Health

I understand I may revoke this consent at any time by giving written notice to Flint Hills Orthopaedics, P.A.

Signed: _____ Date: _____

Print Name: _____

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PATIENT NAME (LAST)	(FIRST)	(MIDDLE)	DATE

REVIEW OF SYSTEMS

PLEASE CHECK THE BOXES BLEOW THAT DESCRIBE YOUR *CURRENT* SYMPTOMS:

GENERAL HEALTH

- ☐ Denies General Health Symptoms
- ☐ Recent Weight Loss of More than 10 pounds
- ☐ Recent Weight Gain of More than 10 pounds
- ☐ Seen Primary Care Physician in the Last Year
- ☐ Fevers
- ☐ Night Sweats
- ☐ Chills

BLOOD/ONCOLOGY

- ☐ Denies Hematologic/Oncologic Symptoms
- ☐ Easy Bruising
- ☐ Blood Thinning Medications
- ☐ Blood Transfusion
- ☐ Organ Transplant

GASTROINTESTINAL

- ☐ Denies Gastrointestinal Symptoms
- ☐ Abdominal Pain
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Liver Problems

MUSCLES, BONES & JOINTS

- ☐ Denies Musculoskeletal Symptoms
- ☐ Shoulder Pain
- ☐ Hip Pain
- ☐ Knee Pain
- ☐ Joint Swelling
- ☐ Muscle Cramps
- ☐ Muscle Weakness
- ☐ Muscle Cramps
- ☐ Fibromyalgia
- ☐ Spine Pain

RESPIRATORY

- ☐ Denies Respiratory Symptoms
- ☐ Wheezing
- ☐ Pneumonia
- ☐ Chronic Cough
- ☐ Sleep Apnea

CARDIAC

- ☐ Denies Cardiac Symptoms
- ☐ Chest Pain
- ☐ Shortness of Breath

KIDNEY AND BLADDER

- ☐ Denies Genitourinary Symptoms
- ☐ Abnormal Kidney Function
- ☐ Pain with Urination
- ☐ Frequent Urinary Infections

NERVOUS SYSTEM

- ☐ Denies Neurological Symptoms
- ☐ Headaches
- ☐ Tremors
- ☐ Poor Speech
- ☐ Changes in Vision

SKIN

- ☐ Denies Skin Symptoms
- ☐ Rash
- ☐ Dryness
- ☐ Itching
- ☐ Lesions

ENDOCRINE SYSTEM

- ☐ Denies Endocrine Symptoms
- ☐ Thyroid Problems
- ☐ Increased

PATIENT MEDICAL HISTORY PAGE 1

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PATIENT NAME (LAST)	(FIRST)	(MIDDLE)	DATE

PLEASE CHECK THE BOXES THAT DESCRIBES YOUR *PREVIOUS* MEDICAL HISTORY

RHEUMATOLOGIC

- ☐ Arthritis
- ☐ Gout
- ☐ Osteoporosis
- ☐ Lupus

RESPIRATORY

- ☐ Asthma
- ☐ COPD
- ☐ Bronchitis
- ☐ CPAP Machine
- ☐ Oxygen Dependent
- ☐ Emphysema
- ☐ Sinusitis
- ☐ Sleep Apnea
- ☐ Pneumonia

NEUROLOGIC

- ☐ Alzheimer's Disease
- ☐ Migraines
- ☐ Multiple Sclerosis
- ☐ Parkinson's Disease
- ☐ Stroke
- ☐ Epilepsy
- ☐ Seizures
- ☐ Fainting Spells

MENTAL HEALTH

- ☐ Anxiety
- ☐ Depression

ENDOCRINE

- ☐ Diabetes Type 1
- ☐ Diabetes Type 2
- ☐ Hypoglycemic
- ☐ Thyroid Problems

HEPATIC

- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ Jaundice

GASTROINTESTINAL

- ☐ Bowel/Stomach Disorder
- ☐ History of Ulcers

CARDIAC

- ☐ High Blood Pressure
- ☐ CVA/Stroke
- ☐ Palpitations
- ☐ Fast Heartbeat
- ☐ Irregular Heartbeat
- ☐ Heart Murmur
- ☐ Deep Vein Thrombosis
- ☐ Heart Disease
- ☐ Chest Pain
- ☐ Metal Heart Valve
- ☐ Non-Metal Heart Valve
- ☐ Pacemaker/Defibrillator
- ☐ Cardiac Stent

What year was stent placed?

What kind of stent?

Are you on medication for the stent?

- ☐ Congestive Heart Failure
- ☐ Treated in the Last 3 Months
- ☐ Heart Attack
- ☐ Treated in the Last 6 Months
- ☐ Short of Breath When You Lie Down?
- ☐ Climb a Flight of Stairs Without Panting?

HEMATOLOGIC

- ☐ Anemia
- ☐ Blood Clotting Disorder
- ☐ Sickle Cell Anemia

PATIENT MEDICAL HISTORY PAGE 2

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PATIENT NAME (LAST) (FIRST) (MIDDLE) DATE

CANCER

☐ Cancer

What type of cancer?

VACCINATIONS

Influenza (Flu) Shot
- ☐ Within the Last 6 months
- ☐ 6 to 12 months
- ☐ 12-24 months
- ☐ More than 2 years ago
- ☐ Never or Can't Remember

Pneumonia Shot
- ☐ Within the Last 2 years
- ☐ 2 to 5 years ago
- ☐ 5 to 10 years ago
- ☐ More than 10 years ago
- ☐ Never or Can't Remember

Covid Vaccine
- ☐ 1st Vaccine
- ☐ 2nd Vaccine
- ☐ Never

URINARY

- ☐ Bladder Disorder
- ☐ Dialysis
- ☐ Kidney Problems
- ☐ Creatine Higher Than 2

FEMALE SPECIFIC

- ☐ Currently Pregnant
- ☐ Not Pregnant

OTHER

- ☐ Glaucoma
- ☐ Hearing Problems
- ☐ Vision Problems
- ☐ Latex Sensitivity
- ☐ Problems with Anesthesia
- ☐ Malignant Hyperthermia

SOCIAL HISTORY

What is your smoking status? Cigars/Day ☐ Packs/Day ☐ Pipes/Day ☐ Chewing Tobacco ☐

- ☐ Everyday Smoker
- ☐ Occasional Smoker
- ☐ Former Smoker
- ☐ Never Smoked
- ☐ Not disclosed

☐ **Use alcohol?**

How many drinks per occasion?
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4 or More
- ☐ N/A

Years of tobacco use?
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 10+
- ☐ 15+
- ☐ 20+
- ☐ 25+

☐ Have you been counseled to quit/cut down on your tobacco use within the last 6 months?

☐ Use recreational drugs?

Have you recently traveled outside of the United States? Yes No
(please circle)

PATIENT MEDICAL HISTORY PAGE 3

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PATIENT NAME (LAST)	(FIRST)	(MIDDLE)	DATE

CHECK BOXES BELOW THAT APPLY

PATIENT FAMILY HISTORY

Patient's Mother ☐ Alive ☐ Deceased ☐ Unknown Patient's Father ☐ Alive ☐ Deceased ☐ Unknown

	Mother	Father	Sister	Brother	Maternal Grandmother	Paternal Grandmother	Maternal Grandfather	Paternal Grandfather	NO History
Aneurysm									
Arthritis									
Bleeding/Clotting									
Breast Cancer									
Cancer (Other Types)									
Colon Cancer									
Depression									
Diabetes Type 1									
Diabetes Type 2									
Heart Disease									
High Blood Pressure									
Mental Illness									
Stroke									

PATIENT'S SURGICAL HISTORY

☐ Orthopaedic Surgery? What type of Orthopaedic surgery? _____

☐ Gynecologic Surgery? What type of gynecologic surgery? _____

☐ Ear, Nose, Throat Surgery? What type of ear, nose, throat surgery? _____

☐ Cardiac Surgery? What type of cardiac surgery? _____

☐ Urological Surgery? What type of urological surgery? _____

☐ Abdominal Surgery? What type of abdominal surgery? _____

☐ Surgeries Not Listed Elsewhere:

_____

PATIENT MEDICAL HISTORY PAGE 4

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PATIENT NAME (LAST)	(FIRST)	(MIDDLE)	DATE

CURRENT MEDICATIONS

Please list all current medication (including any herbal medications and/or supplements):

_____
_____
_____
_____
_____
_____
_____

ALLERGIES

Please list any medication that you are allergic to and your reaction to them:

_____
_____
_____

Pharmacy Name: _____ Phone Number: _____

Patient Signature: _____ Date: _____

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PATIENT NAME (LAST)	(FIRST)	(MIDDLE)	DATE

PREVIOUS TREATMENTS

	How Often?	How Long?	Date of Last Treatment?
Previous Treatments	_____	_____	_____
Chiropractic Care	_____	_____	_____
Heat	_____	_____	_____
Ice	_____	_____	_____

PREVIOUS INJECTIONS

Date of Last Injection?

- ☐ Facet Joint _____
- ☐ Cervical Epidural _____
- ☐ Transforaminal Lumbar Injection _____
- ☐ Lumbar Epidural _____
- ☐ Sacroiliac Joint (SI Joint) _____
- ☐ Nerve Block _____
- ☐ Trigger Point _____

Psychological Consultation for Pain Relief
Other Remedies Tried
_____

Where did you have your last injections?
_____

HOW DO ANY OF THE FOLLOWING AFFECT YOUR PAIN?

Sitting.....	☐ Better	☐ Worse	☐ No Change	Heat.....	☐ Better	☐ Worse	☐ No Change
Standing.....	☐ Better	☐ Worse	☐ No Change	Cold.....	☐ Better	☐ Worse	☐ No Change
Walking.....	☐ Better	☐ Worse	☐ No Change	Massage...	☐ Better	☐ Worse	☐ No Change
Lying Down.....	☐ Better	☐ Worse	☐ No Change	Physical Activity..	☐ Better	☐ Worse	☐ No Change
Rising from a Chair	☐ Better	☐ Worse	☐ No Change				

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ASSOICATED SYMPTOMS

Weakness.....	☐ Arms/Hands	☐ Legs/Feet	☐ None
Numbness (Loss of feeling).....	☐ Arms/Hands	☐ Legs/Feet	☐ None
Tingling (falling asleep).....	☐ Arms/Hands	☐ Legs/Feet	☐ None
Is your pain worse at night?.....	☐ Yes	☐ No	
Does your pain wake you up at night?.....	☐ Yes	☐ No	
Does coughing affect your pain?.....	☐ Yes	☐ No	
Do your legs feel tired or hurt if you walk too far?	☐ Yes	☐ No	
If yes, answer the following:			
How far can you walk?.....	☐ Less Than 1 Block	☐ 1 to 3 Blocks	☐ More Than 3 Blocks
Is this relieved by resting your legs?.....	☐ Yes	☐ No	
Is this relieved by bending forward?.....	☐ Yes	☐ No	

PAIN DIAGRAM

^^^	ooo	xxx	///
Ache ^^^	Numbness ooo	Burning xxx	Stabbing ///
^^^	ooo	xxx	///

Front ***Back***

Right ***Left*** ***Right*** ***Left***

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Informed Consent and Risk/Benefits Notice for Treatment of Chronic, Non-Malignant Pain with Controlled Substances

Your doctor may diagnose you having a condition that causes you pain. Your doctor may recommend that you treat your painful condition with opioids to reduce your pain and improve your infection.
Your doctor wants you to know that there are alternatives to the proposed medications therapy, including physical therapy, chiropractic therapy, acupuncture, psychotherapy, percutaneous neuromodulations therapy, and interventional modalities (such as epidural steroid injections, etc.). There are also other types of medications such as NSAIDS, Cox 2 inhibitors, muscle relaxants, antidepressants, antiseizure medications, and certain blood pressure medications.
Your doctor wants you know that as with the use of any medication, there are potential side effects and risks associated with the use of the above – named controlled substances, including:

- Sleepiness, confusion, difficulty thinking
- Nausea, vomiting, constipation
- Difficulty breathing, shortness of breath, wheezing
- Rash, itching
- Potential for allergic reaction
- Potential for interaction with other medications (increasing effects or side effects of drugs taken together)
- Potential for dose escalation/tolerance (need to higher doses for the same effect may occur with long term use)
- Potential for dependence (after the body adjusts to these medications, they cannot be stopped abruptly without causing physical symptoms)
- Potential for withdrawal (stopping medications abruptly may cause nausea, vomiting abdominal pain, sweating, aching, abnormal heartbeat, or other symptoms that can be life threatening; medications changes should be under provider supervision)
- Potential for addiction (compulsive drug use not related to pain relief)
- Potential for impaired judgment and/or motor skills (driving or operating machinery may be hazardous due to effects on the brain and nerves)
- Potential overdoes from fentanyl patch if they are used in a Jacuzzi or other environment.

This treatment agreement is a platform for communication allowing us to work together in good faith and for you to understand the importance of this medication in allowing you to function better.

NOTE: Flint Hills Orthopaedics, P.A. normally only prescribes Pain Medication for POST OP Patient's for at 6 weeks POST OP and then you will have to contact your PCP for any further medications.

1. You will take the medication exactly as prescribed and will not change the medication dosage and/or frequency without the approval of your physician, physician assistant, and/or nurse practitioner.
2. The controlled substance pain medication prescribed is being given to control pain and allow you to function better. If there are any changes to your activity level or physical condition, the treatment may be changed or discontinued.
3. You agree to act responsibly, including protecting and limiting access to these medications, and to dispose of any unused medication in a proper manner.
4. We expect you not to accept or seek controlled substance medications from other physicians or healthcare providers outside of our practice during your 6-week POST OP care.
5. You agree that Flint Hills Orthopaedics, P.A. may request and use your prescription medication history from other healthcare providers or third-party pharmacy benefit payors for treatment purposes.
6. You understand that it is important to use one pharmacy for all prescriptions to provide consistency.
7. You understand that lost, stolen, or misplaced prescriptions will not be replaced. All patients are expected to act responsibly with medication. This medication is prescribed for you and only your needs for pain control. To allow others to use your pain medication is illegal and will not be tolerated by your physician or our practice.

Patient Signature: _____ Date: _____

Patient Signature (Print Name): _____ Witness Signature: _____

FLINT HILLS ORTHOPAEDICS

700 W. Central Ste 206 / El Dorado, KS 67042
822. N Andover Road / Andover, KS 67002
1301 W. 12th Ave Ste 201 / Emporia, KS 66801
100 W. 16th Street / Eureka, KS 67045
2600 Ottawa Road / Neodesha, KS 66757
Tel: (316) 452-5113 Fax: (316) 452-5171

Dr. Gerard Librodo, MD
Bridget Howard, APRN
Paula Foster, APRN
Ryan Prebble, DNP

Acknowledgement of Receipt of Privacy Notice
(HIPAA Brochure)

I acknowledge that I have received the attached Privacy Notice.

_____ _____

PATIENT DATE

In the event the patient is unable to sign, a signature by the designated personal representative is acceptable.

_____ _____

Personal Representative Date