Welcome!

Our practice combines conventional medicine with complementary approaches to look at the whole person, not just the disease. Our doctor uses state-of-the-art medical treatment approaches and equipment to tackle your illness on all fronts, helping you heal in a friendly, professional atmosphere.

Enclosed, you will find a New Patient Record packet that we would like you to complete and bring with you on the day of your visit. It is important that we have the most up-to-date information so the doctor can deliver the best quality care during your visit.

Date: _______________ Time: ________________

****PLEASE PLAN TO ARRIVE 20-30 MIN PRIOR TO YOUR APPT TIME FOR PROCESSING YOUR PAPERWORK. THIS ENSURES YOUR BEING SEEN IN A TIMELY MANNER.*****

You will need to bring the following information to your appointment:

- Medical Records from all physicians who have seen you for the condition for which you are seeing us. THIS IS VERY IMPORTANT!
- X-ray/MRI/CT reports
- Insurance referral from your Primary Care Physician, if needed
- Insurance Card(s) and Picture I.D.
- Co-pay (Cash/Checks/Credit Cards). This is required at the time of the appointment.
- Completed New Patient Record (front and back).

We look forward to meeting you. We strive to give every patient a complete evaluation. Please help us maintain our quality service by giving us ample notice if you need to reschedule. There will be a $50 cancellation fee charged directly to the patient when an appointment is cancelled less than 48 business hours prior to the appointment time.

Directions to our office:

From 95 North:
- Take EXIT 126, toward FREDERICKSBURG
- Turn LEFT onto US-1 N/US-17/JEFFERSON DAVIS HWY.
- Turn RIGHT onto MARKET ST.
- Turn RIGHT on SPOTSYLVANIA AVE.
- Go 0.2 mi, End at 10340 Spotsylvania Ave
the brick building on the right-hand side

From 95 South:
- Take EXIT 126A, toward SPOTSYLVANIA
- Turn RIGHT onto MARKET ST
- Turn RIGHT on SPOTSYLVANIA AVE.
- Go 0.2 mi, End at 10340 Spotsylvania Ave
the brick building on the right-hand side

From Route 1 South:
- Turn LEFT onto MARKET ST.
- Turn RIGHT on SPOTSYLVANIA AVE.
- Go 0.2 mi, End at 10340 Spotsylvania
the brick building on the right-hand side

From Route 1 North:
- Turn RIGHT onto MARKET ST
- Turn RIGHT on SPOTSYLVANIA AVE
- Go 0.2 mi, End at 10340 Spotsylvania Ave
the brick building on the right-hand side

Thank you,
Dr. Anne Truong and Staff
Board Certified Physical Medicine and Rehabilitation
Patient:

First name: ___________________________ Last Name: __________________________ Middle Initial: _______ Age: _______

Date of Birth: ____/____/_______ (Circle one) Male Female

Mailing Address: __________________________________________ Cellular Ph: (______)_______-__________

Physical Address: __________________________________________ Home Ph: (______)_______-__________

City: __________________________ St. ______ Zip ____________ VA Driver License#: ___________________

Social Security #: ___________-________-______________ Email Address __________________________________

Emergency Contact: __________________________ Relationship: __________ Emergency Phone:(_______) -__________

Pharmacy: __________________________________________ Location: __________________________ Phone: __________________

Spouse: (must complete)

Spouse Name: ______________________________________ Date of Birth: ____/____/_______

Occupation: ______________________________________ Spouse’s Work Ph: (_______)_______-______

Social Security #: ___________-________-______________ Spouse’s Work Address ______________________________________

Employer: (must complete)

Employer: ______________________________________ Occupation: _____________________________

Work Address: ______________________________________ Work Phone:(_______)_______-______ Ext ______

Workman’s Compensation (WC): (must complete)

Are you here for care and treatment related to an injury or issue at work (circle one)? YES / NO

Have you filed a workers’ compensation claim (circle one)? YES / NO

If Yes to any of the above, we can’t treat you unless we have a prior, written authorization from your WC carrier

W/C Carrier: __________________________ Contact: __________________________

Phone Number: __________________________ Fax Number: __________________________

Claim #: __________________________________________ Date of Injury: __________________________

Responsible Party (for insurance): (must complete)

Responsible Party or Guardian (if under 18): __________________________________________

Address: __________________________________________ Relationship: _____________________________

Phone Number: (_______)_______-__________ Social Security #: ___________-________-______________

Employer: ______________________________________ Work Phone: (_______)_______-__________

Insurance: (must complete)

Primary Insurance Co: __________________________

ID#: __________________________ Plan: _______________ Group: __________________________

Subscriber’s Name: __________________________ Relationship: _____________________________

Effective Date of Plan: __________________________

Secondary Insurance Co: __________________________

ID#: __________________________ Plan: _______________ Group: __________________________

Subscriber’s Name: __________________________ Relationship: _____________________________

*To whom do you authorize us to release information? Answering machine ☐ yes ☐ no

Work voice mail ☐ yes ☐ no Other: (Name and Relationship): __________________________

*Preferred method of appointment reminder: ☐ Phone ☐ Email ☐ Both

*What number do you want us to call for appointment reminders and test results? __________________________
AUTHORIZATION FOR TREATMENT

I consent to examination, treatment, and procedures that may be performed during office visits as ordered by my physician, or by his/her consultants, associates, or designees; by any employee personnel; and/or agent of my physician who may carry out part or all of my treatment including emergency treatment considered necessary by my physician and/or designated providers. I understand that the practice of medicine is not an exact science and acknowledge that no guarantees have been made or implied regarding my care and treatment. I hereby authorize my physician to retain, preserve, and/or use for medical documentation, scientific and/or teaching purposes any photographs, specimens and/or tissues taken as a part of my hospital procedure. I understand these will be properly discarded according to my physician’s policy. By law, I understand that if there is an at-risk exposure to my blood or body fluids, I may be tested for HIV, Hepatitis B or C Virus. Those test results will be shared with the healthcare worker who was exposed.

FINANCIAL RESPONSIBILITY & ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign payment directly to this physician for services covered by insurance. I assume financial responsibility for and agree to make payment in full to this physician for all charges for services or medical supplies furnished but not covered by my insurance carrier. Authorization for office visit, if required, must be obtained in advance from your insurance carrier. Though we can assist in this, the patient has primary responsibility for obtaining this important pre-treatment authorization. (Please be aware that a “referral” from your Primary Care Physician is not an “authorization”). Should you arrive at the office without the required insurance authorization, and still choose to be seen by the doctor, you will be expected to pay 100% of all office charges at the time of service. This policy applies to all patients, including those with HMO/PPO coverage. Should you come for a scheduled appointment without the required authorization, and subsequently elect to reschedule, a $25.00 service charge will be added to your account. Insurance does not cover this charge. Any co-pay and/or fees for noncovered services are due at time of visit. If no payment is received from your carrier within 45 days of initial filing, you may be asked to pay your balance in full. We appreciate your understanding.

Please Note: Your insurance provider has a contract with you, and you are ultimately responsible for all charges. Should you receive a bill from our office, payment in full of the “Patient Balance” is due by the due date indicated, unless other arrangements have been specifically made. There will be a $10.00 charge for every subsequent statement that is sent out to you for an unpaid balance. Payment of all balances is due prior to your next appointment.
Returned Check Policy: If a check is returned for insufficient funds, $50.00 will be added to your account. If any balance is not paid in full within 48 hours, an additional $50.00 fee will be added.

Collections Policy: Accounts 120 days overdue, without an arranged payment plan, or as deemed warranted by the practice, will be turned over to our attorney for collection. In the event that your account is referred for collection, you agree to pay all costs incurred in collecting the amount due, including an additional amount for collection fees.

RESCHEDULING/CANCELING/NO-SHOW POLICY/STATEMENT: In order to ensure that our patients enjoy the most timely and reliable access to our physicians, this office has established a firm policy for “No Shows” and late cancellations. Should you fail, without notice, to keep a scheduled appointment, or fail to cancel an appointment with less than at least 48 business hours, Monday to Friday 8:30 am – 4:30 pm in advance. A no show or late cancellation will result in a charge $50 fee on your credit card on file. We will collect your credit card information when you schedule your first appointment and keep confidentially in your account. To cancel your appointment, you can call 540-374-3164, if the office is closed, you can leave a message on voice mail. You can also go online to Patient Portal on our website at www.truongrehab.com or use the Healow app on your smart phone. Insurance will not cover this charge. Note: A 5% fee will be assessed for refund if appointment is canceled prior to 48 business hours. A 10% fee will be assessed for paid treatment on PRP/Stem Cell/BHRT (Hormone)/Weight Loss/Sexual/Aesthetics if canceled.

AUTHORIZATION FOR RELEASE OF INFORMATION
I authorize this physician to release to my insurance carrier and its designated agents any information concerning medical care, advice, treatment or supplies provided to the patient for purposes of administration, review, investigation or evaluation of coverage claims and utilization of services. I know I have a right to receive a copy of this authorization upon request and agree that a photographic copy of this authorization is as valid as the original.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION
I understand that Rehabilitation Medicine Physicians may use and disclose my Protected Health Information for purposes of treatment, payment, and health care operations. A copy of the document Protected Health Information (PHO) is available to you in the reception area, on our website www.truongrehab.com, or on request from us directly. I also acknowledge that I have received, have been offered, or have received in the past, a copy of the practice’s Notice of Privacy Practices (NoPP) which provides information about how the practice and individuals involved in my care in the practice may use and disclose my Protected Health Information. As stated in the NoPP, the terms of the Notice may change. To obtain a copy of any current Notice, I understand that I can contact the Privacy Officer at (540) 374-3164.

I understand that I have the right to request that the practice restrict how my Protected Health Information is used or disclosed for treatment, payment, or health care operations, but I also understand that the practice is not required to agree to a requested restriction. However, if the practice does agree, it is bound by that agreement. I understand that I have the right to revoke this consent in writing at any time, except to the extent that the practice, or individuals involved in my care in the practice, have already used or disclosed Protected Health Information in reliance on my prior consent.

Signature of Patient or Guardian: ___________________________________________ Date __/__/____
Office Staff Signature: ______________________________________________________ Date __/__/____
Allergies (circle if yes)  None  Novocaine  Iodine  Latex
Medication allergies and adverse reactions: _______________________________________________________

Medications / Prescription Drugs
List all the medications you are taking (including over-the-counter medications, herbs, supplements, etc.):

<table>
<thead>
<tr>
<th>Medications</th>
<th>Dosage</th>
<th>Frequency</th>
<th>Prescribing Dr.</th>
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</table>

Supplement Assessment
Do you take supplements? _____________________ Why or why not? ________________________________
If yes, how do you select your supplements? ___________________________________________________
Estimated monthly supplement cost: _______________ Are your supplements working? _________________
How do you know? ____________________________________________________________________________

Besides your number one health concern, please circle any additional concerns that you may have:

Bone and Joint Strength  Immune System  Premature Aging
Cancer  Inflammation  Sleep Patterns
Diabetes  Mental Acuity  Stress
Energy Levels  Mood Swings  Vision (AMD)
Heart Disease  Periodontal Health  Weight Issues

Commitment to Improving your Health
Low Commitment  Medium Commitment  High Commitment  Just Don’t Know

Social History
Status:  Single, Married, Divorced, Partnered, Widowed  __ Retired, __ Working: _____ hrs/week
Currently living with: _________________________  On disability?  No  Yes  When? ___/___/_____
Have you ever smoked?  No  Yes  Alcohol use:  Never, Rarely, Moderate, Daily
If yes, how many / day: ____  Quit: ___/___/_____
History of drug abuse:  No  Yes  Highest Education Level Completed:
History of alcohol abuse:  No  Yes  ______ Grade Completed  ______ High School
____________ College  ______ Post Graduate

What is your primary health concern? ____________________________________________________________
How are you addressing it? ___________________________________________ Do you feel what you are doing is working? yes no
How many servings of fresh fruits and vegetables do you eat daily? ____________  Are you at your ideal weight? yes no
How often do you exercise for 30 minutes or more per day?  2/wk  4/wk  6/wk
### Medical History

#### Past & Current Medical Conditions:

<table>
<thead>
<tr>
<th>Condition</th>
<th>No</th>
<th>Yes</th>
<th>High Blood Pressure</th>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td></td>
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<tr>
<td>Cancer (type: ______________)</td>
<td></td>
<td></td>
<td>Stroke</td>
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<tr>
<td>Heart Arrhythmia (atrial fibrillation)</td>
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<td></td>
<td>Arthritis/gout</td>
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<td>Seizure</td>
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<td></td>
<td>Bleeding tendency</td>
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<tr>
<td>Hereditary defects, (type: ________)</td>
<td></td>
<td></td>
<td>Venereal Disease</td>
<td></td>
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<tr>
<td>Circulation problems</td>
<td></td>
<td></td>
<td>Asthma</td>
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<tr>
<td>Emphysema</td>
<td></td>
<td></td>
<td>Thyroid Disease (low-high)</td>
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<tr>
<td>High Cholesterol</td>
<td></td>
<td></td>
<td>Fibromyalgia</td>
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<tr>
<td>Endometriosis</td>
<td></td>
<td></td>
<td>Heart attacks</td>
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<tr>
<td>Hepatitis (A,B,C)</td>
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<td>Cataract</td>
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<tr>
<td>Ulcer (Stomach, Duodenum)</td>
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<td>Glaucoma</td>
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<td>Hemorrhoids</td>
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<td>Multiple Sclerosis</td>
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<tr>
<td>Thyroid Disease (low-high)</td>
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<td>Lupus</td>
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<tr>
<td>Circulation problems</td>
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<tr>
<td>Other:</td>
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</table>

#### Other:

- Past surgeries: (List date & reason)

- Hospitalizations: (List date & reason)

### Family Medical History

**Check all that apply**

<table>
<thead>
<tr>
<th>Family Members</th>
<th>Diabetes</th>
<th>Hypertension</th>
<th>Heart Disease</th>
<th>Stroke</th>
<th>Mental Illness</th>
<th>Cancer</th>
<th>Unknown</th>
<th>Deceased</th>
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<tbody>
<tr>
<td>Father</td>
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<td>Mother</td>
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<td>Children</td>
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<tr>
<td>Siblings</td>
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</table>

- **Siblings:** # of brothers ____ # of sisters ____ □ Healthy
- **Children:** # of sons ____ # of daughters ____ □ Healthy

### Review of Systems: Patient to Complete - Circle if Applicable

<table>
<thead>
<tr>
<th>System</th>
<th>Constitutional</th>
<th>Skin</th>
<th>Eye, Ear, Nose, Throat, Mouth</th>
<th>Respiratory</th>
<th>Cardiovascular</th>
<th>Gastrointestinal</th>
<th>Genitourinary</th>
<th>Endocrine</th>
<th>Musculoskeletal</th>
<th>Neurologic</th>
<th>Psychiatric</th>
<th>Hematological</th>
<th>Other Systems</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Appetite Change</td>
<td>Itching</td>
<td>Vision Changes</td>
<td>Cough</td>
<td>Chest Pain</td>
<td>Nausea</td>
<td>Frequency</td>
<td>Diabetes</td>
<td>Joint Pain</td>
<td>Headaches</td>
<td>Numbness</td>
<td>Anemia</td>
<td>Abnormal Mammogram</td>
<td>Bone Fractures</td>
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<tr>
<td></td>
<td>Weight Change</td>
<td>Rash</td>
<td>Swollen Glands</td>
<td>Wheezing</td>
<td>Palpitations</td>
<td>Bloody Stool</td>
<td>Blood in Urine</td>
<td>Thyroid Disease</td>
<td>Difficulty Walking</td>
<td>Paralysis</td>
<td>Pain</td>
<td>Bruise Easily</td>
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<tr>
<td></td>
<td>Fever</td>
<td></td>
<td>Headaches</td>
<td>Blood in Sputum</td>
<td>Swelling in Legs</td>
<td>Vomiting</td>
<td>Decreased flow/force/dribbling</td>
<td>Steroid Use</td>
<td>Muscle Pain</td>
<td>Tingling</td>
<td>Stress</td>
<td>Slow Healing</td>
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<tr>
<td></td>
<td>Fatigue</td>
<td></td>
<td>Dizziness</td>
<td>Lung Cancer</td>
<td>Difficulty Breathing</td>
<td>Bowel Incontinence</td>
<td>Urinary Incontinence</td>
<td>Heat/Cold Intolerance</td>
<td>Stiffness</td>
<td>Stroke</td>
<td>Painful Urination</td>
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<td></td>
<td>Hearing Loss</td>
<td>Difficulty Breathing</td>
<td>Constipation</td>
<td>Difficulty Swallowing</td>
<td>Painful Urination</td>
<td>Kidney Stones</td>
<td>Back Pain</td>
<td>Seizures</td>
<td>Difficulty Speaking</td>
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<td>Ringing Ears</td>
<td>Ulcer</td>
<td>Difficulty Swallowing</td>
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<td>Weakness</td>
<td>Head Injuries</td>
<td>Head Injury</td>
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<td>Blood Transfusion</td>
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<td>Cancer</td>
<td>Difficulty Swallowing</td>
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**Other Systems:** Abnormal Mammogram ____ / ____ / ____ **Bone Fractures ____ / ____ / ____

**Comments**
History of Presenting Problem:
Referring physician: ________________________________________________________________
Primary care physician: _____________________________________________________________
Reasons for today’s visit: ___________________________________________________________
What other physician(s) have you seen for this condition? _______________________________
                      When?   /   /   
                      When?   /   /   
Have you had any type of therapy for this condition?                                 
                      When?   /   /   
                      When?   /   /   
Have you received any medications/injections for this condition? If Yes, What? / When?  
How did you hear about us? _________________________________________________________
Where is the pain/problem? _________________________________________________________
Severity of pain (Scale 1-10): _______ How long have you had this problem? ______ Days  
                           ______ Months
Quality of the pain, describe: ____________________________________________________
When did it start?       /    /    (circle one) dull, sharp, ache, burning, tingling, electric shock
What is the characteristic of your pain? ____________________________________________
Does it radiate? (circle one)  No   Yes    Where? _________________________________
What do you want to accomplish by my treating you? ________________________________
What time of day is pain the most severe? ___________________________________________
What do you do to relieve pain? ___________________________________________________
What activity makes the pain worse? ________________________________________________
Any MRI, CAT scan, X-ray for these conditions? ____________________________________  
                      When?   /   /   Where? 
                      When?   /   /   Where? 

All information is accurate and complete. Signature of Patient or Guardian__________________________
Informed Consent for Televisit Consultation and Follow up

I am requesting to take part in a telemedicine consultation with Rehabilitation Medicine Physicians and its physicians, associates, technical assistants and others deemed necessary to assist in my medical care through a telemedicine consultation. I understand the following:

1. The purpose is to assess and treat my medical condition.

2. The telemedicine consult is done through a two-way video HIPAA compliant link-up whereby the physician or other health provider at Rehabilitation Medicine Physicians can see my image on the screen and hear my voice. However, unlike a traditional medical consult, the physician or other health provider does not have the use of the other senses such as touch or smell; and it may not be equal to a face-to-face visit.

3. Since the telemedicine consultants may practice in a different location and do not have the opportunity to meet with me face-to-face, they must rely on information provided by me. The Rehabilitation Medicine Physicians and affiliated telemedicine consultants cannot be responsible for advice, recommendations and/or decisions based on incomplete or inaccurate information provided by me or others.

4. I can ask questions and seek clarification of the procedures and telemedicine technology.

5. I can ask that the telemedicine visit and/or video conference be stopped at any time.

6. I know there are potential risks with the use of this technology. These include but are not limited to:
   ● Interruption of the audio/video link.
   ● Disconnection of the audio/video link
   ● A picture that is not clear enough to meet the needs of the consultation.
   ● Electronic tampering.
   If any of these risks occur, the procedure might need to be stopped.

8. In order to participate in the telemedicine program, I agree to pre-pay for these visits at: select one
   [ ] $150 for 15 minutes – Prepaid. I understand the service will stop at the 15 minute mark automatically. This fee will not be refundable or applied to future visit if the appointment is cancelled less than 48 business hours. A 5% fee will be assessed for refund if appointment is canceled prior to 48 business hours.
   [ ] $300 for 30 minutes (initial consultation) – Prepaid. I understand the service will stop at the 30 minute mark automatically. This fee will not be refundable or applied to future visit if the appointment is cancelled less than 48 business hours. A 5% fee will be assessed for refund if appointment is canceled prior to 48 business hours.
   [ ] Copay with Anthem Insurance – Prepaid. I understand the service will stop at the 15 minute mark automatically. This fee will not be refundable or applied to future visit if the appointment is cancelled less than 48 business hours. A 5% fee will be assessed for refund if appointment is canceled prior to 48 business hours.

By signing this consent, I agree to the charges on my credit card or Care Credit. I understand these services are self-pay or bill to Anthem. I, the undersigned patient, do hereby understand and state that I agree to the above consents and I am doing so of my own free will. I understand I can always opt for an in person office visit. I certify that this form has been fully explained to me. I have read it or have had it read to me. I understand and agree to its contents.

I volunteer to participate in the telemedicine examination. I authorize Rehabilitation Medicine Physicians and the doctors, nurses, and other providers involved to perform procedures that may be necessary for my current medical condition.

Date: _______________ Signature:_________________________________________________

Printed Name: _______________________________  8 of 8

07/19/2021