



Womens Health Surgeons

Patient Name: _____ **SS#** _____ **Date of Birth:** _____
(Last) (First) (MI)

Address: _____ **Sex:** M _____ F _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: () _____ **Cell Phone:** () _____

Email: _____

Marital Status: Single Married Divorced Widowed Other: _____

Primary Language:

- English
- Spanish
- Other: _____
- Unreported/Refused

Race:

- White
- Black / African-American
- Asian
- American Indian/Alaskan Native
- Other: _____
- Unreported/Refused

Are You:

- Hispanic/Latino
- Not Hispanic/Latino
- Other: _____
- Unreported/Refused

Pharmacy Preference (Name/Zip Code/phone): _____

Referring Physician (Name/Phone): _____

Responsible Party/Guardian Name: _____ **Relationship:** _____

Address: _____ **Apt#** _____

City: _____ **State:** _____ **Zip:** _____

Phone: () _____ **Date of Birth:** _____ **SS#** _____ **Sex:** M _____ F _____

Primary Insurance Company Name: _____

Policy Holders Name: _____ **Date of Birth** _____

Employer: _____ **Employer's Phone:** () _____

Policy or ID# _____ **Group#** _____

Insurance Company Address _____

City: _____ **State:** _____ **Zip:** _____

Secondary Insurance Company Name: _____

Policy Holders Name: _____ **Date of Birth** _____

Employer: _____ **Employer's Phone:** () _____

Policy or ID# _____ **Group#** _____

Insurance Company Address _____

City: _____ **State:** _____ **Zip:** _____

****Emergency Contact**** Name: _____ Relationship: _____

Home Phone: () _____ Cell: () _____ Work: () _____

You are to provide copies of your current Insurance Card(s) & Drivers License or Photo ID. We reserve the right to refuse treatment if these items are not provided. We also reserve the right to refuse treatment to those persons who use vulgarity or threats to staff or physicians.

ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PURSUE ERISA AND OTHER LEGAL AND ADMINISTRATIVE CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE AND/OR HEALTH BENEFIT PLAN (INCLUDING BREACH OF FIDUCIARY DUTY) AND DESIGNATION OF AUTHORIZED REPRESENTATIVE

I hereby assign and convey directly to the above-named health care provider, as my designated authorized representative, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, and/or medications rendered or provided by the above-named health care provider, regardless of its managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the above-named health care provider to release all medical information necessary to process my claims. Further, I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to the above named health care provider any and all plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from the above-named health care provider or its attorneys in order to claim such medical benefits.

In addition to the assignment of the medical benefits and/or insurance reimbursement above, I also assign and/or convey to the above named health care provider any legal or administrative claim or chose an action arising under any group health plan, employee benefits plan, health insurance or tort fees or insurance concerning medical expenses incurred as a result of the medical services, treatments, therapies, and/or medications I receive from the above-named health care provider (including any right to pursue those legal or administrative claims or chose an action). This constitutes an express and knowing assignment of ERISA breach or fiduciary duty claims and other legal and/or administrative claims.

I intend by this assignment and designation of authorized representative to convey to the above-named provider all of my rights to claim (or place a lien on) the medical benefits related to the services, treatments, therapies, and/or mediations provided by the above-named health care provider, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA branch of fiduciary duty claims). The assignee and/or designated representative (above-named provider) is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chose in action or right against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. The above-named provider as my assignee and my designated authorized representative may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense.

Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA (health care reform legislation), ERISA, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if it was the original.

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

Patient name (please print)

Patient DOB

Patient Signature

Date

Concepcion Diaz-Arrastia, M.D., F.A.C.O.G.

Name: _____

Today's Date: _____

Why are you here today?

PCP (Who sent you?): _____

Pharmacy:
 Zip and Phone#: _____

What is your Insurance? _____

Review Of <u>Current</u> Symptoms · Check All That Apply				
Constitutional	Respiratory	<input type="checkbox"/> Dyspareunia	Skin	Other Conditions:
<input type="checkbox"/> Weight Loss	<input type="checkbox"/> Shortness Of Breath	<input type="checkbox"/> Pelvic pain	<input type="checkbox"/> Rash	
<input type="checkbox"/> Weight Gain	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Postcoital bleeding	<input type="checkbox"/> Lesions	
<input type="checkbox"/> Fever	<input type="checkbox"/> Cough	<input type="checkbox"/> Abnormal vaginal bleed	<input type="checkbox"/> Alopecia	
<input type="checkbox"/> Chills	Gastrointestinal	Musculoskeletal	<input type="checkbox"/> Nail changes	
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> Muscle weakness	Psychiatry	
Eyes	<input type="checkbox"/> Nausea	<input type="checkbox"/> Muscle aches	<input type="checkbox"/> Depression	
<input type="checkbox"/> Vision Changes	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Arthralgia	<input type="checkbox"/> Anxiety	
<input type="checkbox"/> Glasses/Contacts	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Joint swelling	Endocrinology	
ENT	<input type="checkbox"/> Constipation	<input type="checkbox"/> Back pain	<input type="checkbox"/> Hot flashes	
<input type="checkbox"/> Ringing in ears	<input type="checkbox"/> Blood in stool	<input type="checkbox"/> Edema	<input type="checkbox"/> Night sweats	
<input type="checkbox"/> Nose Bleeds	<input type="checkbox"/> Abdominal Bloating	Neurology	Hematological/Lymphatic	
<input type="checkbox"/> Bleeding gums	<input type="checkbox"/> Decreased appetite	<input type="checkbox"/> Burning sensation	<input type="checkbox"/> Easy Bruising	
Cardiovascular	<input type="checkbox"/> Taste disturbances	<input type="checkbox"/> Poor coordination	<input type="checkbox"/> Lymphedema	
<input type="checkbox"/> Chest Pain	Genitourinary	<input type="checkbox"/> Headache	<input type="checkbox"/> Enlarged lymph glands	
<input type="checkbox"/> Palpitations	<input type="checkbox"/> Urinary frequency	<input type="checkbox"/> Difficulty walking		
Chest/Breast	<input type="checkbox"/> Dysuria	<input type="checkbox"/> Tingling		
<input type="checkbox"/> Breast lump	<input type="checkbox"/> Urinary urgency	<input type="checkbox"/> Numbness		
<input type="checkbox"/> Breast pain	<input type="checkbox"/> Hematuria	<input type="checkbox"/> Dizziness		
<input type="checkbox"/> Nipple discharge	<input type="checkbox"/> Bladder pain			

Current Medications		
Name	Dose	Frequency

Health History Form

Patient Name: _____ **Today's Date:** _____

Allergies / Type of Reactions

<input type="checkbox"/> Penicillin	<input type="checkbox"/> Cephalosporin	<input type="checkbox"/> Tetracycline	<input type="checkbox"/> NSAIDS	<input type="checkbox"/> Anesthetics
<input type="checkbox"/> Bandaging Tape	<input type="checkbox"/> Sulfa Drugs	<input type="checkbox"/> Aspirin	<input type="checkbox"/> Narcotics	<input type="checkbox"/> Latex
<input type="checkbox"/> Contrast Material - Iodine	<input type="checkbox"/> Yes - <input type="checkbox"/> No Other _____			

For all that is checked, please explain reaction.

Women's History

Last Period: _____	Age of first period: _____	<input type="checkbox"/> Regular Cycles	Last Pap Smear: _____	Last Pap Smear: _____
Age at 1 st Delivery _____	Pregnancies (Gravida): _____	Deliveries (Para): _____	Abortions (incl. miscarriages): _____	<input type="checkbox"/> Menopause

Medical History (Include Date)

<input type="checkbox"/> Headache/Migraine	<input type="checkbox"/> COPD	<input type="checkbox"/> Reflux	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Peptic Ulcer	<input type="checkbox"/> Bladder Disorder	<input type="checkbox"/> Depression
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Prostate Disorder	<input type="checkbox"/> Cancer
<input type="checkbox"/> Pituitary/Hypothalamic	<input type="checkbox"/> Sleep Apnea	<input type="checkbox"/> Gallstones	<input type="checkbox"/> Venereal Disease	<input type="checkbox"/> HIV
<input type="checkbox"/> Allerg.Rhinitis/Hayfever	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Pancreatitis	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Hyperlipidemia
<input type="checkbox"/> Chronic Sinusitis	<input type="checkbox"/> Angina (Chest Pain)	<input type="checkbox"/> Diabetes Mellitus	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Blood transfusion
<input type="checkbox"/> Thyroid Disorders	<input type="checkbox"/> Peripheral Vasc Dis.	<input type="checkbox"/> Adrenal Disorder	<input type="checkbox"/> Easy Bleeding	
<input type="checkbox"/> Asthma	<input type="checkbox"/> Heart Disorders	<input type="checkbox"/> Renal Disorders	<input type="checkbox"/> Anemia	
<input type="checkbox"/> Other: _____				

Surgical History (Please Check And Date All That Apply)

<input type="checkbox"/> Eye Surgery	<input type="checkbox"/> Parathyroid Surgery	<input type="checkbox"/> Mastectomy	<input type="checkbox"/> D&C	<input type="checkbox"/> Orthopedic Surgery
<input type="checkbox"/> Adenoidectomy	<input type="checkbox"/> Heart Surgery	<input type="checkbox"/> Abdominal Surgery	<input type="checkbox"/> Cesarean Section	<input type="checkbox"/> Spinal Surgery
<input type="checkbox"/> Tonsillectomy	<input type="checkbox"/> Heart Valve Repair	<input type="checkbox"/> Hernia Repair	<input type="checkbox"/> Tubal Ligation	<input type="checkbox"/> Gallbladder Removal
<input type="checkbox"/> Sinus Surgery	<input type="checkbox"/> Abdominal Aortic Aneurism	<input type="checkbox"/> Appendix Removal	<input type="checkbox"/> Tubes Removed	
<input type="checkbox"/> Thyroid Surgery	<input type="checkbox"/> Breast Lumpectomy	<input type="checkbox"/> Breast Biopsy	<input type="checkbox"/> Hysterectomy	<input type="checkbox"/> No Prior Surgery
<input type="checkbox"/> Other: _____				

Social History (Check All That Apply)

<input type="checkbox"/> Single	<input type="checkbox"/> Married, Yrs: _____	<input type="checkbox"/> Separated	<input type="checkbox"/> Widowed	<input type="checkbox"/> Divorced
<input type="checkbox"/> Alcohol Use	<input type="checkbox"/> Do You Smoke? _____	<input type="checkbox"/> Caffeine Use	Cups of Tea/ Day: _____	<input type="checkbox"/> Chocolate Intake
Drinks per day: _____	Cigarette packs per day: _____	Cups of Coffee/ Day: _____	<input type="checkbox"/> Recreational Drug Use	<input type="checkbox"/> Regular Exercise

Previous Tests (Include Date)

<input type="checkbox"/> EKG:	<input type="checkbox"/> Breathing Tests:	<input type="checkbox"/> Mammogram:	<input type="checkbox"/> Test For Stool Blood:	<input type="checkbox"/> Cholesterol:
<input type="checkbox"/> Chest X-Ray:	<input type="checkbox"/> Blood Tests:	<input type="checkbox"/> Prostate Exam:	<input type="checkbox"/> Echocardiogram	<input type="checkbox"/> Cardio Stress Test
<input type="checkbox"/> Colonoscopy				

Patient Name:	Today's Date:
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Family History										
Condition	Father	Mother	Brothers	Sisters	Sons	Daughters	Maternal Grand Mother	Maternal Grand Father	Paternal Grand Mother	Paternal Grand Father
Deceased	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes Mellitus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lung Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ovarian Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breast Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colon Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Adopted: Family History Unavailable										

Family History: Hereditary Breast and Ovarian Cancer Syndromes

Are you of Ashkenazi Jewish descent? YES / NO (circle one)

Please place a check (✓) mark in the boxes below for yourself and family members who have had cancer as indicated. Consider parents, children, brothers, sisters, grandparents, aunts, uncles, and cousins.

Have you or any family members ever been diagnosed with:	You			Family Members			
	No	Yes	Age of diagnosis	No	Yes	Mother's side (✓)	Father's side (✓)
Breast cancer?							
Two or more breast cancers (bilateral or contralateral)?							
Ovarian cancer?							
Male breast cancer?							

List any other cancers in you or your family:

** List all relatives (relation, not name) diagnosed with the above cancers along with age of diagnosis: _____

If you checked yes in one or more boxes on the Family History Questionnaire ask your doctor to assess your cancer history. If your history indicates that you may have an inherited risk of cancer, there is a blood test that can help determine if you are at risk for hereditary cancer.

Please talk to your doctor about reducing your risk and possibly preventing cancer.

P-1: 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.

Uses and Disclosures of Treatment, Payment and Healthcare Operations (TPO) Information

1. Treatment: Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.
2. Payment: Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.
3. Health care operations: Your health information may be used as necessary to support the day-to-day activities and management of **Elizabeth Bonefas, MD, PA**. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.
4. Law enforcement: Your health information may be disclosed to law enforcement agencies without your permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.
5. Public health reporting: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Non- TPO Information:

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

Additional Uses of Information

1. Appointment reminders: Your health information will be used by our staff to send you appointment reminders.
2. Information about treatments: Your health information may be used to send you information on the treatment and management of your condition that you may find to be of interest. We may also send you information describing other health-related goods and services that we believe may interest you.

Individual Rights

You have certain rights under the federal privacy standards. These include:

- the right to request restrictions on the use and disclosure of your protected health information
- the right to receive confidential communications concerning your medical condition and treatment
- the right to inspect and copy your protected health information
- the right to amend or submit corrections to your protected health information
- the right to receive an accounting of how and to whom your protected health information has been disclosed
- the right to receive a printed copy of this notice

Elizabeth Bonefas, MD, PA

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. 'Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

Requests to Inspect Protected Health Information

As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting Frances Schock, Privacy Officer.

Complaints

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Frances Schock
Elizabeth Bonefas, M.D., P.A.
Concepcion Diaz-Arrastia, M.D., P.L.L.C.

1213 Hermann Drive, Suite 675
Houston, Texas 77004

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.

The name and address of the person you can contact for further information concerning our privacy practices is:

Frances Schock, Privacy Officer

**Elizabeth Bonefas, M.D., P.A.
Concepcion Diaz-Arrastia, M.D., P.L.L.C.
1213 Hermann Drive, Suite 675
Houston, Texas 77004
713-756-8555**

Effective Date

This Notice is effective on or after April 15, 2003.

Patient Acknowledgement:

I have received and read the Privacy Notice given to me by the above named Practice. I understand that the disclosure of my protected health information (PHI) will be according to the HIPAA guidelines, as described above.

Name of the Patient

Signature of Patient/Legal Representative

Date



Womens Health Surgeons

PHYSICIAN OWNERSHIP DISCLOSURE FORM

To: New Patients on Date of First Visit with Elizabeth Bonefas, M.D.

During the course of your physician/patient relationship with, Elizabeth Bonefas, M.D. may refer you to St. Joseph Medical Center, Memorial Houston Surgical Center, or St Joseph Cancer Center, (the "Facility").

In connection with any referral to the Facility, you are hereby advised that Elizabeth Bonefas, M.D. has an investment interest in the Facility and therefore will receive, directly or indirectly, remuneration as a result of such referral.

This information is being provided to you at the time of Elizabeth Bonefas, M.D. 's first contact with you as a patient and will also be provided to you at the time of referral, if any, to help you make an informed decision about your health care. You have the right to choose your health care provider. You have the option of obtaining health care ordered by your physician at a different facility other than the Facility. You will not be treated differently by your physician, the physician's staff, or the Facility if you choose to use a different facility.

Should Elizabeth Bonefas, M.D. at any time refer you to the Facility and you prefer to use a different health care provider, you will be advised of alternative health care providers and your right to choose one of these alternative health care providers.

Patient name (please print)

Patient signature

Date