PREMIER PSYCHIATRY

PSYCHIATRIC AND BEHAVIORAL HEALTH SERVICES

Orland Park: 10745 165th Street, Orland Park, IL 60467
Willowbrook: 6833 Kingery Hwy, Willowbrook, IL 60527
(708) 799-8384 | Fax (708) 799-1305 | www.premierpsychiatry.net

NEW PATIENT INTAKE PACKET

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1. PATIENT INFORMATION

Full Name: _____

Date of Birth: _____

Phone: _____

Email: _____

Address: _____

City / State / ZIP: _____

Form completed by (if not the patient): _____

Relationship to patient: _____

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2. EMERGENCY CONTACT

Name: _____

Relationship: _____

Phone: _____

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3. INSURANCE INFORMATION

Primary Insurance: _____

Member ID: _____

Group #: _____

Policy Holder (if different): _____

Secondary Insurance (if applicable): _____

Secondary Member ID: _____

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4. CONSENTS & POLICIES (PLEASE READ CAREFULLY)

By signing this packet, I acknowledge and agree to the following general consents and policies. Separate authorizations are used where required by law.

Privacy Practices

- **I acknowledge that I have received or been offered Premier Psychiatry's Notice of Privacy Practices and understand that I may request a paper or electronic copy.**
- **I understand that mental health records and communications are confidential and will be used or disclosed as permitted or required by applicable federal and state law.**
- **Full notice available at: www.premierpsychiatry.net**

Communication Consent

- **I consent to receive communication via phone, text message, email, and/or patient portal**
- **I understand messages may not be fully secure**
- **I may opt out at any time**

Telehealth Consent

- **I consent to participate in telehealth services as described in Premier Psychiatry's Telehealth Consent, including the associated risks, benefits, and my right to withdraw consent at any time. A copy of this consent is available upon request.**

Financial Policy

- **Payment, including applicable copayments and other patient responsibility, is due at the time of service unless other arrangements have been made.**
- **I understand that insurance coverage is an agreement between me and my insurer. I am responsible for deductibles, coinsurance, copayments, non-**

covered services, and amounts determined by my insurer to be my responsibility, subject to applicable law and payer contracts.

- **I agree to provide current insurance information and promptly notify Premier Psychiatry of coverage changes.**
- **Premier Psychiatry may submit claims to my insurer as a courtesy. I authorize payment of benefits for covered services directly to Premier Psychiatry to the extent permitted by my plan and applicable law.**
- **I authorize Premier Psychiatry to disclose information reasonably necessary for treatment, payment, and health care operations as permitted by law. A separate authorization will be obtained when required for disclosure of protected mental health records.**
- **A 24-hour cancellation notice is requested. A $50 missed appointment/late-cancellation fee may apply in accordance with practice policy and applicable law; such fees are generally not billed to insurance.**
- **I authorize Premier Psychiatry to keep a card on file and charge it as described in the practice's Credit Card Authorization, included with this packet.**

Consent to Treatment

- **I voluntarily consent to psychiatric evaluation and treatment by Premier Psychiatry and its licensed clinicians.**

- **Treatment may include diagnostic assessment, medication management, laboratory or other monitoring, referrals, and other clinically appropriate psychiatric services.**

- **I understand that my clinician will discuss material risks, expected benefits, and reasonable alternatives for recommended treatment, including psychotropic medications, as appropriate to my care.**

- **I understand that medications and other psychiatric treatments may cause side effects, may not work as expected, and that no particular result or outcome can be guaranteed.**
- **If psychotropic medication is recommended for me, I understand this is addressed further in Premier Psychiatry's Psychotropic Medication Consent, including FDA-specific warnings and medication-class-specific risks. A copy of this consent is available upon request.**
- **If controlled substances are prescribed for me, I agree to the terms described in Premier Psychiatry's Controlled Substance Agreement, including monitoring and reporting requirements. A copy of this agreement is available upon request.**

- **I have the right to ask questions, participate in treatment decisions, request alternatives, and refuse or withdraw from treatment, subject to applicable law and safe clinical transition.**

- **I agree to provide accurate information, report significant side effects or changes in my condition, complete clinically indicated monitoring, and discuss medication changes with my clinician rather than stopping or changing prescribed medication without consultation when reasonably possible.**
- **I understand that emergency or crisis care may require services outside Premier Psychiatry. For life-threatening emergencies or suicidal ideation, I will call 911, go to the nearest emergency department, or call/text 988 (Suicide & Crisis Lifeline).**
- **For urgent, non-life-threatening questions after hours, an on-call physician is available; there is no fee for after-hours calls.**

Patient Rights

- **I have the right to safe, considerate, and respectful care.**
- **I have the right to have my records and communications treated as confidential, as protected by applicable law.**
- **I have the right to receive complete information about my diagnosis, treatment plan, and prognosis.**
- **I have the right to participate in decisions about my care, including the right to refuse treatment.**
- **I have the right to obtain a copy of my medical records.**
- **I have the right to file a complaint about my care without fear of retaliation.**

Discharge & Termination Policy

- **I understand that Premier Psychiatry may discontinue my treatment under the circumstances described in the practice's Discharge and Termination Policy, including but not limited to non-adherence to treatment, missed appointments, unsafe behavior, or failure to comply with financial policies.**
- **A copy of this policy is available upon request.**

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5. CLINICAL INTAKE

Chief Complaint / Reason for Visit

_____

Symptom Screen (check all that apply)

Depression: ☐ Depressed/sad mood ☐ Anhedonia ☐ Low energy ☐ Guilt/worthlessness ☐ Poor concentration ☐ Thoughts of death/SI

Anxiety: ☐ Excessive worry ☐ Restlessness ☐ Panic attacks ☐ Avoidance ☐ Muscle tension

Mania: ☐ Elevated/irritable mood ☐ Decreased need for sleep ☐ Grandiosity ☐ Racing thoughts ☐ Impulsivity

Psychosis: ☐ Hallucinations ☐ Delusions ☐ Paranoia ☐ Disorganized thinking

OCD: ☐ Obsessions/intrusive thoughts ☐ Compulsions/rituals

Sleep: ☐ Insomnia (onset) ☐ Insomnia (maintenance) ☐ Hypersomnia ☐ Nightmares

Appetite: ☐ Increased ☐ Decreased ☐ No change

Substance Use

Alcohol: ☐ None ☐ Occasional ☐ Regular — Frequency/amount: _____

Tobacco/Nicotine: ☐ None ☐ Cigarettes ☐ Vape ☐ Other — Frequency: _____

Cannabis: ☐ None ☐ Occasional ☐ Regular

Other substances (specify): _____

History of substance use treatment (rehab/detox): ☐ Yes ☐ No

If yes, details: _____

Past Psychiatric History

Prior psychiatric hospitalizations: ☐ Yes ☐ No — Number of times: _____

Suicide attempt(s): ☐ Yes ☐ No — Number of attempts: _____

History of self-injurious behavior (cutting, burning, etc.): ☐ Yes ☐ No — Details: _____

Past psychiatric medication trials (medication, dose, response/tolerability, reason stopped):

_____

_____

_____

_____

_____

_____

_____

_____

Medical History

Chronic medical conditions: _____

_____

_____

_____

_____

Primary Care Physician: Name _____ **Phone** _____

Current Medications

Medication: _____ **Dose:** _____ **Frequency:** _____

Medication: _____ **Dose:** _____ **Frequency:** _____

Medication: _____ **Dose:** _____ **Frequency:** _____

Medication: _____ **Dose:** _____ **Frequency:** _____

Medication: _____ **Dose:** _____ **Frequency:** _____

Medication: _____ **Dose:** _____ **Frequency:** _____

Allergies

Medication allergies and reactions: _____

Social History

City/Town of residence: _____

Who lives in the home with you: _____

For adult patients:

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partnered

Children: ☐ Yes ☐ No — If yes, ages: _____

Employment: ☐ Employed ☐ Unemployed ☐ Retired ☐ Disabled ☐ Student

Occupation: _____

For minor patients:

School name: _____ Grade: _____

Family Psychiatric History

Family history of psychiatric illness: ☐ Yes ☐ No

If yes, describe (relationship & condition — e.g., mother: anxiety; father: depression):

_____

_____

PREMIER PSYCHIATRY

PSYCHIATRIC AND BEHAVIORAL HEALTH SERVICES

P: 708-799-8384 F: 708-799-1305 www.premierpsychiatry.net

NOTICE OF PRIVACY PRACTICES

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.

This Notice of Privacy Practices describes how Premier Psychiatry may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations, and for other purposes permitted or required by law. It also describes your rights to access and control your PHI. “Protected health information” is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

We are required by law to maintain the privacy of your PHI, to provide you with this notice of our legal duties and privacy practices, to abide by the terms of the notice currently in effect, and to notify you if a breach of your unsecured PHI occurs.

1. How We May Use and Disclose Your Information

Treatment

We may use and disclose your PHI to provide, coordinate, or manage your care and related services, including sharing information with other providers involved in your treatment, such as a referring physician or a pharmacy filling your prescriptions.

Payment

We may use and disclose your PHI to bill and collect payment for services, including verifying insurance coverage, submitting claims, and responding to your insurer's requests for information about services rendered.

Health Care Operations

We may use and disclose your PHI to support the internal operations of our practice, such as quality assessment, staff training, licensing, and business management activities.

Other Permitted or Required Uses and Disclosures

We may also use or disclose your PHI, without your authorization, in the following circumstances:

- As required by law.
- For public health activities, such as reporting disease, injury, or disability.
- To report suspected abuse, neglect, or domestic violence, as authorized by law.
- For health oversight activities, such as audits or investigations.
- In connection with judicial or administrative proceedings, such as in response to a court order or, in certain circumstances, a subpoena.
- For law enforcement purposes, as permitted by law.
- To coroners, medical examiners, or funeral directors, and for organ or tissue donation purposes.

- For research, where the research has been approved through an appropriate approval process that protects the privacy of your information.
- To prevent or lessen a serious and imminent threat to the health or safety of a person or the public.
- For workers' compensation, as authorized by law.
- To your family, a friend, or another person involved in your care or payment for your care, unless you object.

Special Protections for Mental Health and Substance Use Records

Records relating to your mental health treatment are subject to additional protections under the Illinois Mental Health and Developmental Disabilities Confidentiality Act, and, where applicable, records relating to substance use disorder treatment are subject to additional protections under 42 CFR Part 2. These records generally require your specific written authorization before they may be disclosed, separate from the general authorization described in this notice, except as otherwise permitted or required by law. Psychotherapy notes, where maintained separately from the rest of your medical record, receive further protection and generally require your specific authorization before release.

Uses and Disclosures Requiring Your Written Authorization

Other than as described above, we will not use or disclose your PHI without your written authorization. You may revoke that authorization in writing at any time, except to the extent we have already relied on it.

2. Your Rights

- Right to Inspect and Copy. You may request to inspect and obtain a copy of your PHI, with limited exceptions such as psychotherapy notes.
- Right to Request Restrictions. You may ask us not to use or disclose certain PHI for treatment, payment, or health care operations. We are not required to agree, except in certain circumstances involving disclosures to a health plan when you have paid out of pocket in full.
- Right to Request Confidential Communications. You may ask us to communicate with you in a certain way or at a certain location, and we will accommodate reasonable requests.
- Right to Request Amendment. You may ask us to amend your PHI if you believe it is incorrect or incomplete. We may deny the request in certain circumstances.
- Right to an Accounting of Disclosures. You may request a list of certain disclosures we have made of your PHI.
- Right to a Paper Copy of This Notice. You may request a paper copy of this notice at any time, even if you agreed to receive it electronically.

3. Complaints

If you believe your privacy rights have been violated, you may file a complaint with our Privacy Officer using the contact information below, or with the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you for filing a complaint.

4. Changes to This Notice

We reserve the right to change the terms of this notice and to make the revised notice effective for PHI we already maintain, as well as PHI we receive in the future. The current notice will be available at our office and posted on our website.

5. Contact Information

Questions about this notice, or requests described above, may be directed to our Privacy Officer at Premier Psychiatry, 10745 165th Street, Orland Park, IL 60467, or by phone at 708-799-8384.

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CREDIT CARD AUTHORIZATION FORM

To simplify billing, Premier Psychiatry accepts credit and debit cards as a form of payment. Card information is kept secure and filed with your confidential patient information.

What I Am Authorizing

I authorize Premier Psychiatry to charge the card on file for:

- Copayments due at the time of each visit.
- Coinsurance, deductibles, or other patient responsibility remaining after my insurance has processed a claim.
- Self-pay balances for services not billed to insurance, including Spravato and TMS visits, at the rates disclosed to me.
- Missed appointment or late-cancellation fees, as described in the practice's cancellation policy.

For charges resulting from insurance processing, I understand Premier Psychiatry will provide a receipt by email or, if requested, by phone notification before charging amounts over $500.

Cardholder Information

Patient Name: _____ Date of Birth: _____

Cardholder Name (if different from patient): _____

Billing Address: _____

City: _____ State: _____ ZIP: _____

Card Information

Card Type: ☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

Card Number: _____

Expiration Date: _____ / _____ CVV: _____

I certify that I am an authorized user of this card and have the right to authorize the charges described above. I understand that if this card becomes invalid or is declined, I will be asked to provide a new card. I understand I may revoke this authorization in writing at any time, though I remain responsible for any balance owed for services already rendered.

This Credit Card Authorization is provided as part of, and acknowledged through, my signature on Premier Psychiatry's New Patient Intake Packet.

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TELEHEALTH CONSENT

Telehealth involves the use of secure video, audio, or telephone technology to deliver psychiatric evaluation, medication management, and follow-up care when I am not in the same physical location as my provider.

Telehealth is always optional. I understand that I may choose an in-person visit at either Premier Psychiatry office instead of telehealth for any appointment, for any reason.

Expected Benefits

- Improved access to care without the need to travel to the office.
- Greater flexibility in scheduling and continuity of care.
- The ability to receive care from my established provider even when an in-person visit isn't possible.

Possible Risks

- Technical failures or interruptions may delay or limit a session.
- Poor audio or video quality could, in rare cases, affect my provider's ability to fully assess me.
- As with any electronic communication, there is a small risk that security protocols could fail, potentially affecting the privacy of my information.
- Telehealth may not be appropriate for all situations, including psychiatric emergencies, which require in-person or emergency care.

My Rights

- I understand that the same laws protecting the privacy and confidentiality of my medical information apply to telehealth.
- I have the right to withhold or withdraw my consent to telehealth at any time, without affecting my right to future in-person care.
- I have the right to switch to in-person care at any time, including mid-treatment, without needing to justify my reason.
- I have the right to inspect and receive copies of information recorded during a telehealth encounter, consistent with Premier Psychiatry's Notice of Privacy Practices.
- Upon request, I will be given information about my provider's license and how to contact them directly.

My Responsibilities

- I will be in a private location during telehealth visits to protect my own confidentiality.
- I will inform my provider, at the start of each telehealth visit, of my physical location at that time. This is required for my provider to legally prescribe medication to me, including controlled substances, under state and federal telehealth prescribing laws.
- I will inform my provider of any other health care providers or electronic interactions relevant to my care.

No Guarantee of Outcome

I understand that telehealth is one method of delivering care, and that my provider will use their clinical judgment to determine whether telehealth is appropriate for a given visit. No specific outcome or result can be guaranteed.

By signing below, I confirm that I have read and understand this Telehealth Consent, have had the opportunity to ask questions, and voluntarily consent to receive care from Premier Psychiatry via telehealth.

This Telehealth Consent is provided as part of, and acknowledged through, my signature on Premier Psychiatry's New Patient Intake Packet.

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PSYCHOTROPIC MEDICATION CONSENT

This consent describes general information about psychotropic medications (medications used to treat psychiatric conditions, such as antidepressants, antipsychotics, mood stabilizers, and stimulants) that my provider may prescribe as part of my care at Premier Psychiatry.

General Risks and Benefits

I understand that psychotropic medications can be effective in treating psychiatric symptoms, but that response varies by individual, and no specific outcome can be guaranteed. Common risks across psychotropic medications may include, but are not limited to, drowsiness, activation or restlessness, gastrointestinal upset, weight change, sexual side effects, and allergic reaction. My provider will discuss the risks and benefits specific to any medication recommended for me.

FDA Boxed Warning — Antidepressants and Suicide Risk: Antidepressant medications carry an FDA boxed warning for an increased risk of suicidal thinking and behavior in children, adolescents, and young adults up to age 25, particularly during the first few months of treatment or after a dose change. I understand that close monitoring is important during this period, and I agree to promptly report any worsening depression, agitation, or new or worsening suicidal thoughts to my provider.

Additional Risks of Antipsychotic Medications

If I am prescribed an antipsychotic medication, I understand this class of medication carries additional risks that may include:

- Metabolic effects, including weight gain, elevated blood sugar, and elevated cholesterol, which may require periodic lab monitoring.
- Movement-related side effects, including a risk of tardive dyskinesia (a condition involving involuntary movements) that may not fully resolve even after the medication is stopped, particularly with longer-term use.
- Rare but serious risks, including neuroleptic malignant syndrome, which requires immediate medical attention.

Discontinuation and Withdrawal

I understand that stopping certain psychotropic medications abruptly, without my provider's guidance, may cause a discontinuation or withdrawal syndrome, and in some cases may cause my underlying symptoms to worsen or return. I agree to discuss any desire to stop or change my medication with my provider before doing so, except in a medical emergency.

Off-Label Use

I understand that my provider may recommend a medication for a use that has not been specifically approved by the FDA for my condition ("off-label" use), based on clinical evidence and professional judgment. This is a common and accepted practice in psychiatric care. My provider will inform me if a recommended medication is being used off-label.

Pregnancy and Breastfeeding

Some psychotropic medications carry specific risks during pregnancy or breastfeeding. I agree to inform my provider promptly if I am pregnant, become pregnant, are trying to become pregnant, or are breastfeeding, so that my treatment can be reviewed accordingly.

Drug Interactions and Disclosure

I agree to provide my provider with a complete and current list of all medications, over-the-counter drugs, supplements, and substances I am taking, and to inform my provider before starting any new medication or supplement, since combinations may increase the risk of side effects or reduce effectiveness.

Monitoring

I understand that my provider may recommend periodic monitoring appropriate to my medication, which may include lab work, vital signs, weight, or other clinical assessments, and I agree to complete monitoring as recommended.

By signing below, I confirm that I have read and understand this Psychotropic Medication Consent, have had the opportunity to ask questions, and voluntarily consent to treatment with psychotropic medication as recommended by my Premier Psychiatry provider.

This Psychotropic Medication Consent is provided as part of, and acknowledged through, my signature on Premier Psychiatry's New Patient Intake Packet.

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CONTROLLED SUBSTANCE AGREEMENT

I, _____ (patient name), acknowledge and agree to the following terms and conditions regarding the use of controlled substances as part of my psychiatric treatment at Premier Psychiatry.

1. Treatment Eligibility

Controlled substances will only be prescribed to me if my provider determines they are clinically necessary for the management of my diagnosed condition.

2. Informed Consent

I have been provided with information about the risks, benefits, alternatives, and expectations associated with treatment using controlled substances. I understand these risks, including the potential for dependence, misuse, addiction, overdose, and other adverse effects, and I consent to receive this treatment.

3. My Responsibilities

I agree to:

- Take my medication exactly as prescribed, including dose, frequency, and any specific instructions from my provider.
- Attend scheduled appointments and complete any monitoring my provider determines is clinically appropriate.
- Store my medication securely to prevent unauthorized access, loss, or theft.
- Promptly report any changes in my symptoms, side effects, or difficulty following my treatment plan.
- Dispose of unused or expired medication properly, following guidance from my provider or local authorities.
- Obtain controlled substance prescriptions for a given condition only from my Premier Psychiatry provider, unless I have informed my provider and received authorization to receive such prescriptions elsewhere.
- Understand that early refill requests may not be honored except in circumstances my provider determines are appropriate.

4. Monitoring

My provider will determine the type and frequency of monitoring appropriate to my treatment based on clinical judgment, which may include review of the Prescription Drug Monitoring Program (PDMP), urine drug

screening, pill counts, or other clinical assessment. I agree to cooperate with any monitoring my provider requests.

5. Reporting and Accountability

I agree to promptly report any lost or stolen medication, suspicious activity, or concerns about potential misuse or diversion to my provider or appropriate authorities. I understand that I am responsible for the safekeeping and appropriate use of my medication.

6. Reasons Treatment May Be Discontinued

I understand that my provider may discontinue controlled substance prescribing, up to and including termination of this treatment relationship, if I do not comply with the terms of this agreement. This may include, but is not limited to: using medication in a manner inconsistent with how it was prescribed; obtaining controlled substances from another prescriber without disclosing this to my provider; a drug screen result inconsistent with my prescribed treatment; suspected diversion; or repeated early refill requests. This is not an exclusive list.

7. Agreement Review and Revision

This agreement may be reviewed and revised periodically to reflect changes in my treatment, clinic policy, or applicable law. I may be asked to review or sign an updated agreement reflecting these changes.

I have read and understand the terms of this agreement and agree to comply with its provisions.

This Controlled Substance Agreement is provided as part of, and acknowledged through, my signature on Premier Psychiatry's New Patient Intake Packet.

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PATIENT DISCHARGE AND TERMINATION POLICY

Premier Psychiatry is committed to providing continuity of care to our patients. In some circumstances, however, it may become necessary to end the treatment relationship. This policy describes when and how that may occur.

1. Reasons Treatment May Be Discontinued

Premier Psychiatry may discontinue treatment for reasons including, but not limited to:

- The provider determines that their training, skills, or approach are no longer appropriate for the patient's needs.
- Treatment goals have been met and further services are not clinically indicated.
- Repeated non-adherence to treatment recommendations creates a conflict of care or has damaged the provider-patient relationship.
- The patient moves to a state where the treating provider is not licensed to practice.
- Repeated missed appointments, or failure to reschedule or contact the practice within a reasonable time.
- Behavior toward staff or other patients that is abusive, threatening, or unsafe.
- Violation of a signed controlled substance agreement, where applicable.
- Failure to comply with the practice's financial policies, including maintaining a significant unresolved balance despite the opportunity to arrange a payment plan with our billing department.
- The patient initiates a lawsuit, files a formal licensing board complaint, or issues a subpoena against Premier Psychiatry or its providers in a way that creates a conflict of interest with continued treatment.

This is not an exclusive list.

2. Notice and Transition

Except where immediate discontinuation is necessary (see Section 3), Premier Psychiatry will provide written notice of discharge at least 30 days in advance. During this notice period:

- The provider will continue to provide medically necessary care, including prescription refills, as clinically appropriate.
- The practice will offer a written list of referral resources or assist the patient in identifying options for continued care.

- Records will be transferred to a new provider upon the patient's signed authorization.

3. Immediate Discontinuation

Premier Psychiatry may discontinue treatment without the standard notice period if the patient's behavior poses an immediate safety threat to staff, other patients, or the patient, or if continued treatment would violate the law or the practice's licensing requirements. In these circumstances, the practice will still make reasonable efforts to provide the patient with information about emergency resources (911, or 988 for the Suicide & Crisis Lifeline) and options for continued care elsewhere.

4. Provider Unavailability

If a patient's treating provider becomes unavailable to continue care — for example, if they leave the practice — Premier Psychiatry will make reasonable efforts to arrange care with another provider within the practice or to provide appropriate referrals, and will notify the patient in writing.

5. Patient-Initiated Discharge

Patients may choose to end treatment with Premier Psychiatry at any time. We ask that patients notify us in writing when possible so we can assist with a safe transition, including record transfer and referral information upon request.

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FINAL ACKNOWLEDGMENT AND SIGNATURE

By signing below, I confirm that I have read, or had the opportunity to read, and understand the following documents included in this packet, have had the opportunity to ask questions, and agree to their terms:

- New Patient Intake Packet (Sections 1–5), including the Consents & Policies in Section 4
- Notice of Privacy Practices
- Credit Card Authorization
- Telehealth Consent
- Psychotropic Medication Consent
- Controlled Substance Agreement (applicable if controlled substances are prescribed)
- Discharge & Termination Policy

This signature does not apply to Premier Psychiatry's Consent to Exchange Information (ROI), which requires a separate, specific signature and is completed only when needed.

I confirm that the information I provided throughout this packet is accurate to the best of my knowledge.

Patient Name: _____

Patient Signature: _____ Date: _____

If signed by parent/guardian/personal representative:

Print Name: _____

Relationship to Patient: _____