TODAY'S DATE: _____ **NAME:** _____

CDC FACILITIES COVID-19 SCREENING

Accessible version available at https://www.cdc.gov/screening/

PLEASE READ EACH QUESTION CAREFULLY	PLEASE CIRCLE THE ANSWER THAT APPLIES TO YOU	
1. Regardless of your vaccination status, have you experienced any of the symptoms in the list below in the past 48 hours? • fever or chills • cough • shortness of breath or difficulty breathing • fatigue • muscle or body aches • headache • new loss of taste or smell • sore throat • congestion or runny nose • nausea or vomiting • diarrhea	**YES**	**NO**
2. Are you isolating or quarantining because you may have been exposed to a person with COVID-19 or are worried that you may be sick with COVID-19?	**YES**	**NO**
3. Have you been in close physical contact in the last 14 days with: • Anyone who is known to have laboratory-confirmed COVID-19? OR • Anyone who has any symptoms consistent with COVID-19?	**YES**	**NO**
4. Have you traveled in the past 10 days? *Travel is defined as any trip that is overnight AND on public transportation (plane, train, bus, Uber, Lyft, cab, etc.) OR any trip that is overnight AND with people who are not in your household.*	**YES**	**NO**
5. Are you currently waiting on the results of a COVID-19 test	**YES**	**NO**
Did you answer NO to ALL QUESTIONS?	Access to COLFS facilities APPROVED. Please show this to security at the facility entrance. Thank you for helping us protect you and others during this time	
Did you answer YES to ANY QUESTION?	Access to COLFS facilities NOT APPROVED. Please see page 2 for further instructions. Thank you for helping us protect you and others during this time	

CDC Centers for Disease Control and Prevention CS326233-D

cdc.gov/screening

cdc.gov/screening/further-instructions.html

Culture of Life Family Health Care
COLFS Medical Clinic
A Holistic Approach to Healthcare

REGISTRATION FORM

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:	Home phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Chose clinic because/Referred to clinic by (please check one box): ❑ Dr. _____ ❑ Insurance Plan ❑ Hospital
❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other

Other family members seen here: E-mail:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this persona patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance ❑ [Insurance] ❑ [Insurance] ❑ [Insurance] ❑ [Insurance] ❑ [Insurance]
❑ [Insurance] ❑ [Insurance] ❑ [Insurance] ❑ Welfare *(Please provide coupon)* ❑ Other

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian signature *Date*

Mission Statement

Our mission is to promote a culture of life by improving the physical, spiritual and social health of the community. In doing so, we strive to offer the highest quality of compassionate, personalized medical care to all of our patients and clients.

Our ethical guideposts are traditional Christian teachings as set forth by the Catholic Church. We seek to promote and to protect the sanctity of life from the moment of conception until the time of natural death. We acknowledge the dignity of all people and support the basic building block of society, the family.

In supporting life and respecting God's design for human procreation, we offer instruction in the very effective form of natural planning called the Creighton Model of Fertility Care. We also offer NaPro Technology treatments which are aimed at correcting underlying defects in the female reproductive system.

Because of our ethical and moral foundations, we do not prescribe or refer for abortion, contraception, sterilization procedures or euthanasia. We only prescribe erectile devices to men married to women.

We realize that all people may not agree with our mission or our ethical beliefs and we respect their right to disagree. Our refusal to provide certain services that are widely available elsewhere is not intended to be a judgement of others on our part. Rather, this is simply what we are able to offer in good conscience.

I have had an opportunity to review the mission statement.

Signature: _____ *Date:*_____

Culture of Life
Family Health Care

Review of Systems Visit Questionnaire

Before you are seen by our provider, please take a moment to fill out our office visit questionnaire.

Patient Name: _____ Date: _____

Are you currently experiencing any of the following ?

Symptom:	Yes	No
General		
Unexplained weight loss		
Fever		
Allergy/Immunology		
Allergic reaction to medication or environment		
Ear/ Nose/ Eyes/ Throat		
New vision problems		
Sore throat		
Endocrine		
Excessive sweating		
Cold intolerance		
Respiratory		
Cough		
Wheezing		
Shortness of Breath		
Breast		
Breast mass or nodules		
Nipple Discharge		
Heart		
Chest pain		
Heart palpitations		
Abdomen		
Abdominal pain		
Hematology		
Anemia		
Urinary Problems		
Painful urination		
Orthopedics		
Joint pain		
Joint swelling		
Neurology		
Headache		
Numbness/tingling		
Loss of strength		
Psycho-Social		
Depressed mood		
Anxiety or Panic		
FEMALES ONLY		
Irregular periods		
No periods		

Culture of Life Family Health Care

COLFS Medical Clinic
A Holistic Approach to Healthcare

Name: _____

Date: ____/____/_____

Patient Health Questionnaire (PHQ - 9)

Over the last two weeks, how often have you been bothered by any of the following problems?
(*Use "☑ " to indicate your answer*)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself- or that you are a failure or have let yourself or your family down.	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite- being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself.	0	1	2	3

Add Columns: _____+_____+_____

Total: _____

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all ____ Somewhat difficult ____ Very Difficult ____ Extremely Difficult ____

Name: _____

Age: _____ DOB: _____Date: _____

COLFS
Medical Clinic
A Holistic Approach to Healthcare

Adult TB Exposure Risk Assessment

Please answer the following questions by checking the appropriate box:
Por favor de contestar a las siguientes preguntas marcando la respuesta adecuada:

1.	Have you or anyone you see regularly been diagnosed or suspected sick with active TB disease? *¿Usted o cualquier persona que frecuenta ha sido diagnosticado o se sospecha de ser enfermo con tuberculosis activo?*	☐ Yes/Si ☐ No
2.	Have you had symptoms of TB such as cough, chest congestion, fever, night sweats and/or weight loss? *¿Ha tenido síntomas de la tuberculosis tales como tos, congestión de pecho, fiebre, sudor en las noches y/o pérdida de peso?*	☐ Yes/Si ☐ No
3.	Were you born in or travel to high TB prevalence countries (most countries from Asia, Africa, Latin America and parts of Eastern Europe)? *¿Usted es nacido o viaja frecuentemente a países altamente expuestos a la tuberculosis?*	☐ Yes/Si ☐ No
4.	Do you live in out of home placements (such as board & care or residential facilities)? *¿Usted vive en colocaciones caseras (tales como casa de huéspedes o instalaciones residenciales)?*	☐ Yes/Si ☐ No
5.	Do you have an HIV infection or other immunosuppressive condition? *¿Usted tiene la infección de VIH u otra condición inmunosupresora?*	☐ Yes/Si ☐ No
6.	Do you live with someone with HIV? *¿Usted vive con alguien con VIH?*	☐ Yes/Si ☐ No
7.	Do you live or frequently visit with persons who have been incarcerated in the last 5 years? *¿Usted vive o visita con frecuencia a alguien que fue encarcelado en los últimos 5 años?*	☐ Yes/Si ☐ No
8.	Do you have family members or frequent visitors who were born in high TB prevalence countries (most countries from Asia, Africa, Latin America and parts of Eastern Europe)? *¿Usted tiene miembros de familia o invitados nacidos en países altamente expuestos a la tuberculosis?*	☐ Yes/Si ☐ No
9.	Do you live among or been frequently around individuals who are homeless, migrant workers, users of street drugs or residents in nursing homes? *¿Vive usted entre o frecuenta a individuos sin hogar, trabajadores emigrantes, usuarios de drogas o residentes en clínicas de reposo?*	☐ Yes/Si ☐ No

*****TO BE COMPLETED BY THE MEDICAL STAFF/ PARA SER COMPLETADO POR EL PERSONAL MEDICO*****

Administer the Mantoux TB skin test to all adult who have any of the above risk factors (indicated by a Yes response) UNLESS,

1. The patient has a previously documented positive Mantoux TB skin test, or
2. The patient has had a TB skin test within the last 12 months, or
3. The patient has been vaccinated with BCG within the last 12 months.

Reason for TB skin test if other than periodic evaluation:

☐Work ☐School ☐TB Contact ☐Prenatal ☐Other, Specify: _____

Note: Only trained licensed personnel, not parents or guardians may read/interpret the skin test.

Nurse/Provider Signature: _____ Date: _____

Staying Healthy Assessment

Senior

Patient's Name (first & last)	Date of Birth	☐ Female ☐ Male	Today's Date
Person Completing Form *(if patient needs help)*	☐ Family Member ☐ Friend ☐ Other *(Specify)*		Need help with form? ☐ Yes ☐ No

Please answer all the questions on this form as best you can. Circle "Skip" if you do not know an answer or do not wish to answer. Be sure to talk to the doctor if you have questions about anything on this form. Your answers will be protected as part of your medical record.

Need Interpreter? ☐ Yes ☐ No

					Clinic Use Only:
1	Do you drink or eat 3 servings of calcium-rich foods daily, such as milk, cheese, yogurt, soy milk, or tofu?	Yes	No	Skip	Nutrition
2	Do you eat fruits and vegetables every day?	Yes	No	Skip	
3	Do you limit the amount of fried food or fast food that you eat?	Yes	No	Skip	
4	Are you easily able to get enough healthy food?	Yes	No	Skip	
5	Do you drink a soda, juice drink, sports or energy drink most days of the week?	No	Yes	Skip	
6	Do you often eat too much or too little food?	No	Yes	Skip	
7	Do you have difficulty chewing or swallowing?	No	Yes	Skip	
8	Are you concerned about your weight?	No	Yes	Skip	
9	Do you exercise or spend time doing activities, such as walking, gardening, or swimming for at least ½ hour a day?	Yes	No	Skip	Physical Activity
10	Do you feel safe where you live?	Yes	No	Skip	Safety
11	Do you often have trouble keeping track of your medicines?	No	Yes	Skip	
12	Are family members or friends worried about your driving?	No	Yes	Skip	
13	Have you had any car accidents lately?	No	Yes	Skip	
14	Do you sometimes fall and hurt yourself, or is it hard to get up?	No	Yes	Skip	
15	Have you been hit, slapped, kicked, or physically hurt by someone in the past year?	No	Yes	Skip	
16	Do you keep a gun in your house or place where you live?	No	Yes	Skip	
17	Do you brush and floss your teeth daily?	Yes	No	Skip	Dental Health
18	Do you often feel sad, hopeless, angry, or worried?	No	Yes	Skip	Mental Health
19	Do you often have trouble sleeping?	No	Yes	Skip	
20	Do you or others think that you are having trouble remembering things?	No	Yes	Skip	

21	Do you smoke or chew tobacco?	No	Yes	Skip	Alcohol, Tobacco, Drug Use
22	Do friends or family members smoke in your house or where you live?	No	Yes	Skip	
23	In the past year, have you had 4 or more alcohol drinks in one day?	No	Yes	Skip	
24	Do you use any drugs or medicines to help you sleep, relax, calm down, feel better, or lose weight?	No	Yes	Skip	
25	Do you think you or your partner could have a sexually transmitted infection (STI), such as Chlamydia, Gonorrhea, genital warts, etc.?	No	Yes	Skip	Sexual Issues
26	Have you or your partner(s) had sex with other people in the past year?	No	Yes	Skip	
27	Have you or your partner(s) had sex without a condom in the past year?	No	Yes	Skip	
28	Have you ever been forced or pressured to have sex?	No	Yes	Skip	
29	Do you have someone to help you make decisions about your health and medical care?	Yes	No	Skip	Independent Living
30	Do you need help bathing, eating, walking, dressing, or using the bathroom?	No	Yes	Skip	
31	Do you have someone to call when you need help in an emergency?	Yes	No	Skip	
32	Do you have other questions or concerns about your health?	No	Yes	Skip	Other Questions

If yes, please describe:

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered
☐ Nutrition	☐	☐	☐	☐
☐ Physical activity	☐	☐	☐	☐
☐ Safety	☐	☐	☐	☐
☐ Dental Health	☐	☐	☐	☐
☐ Mental Health	☐	☐	☐	☐
☐ Alcohol, Tobacco, Drug Use	☐	☐	☐	☐
☐ Sexual Issues	☐	☐	☐	☐
☐ Independent Living	☐	☐	☐	☐

Comments:

☐ **Patient Declined the SHA**

PCP's Signature:	Print Name:	Date:

SHA ANNUAL REVIEW

PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:

Office Policy

We strive to offer the best quality care to our patients.

In order to accommodate the needs of all, we have established several policies.

Please note the following:

1. All co-payments and patient payments are due the day of your visit.
2. Complete information must be provided regarding your Insurance, your medical history, your address and your phone number.
3. Individual forms (WIC, Physicals, etc.) must be filled out and completed prior to your appointment.
4. Appointments will be rescheduled for late arrivals.
5. **A cancellation fee of $45.00 will be applied for cancelled or missed appointments without 24 hours of notice.**
6. In order to protect the privacy of all our patients, only one person is permitted at the front desk reception. Please take a seat and wait until called.
7. If your insurance denies a medical claim, you will be responsible for all charges.

Thank you for your consideration.

By signing this consent form, I have agreed to the terms and policies listed above.

Signature: _____Date: _____

AUTHORIZATION FOR MEDICAL TREATMENT AND FINANCIALRESPONSIBILITY

COLFS Medical Clinic
A Holistic Approach to Healthcare

Patient Name: _____ **DOB:** _____

1. CONSENT

I authorize my physician and other physicians who may attend me, their assistants, including those employed by the Culture of Life Family Health Care or COLFS Medical Clinic to provide the medical care, tests, procedures, drugs, blood and blood products, services and supplies considered advisable by my physician. These services may includepathology, radiology, emergency services and other special services ordered by my physician(s). In consenting to treatment, I have not relied on any statements as to results.

In the event that any personnel assisting in the provision of care and treatment suffer inadvertent exposure to any of my blood and/or other bodily substance that are capable of transmitting disease and I am unable to consult timely with my physician prior to testing, I consent to limited testing to determine the presence, if any, of antibodies to hepatitis A, B, and C and HIV.

2. MEDICARE/TRICARE INSURANCE BENEFITS

I certify that the information given by me in applying for payment under the Title XVIII of the Social Security Act is correct. I authorize the release of medical or other information to the Medicare Program or its Intermediaries or carriers concerning this, or a related claim filed by Culture of Life Family Health Care or COLFS Medical Clinic. I request that payment of authorized benefits be made on my behalf. I understand that I am responsible for the Part B deductible for each year and/or visit, the remaining co-insurance and any other non-covered personal charges.

I (or my representative) certify that I (or he/she) have read (or if the patient/representative is unable to read has had the form read to him/her) and understand, accepts the above and further certify that I am the patient, or am duly authorized on behalf of the patient to execute such an agreement.

3. GUARANTEE FOR PAYMENT

In accordance with the above terms and in consideration of the services provided to the above-named patient by Culture of Life Family Health Care or COLFS Medical Clinic, the undersigned agrees, whether he/she signs as patient or guarantor, to pay Culture of Life Family Health Care or COLFS Medical Clinic for all services ordered by the attending physician or requested by the patient and/or the patient's family. If the requirements for referral, second opinion or pre-certification of care, as outlined by my insurer, benefit plan or other payer, have not been followed, the patient and/or guarantor may in some instances be personally responsible for all charges incurred.

COLFS
Medical Clinic
A Holistic Approach to Healthcare

4. ASSIGNMENT OF INSURANCE BENEFITS

In consideration of any and all medical services, care, drugs, supplies, equipment and facilities furnished by Culture of Life Family Health Care or COLFS Medical Clinic, all attending physicians, I authorize direct payment to Culture of Life Family Health Care or COLFS Medical Clinic of all insurance benefits applicable to these medical services, which are now, or which shall become due and payable to me.

.

HIPAA – Notice of Privacy Practices Acknowledgement

I acknowledge that I have received, or I have been provided the opportunity to receive a copy of the "Notice of Privacy Practice" that explains when, where, and why my confidential health information may be used or shared. I acknowledge that Culture of Life Family Health Care or COLFS Medical Clinic, the physicians, the nurses and other COLFS staff may use and share my confidential health information with others in order to treat me, in order to arrange for payment of my bill and for issues that concern Culture of Life Family Health Care or COLFS Medical Clinic operations and responsibilities.

Initials of patient or person authorized to sign HIPAA Notice for patient _____

_____

Signature of patient or person Date Patient's relationship to person Authorized to consent

_____

Printed name of patient Patient DOB

_____ _____

Signature of Guarantor Date Patient's Relationship to Guarantor

_____

Signature of Witness Date

HIPPA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describe how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health 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.

Uses and Disclosures of protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside your protected health information may be used and disclosed by your physician, our office staff and other outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to physician to whom you may have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining, approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical students that see patients at our office for learning purposes.

We may use or disclose your protected health information in the following situations without your authorization. These situations include, as required by law: Public Health issues as required by law, Communicable Diseases, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Corners, Funeral Directors, and Organ donation, Research, Criminal Activity, Military Activity and National Security, Worker's Compensation, Inmates.

Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law. You may revoke this authorization at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on this use of disclosure indicated in the authorization.

Your Rights: following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however you may not inspect or copy the following records: psychotherapy notes, information complied in reasonable anticipation of or use in, a civil criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits your request in writing to Culture of Life Family Health Care, Medical Records. You have a right to receive a copy within 30 days of your written request.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restrictions to apply.

Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to receive an accounting of certain disclosures we have made of any of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints:

You may complain to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was re-published and becomes effective on/or before February 12, 2015.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. Please call our office if you have any questions.

I acknowledge that I have read the HIPPA Notice of Privacy Practices. I am signing in the space provided below and giving this along with my Patient Information Sheet with a copy of my Insurance Card.

_____ _____

Signature Date

RX CONSENT

I, _____, give permission for COLFS Medical Clinic to retrieve my prescription history from an external source.

_____

Name Date

Consentimiento de Prescipciones Medicas

Yo, _____, doy permiso para que COLFS Medical Clinic recuperar mi historial de recetas de una fuentes externas.

_____

Nombre Fecha

Staff Initials: _____

Advanced Directives Acknowledgement

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF ADVANCED DIRECTIVE INFORMATION AND FORMS

I acknowledge that I have been given information regarding my right to create Advanced (healthcare) Directives by the staff of Culture of Life Family Healthcare.

I understand that this information will become a part of my permanent medical record.

*If a copy of the package is required, please see receptionist at the front desk.

Name: _____ Date: _____

RECONOCIMIENTO DE LA DECLARACION DE VOLUNTAD ANTICIPADA

Yo reconozco que el personal de Culture of Life Family Healthcare me ha dado la informacion con respecto a mi derecho a crear mi Declaracion de Voluntad Anticipada.

Entiendo que esta informacion formara parte de mi record medico.

*Si require una copia de dicha forma, favor de ir a recepcion.

Nombre: _____ Fecha: _____

PERMISSION TO FURNISH MEDICAL INFORMATION

_____ Initial here if you wish us to furnish information ONLY to you.
In this instance, we will leave a message for you to call our office if you are not immediately available.

OR

Please list persons to whom we may furnish medical information about you (example: blood test results, other tests results, doctor's instructions, etc.) in the event you are not immediately available. Unless otherwise indicated, we will leave a message on your answer machine or voice mail with any routine results or instructions.

THIS AUTHORIZATION WILL BE IN EFFECT UNTIL REVOKED IN WRITING

Approved Person (S)	Relationship to you	Phone #
_____	_____	_____
_____	_____	_____
_____	_____	_____

Patient Name: _____ Date of Birth: _____

Signature: _____ Date: _____