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Sean Wren, PA-C

Louis R. Jordan, MD, *Emeritus*  
David B. Young, MD, *Emeritus*

Jim McNamara, CEO

Welcome to the Jordan-Young Institute for Orthopedic Surgery, Sports Medicine, Neurosurgery, and Physical Medicine & Rehabilitation. Thank you for choosing us to serve you. It is our pleasure to assist you in improving your quality of life with medical and surgical options that will maximize your mobility and minimize your pain.

In this packet, you will find both information about our practice and forms you must complete for us to assist in your care. Please read these forms carefully and fully complete each one prior to your appointment. In addition to these completed forms, you will need to bring the following to your appointment:

- Your current insurance cards
- Photo identification
- A referral from your primary care provider, if required by your insurance carrier
- Films and reports from any pertinent diagnostic testing, such as x-rays, MRIs, EMGs, CT scans, and bone density studies
- Any co-payment and deductible payments that your insurance coverage holds you responsible for to receive care. We accept cash, check, VISA, MasterCard, Discover, and American Express. Your appointment will be rescheduled if you cannot pay your co-pay before being seen.

PLEASE PLAN TO ARRIVE 30 MINUTES PRIOR TO OUR SCHEDULED APPOINTMENT TIME so that we can complete your registration, medical record and x-rays prior to your appointment with the physician. Even if you bring x-rays or other diagnostic tests with you, your physician may require additional films to be taken in our office. Dress in comfortable clothing that will allow your physician to easily view the injured or painful areas of your body. While your physician strives to maintain a timely office schedule, please realize that some wait time may occur. Our physicians give each patient the time necessary to understand their condition and the options available for treatment.

If you have additional questions about our practice, our providers, or your appointment, please visit our website at [www.Jordan-YoungInstitute.com](http://www.Jordan-YoungInstitute.com) or call our office at (757)490-4802.

Again, thank you for choosing Jordan-Young Institute. We look forward to seeing you.

## DIRECTIONS TO JORDAN-YOUNG INSTITUTE

5716 Cleveland Street, Virginia Beach, VA – (757)490-4802 - [www.Jordan-YoungInstitute.com](http://www.Jordan-YoungInstitute.com)

Jordan-Young Institute is located on Cleveland Street off Newtown Road. Cleveland Street from the Pembroke area ends at Clearfield. There is no direct roadway to Jordan Young Institute on Cleveland Street coming from the east.

### FROM NORFOLK/PORTSMOUTH

- Take 264 East
- Exit toward 1-64 E/Chesapeake/Newtown Road
- Take Newtown Road (Exit 15A - stay to the left when exiting)
- Left on Newtown Road. Go down three traffic lights.
- Right onto Cleveland Street (Patient First is on the corner)
- Jordan-Young Institute is first business building on the left (the name is on building)
- Our office is on the second floor
- **Please note Dr. Horn & Dr. Levi's office is on the 1st floor - Suite 140**

### FROM THE BEACH

- Take 264 West
- Exit Newtown Road (Exit 15)
- Turn right onto Newtown Road.
- Turn right onto Cleveland Street (Patient First is on the corner)
- Jordan-Young Institute is first business building on left (the name is on the building)
- Our office is on the second floor
- **Please note Dr. Horn & Dr. Levi's office is on the 1st floor - Suite 140**

### FROM CHESAPEAKE

- Take Route 64 to Route 264 exit toward Virginia Beach.
- Take Newtown Road (Exit 15A- stay to the left when exiting)
- Left on Newtown Road. Go down three traffic lights.
- Right onto Cleveland Street (Patient First is on the corner)
- Jordan-Young Institute is first business building on left (the name is on the building)
- Our office is on the second floor
- **Please note Dr. Horn & Dr. Levi's office is on the 1st floor - Suite 140**

### FROM HAMPTON AND NEWPORT NEWS AREA

- Take 64 East
- Exit Newtown Road. (Exit 284B)
- Take Newtown Road (Exit 15A- stay to the left when exiting)
- Left on Newtown Road. Go down three traffic lights.
- Right onto Cleveland Street (Patient First is on the corner)
- Jordan-Young Institute is first business building on left (the name is on the building)
- Our office is on the second floor
- **Please note Dr. Horn & Dr. Levi's office is on the 1st floor - Suite 140**

**PLEASE BRING YOUR INSURANCE CARDS AND THIS COMPLETED FORM TO YOUR FIRST APPOINTMENT**



**PATIENT INFORMATION**

ACCOUNT # \_\_\_\_\_

PATIENT NAME \_\_\_\_\_ MAIDEN/OTHER NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_ EMAIL \_\_\_\_\_

AGE \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_  MALE  FEMALE MARITAL STATUS \_\_\_\_\_

HOME PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_

SOCIAL SECURITY NUMBER \_\_\_\_\_

EMPLOYER \_\_\_\_\_ EMPLOYER PHONE \_\_\_\_\_

OCCUPATION \_\_\_\_\_

PRIMARY CARE PROVIDER \_\_\_\_\_

REFERRING PHYSICIAN \_\_\_\_\_

**RESPONSIBLE PARTY OR SPOUSE**

NAME \_\_\_\_\_ MAIDEN/OTHER NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

HOME PHONE \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_

CELL PHONE \_\_\_\_\_ OCCUPATION \_\_\_\_\_

EMPLOYER \_\_\_\_\_ EMPLOYER PHONE \_\_\_\_\_

**PRIMARY HEALTH INSURANCE INFORMATION**

COMPANY NAME \_\_\_\_\_ EFFECTIVE DATE \_\_\_\_\_

POLICY HOLDER NAME \_\_\_\_\_ POLICY NUMBER \_\_\_\_\_

POLICY HOLDER DATE OF BIRTH \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_

PATIENT'S RELATIONSHIP TO POLICY HOLDER:  SELF  SPOUSE  CHILD  OTHER

GROUP # \_\_\_\_\_

**SECONDARY HEALTH INSURANCE INFORMATION**

COMPANY NAME \_\_\_\_\_ EFFECTIVE DATE \_\_\_\_\_

POLICY HOLDER NAME \_\_\_\_\_ POLICY NUMBER \_\_\_\_\_

POLICY HOLDER DATE OF BIRTH \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_

PATIENT'S RELATIONSHIP TO POLICY HOLDER:  SELF  SPOUSE  CHILD  OTHER

GROUP # \_\_\_\_\_

**EMERGENCY CONTACT INFORMATION**

NAME OF CONTACT \_\_\_\_\_

TELEPHONE \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

**I HEREBY CONSENT TO TREATMENT** by Jordan Young Institute physicians, their associates, and/or assistants and accept responsibility for fees for such medical services. I understand that treatment may include x-rays, injections, medical appliances and/or other procedures as deemed necessary.

### **DEEMED CONSENT**

I understand that, in accordance with Section 32.1-45.1 of the Code of Virginia, 1905, as amended, if a Jordan-Young Institute, P.C. healthcare provider is exposed to my blood or other bodily fluids in a manner which may transmit disease, I may be tested for infection with Human Immunodeficiency Virus (HIV), the virus which causes Acquired Immune Deficiency Syndrome (AIDS) or Hepatitis B or C viruses. I further understand that the results of any such test will be shared with me and the exposed healthcare provider; that the Virginia Department of Health will be notified; and that appropriate counseling shall be provided if the results are positive.

### **DISABILITY / FMLA FORM INFORMATION**

Jordan-Young Institute, P.C. staff will complete all disability and/or FMLA forms that you require, within two weeks of the date requested. We are unable to complete forms while you wait. We require a fee of \$35 for completion of all disability and FMLA forms.

### **PATIENT AUTHORIZATION**

I authorize Jordan-Young Institute, P.C. to release medical information necessary to submit my health insurance or Worker's Compensation Claims. I request that my health insurance or Worker's Compensation claims be paid directly to Jordan-Young Institute, P.C. In consideration of the services rendered, I/we agree and understand that each person(s) signing this document jointly and severable agrees to pay for all services rendered by Jordan-Young Institute, P.C. If this account is referred to an outside collection agency or attorney, then the undersigned person(s) agree and promise to pay all collection costs including attorney fees of 33 1/3 % of the principal amount due and owing when turned over for collection and do further agree to pay interest on the unpaid balance at the legal rate from the date services were last rendered. I authorize photocopies of this form to be valid as the original.

### **POLICY FOR FORMS COMPLETION AND THE COPYING OF MEDICAL RECORDS AND X-RAYS**

Any request for medical records require a medical release to be completed. Medical records will be filled within two weeks of date requested. Please see medical release form for all charges that may apply. Please allow one week for any request of x-ray films. There will be a charge of \$5 per x-ray film.

### **PRESCRIPTION REFILL POLICY**

To request a prescription refill, please call us Monday through Friday, from 9:00a.m. to 4:00 p.m. .. Please allow 24 hours for us to process your prescription refill request. Prescriptions for narcotics cannot be ordered after hours or on weekends. Please remember to call us in advance so that we can assist you in a timely manner.

### **CLINICAL RESEARCH ACTIVITY**

The physicians of Jordan-Young Institute are involved in clinical research studies and trials and work closely with Jordan Research Foundation. The companies sponsoring these studies and trials provide financial support for research staff as well as for activities the physicians perform outside of clinical practice. These activities may include consulting, advisory boards, giving speeches and/or presentations, or writing reports. If you would like more information please ask to speak with the Jordan Research Foundation's Research Coordinator.

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Patient or Guardian's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Relationship to Patient** \_\_\_\_\_

# PATIENT HISTORY

**PLEASE BRING THIS COMPLETED FORM WITH YOU TO  
YOUR FIRST APPOINTMENT**



**JORDAN YOUNG INSTITUTE**

ORTHOPEDIC SURGERY • SPORTS MEDICINE  
NEUROSURGERY • PHYSICAL MEDICINE & REHABILITATION

TODAY'S DATE \_\_\_\_\_

NAME \_\_\_\_\_ NICKNAME \_\_\_\_\_ AGE \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ HEIGHT \_\_\_\_\_ FT \_\_\_\_\_ IN WEIGHT \_\_\_\_\_ LBS BMI \_\_\_\_\_

WHO REFERRED YOU HERE? (NAME/ADDRESS) \_\_\_\_\_

INTERNIST/PCP NAME/ADDRESS \_\_\_\_\_

CARDIOLOGIST \_\_\_\_\_ OTHER SPECIALIST(S) \_\_\_\_\_

REASON FOR YOUR VISIT (HIP/KNEE) \_\_\_\_\_ LEFT/RIGHT/BOTH FOR \_\_\_\_\_ MONTHS \_\_\_\_\_ YEARS

WHERE IS THE PAIN? FRONT/BACK/INNER/OUTER/ALL OVER \_\_\_\_\_

WHAT MAKES IT BETTER? \_\_\_\_\_

WHAT MAKES IT WORSE? \_\_\_\_\_

HAVE YOU TRIED ANY OF THESE?  BRACING  CANE  WEIGHT LOSS \_\_\_\_\_ #  THERAPY HOW LONG? \_\_\_\_\_

INJECTIONS?  STEROID LAST: \_\_\_\_\_ HOW MANY \_\_\_\_\_  VISCO (SYNVISC, EUFLEXXA, ETC) LAST: \_\_\_\_\_ HOW MANY \_\_\_\_\_

ANTI-INFLAMMATORY MEDICATIONS (PAST AND PRESENT – WHICH? ALEVE, ADVIL, CELEBREX, MOBIC, ETC.) \_\_\_\_\_

HAVE YOU HAD SURGERY ON THIS BODY PART? (Scope or Other and When) \_\_\_\_\_

HAVE YOU HAD A CT SCAN OR MRI OF THIS BODY PART? (WHERE/WHEN) \_\_\_\_\_

HAVE YOU SEEN OTHER PROVIDERS FOR THIS CONDITION (WHO/WHEN) \_\_\_\_\_

IS THIS PROBLEM DUE TO AN ACCIDENT?  Y  N IS THIS A WORKERS COMP CLAIM?  Y  N

DATE OF INJURY \_\_\_\_\_ WHERE DID THE INJURY OCCUR? \_\_\_\_\_

HOW DID THE INJURY OCCUR (SPORTS, WORK, MOTOR VEHICLE ACCIDENT)? \_\_\_\_\_

PAIN AT NIGHT:  Y  N PAIN LEVEL (1-10) \_\_\_\_\_ DIFFICULTY SLEEPING:  Y  N BACK PAIN:  Y  N

**PAIN:** MILD MODERATE SEVERE TOTALLY DISABLING **LIMP:** MILD MODERATE SEVERE UNABLE TO WALK

**NEED ASSISTANCE:** NONE CANE AT TIMES CANE FULL TIME WALKER WHEELCHAIR

**HOW FAR CAN YOU WALK?** UNLIMITED 6 BLOCKS 2-3 BLOCKS INDOOR ONLY UNABLE

**CAN YOU CLIMB STAIRS?** NORMALLY NORMALLY WITH THE RAIL WITH DIFFICULTY UNABLE

**CAN YOU PUT ON SOCKS AND SHOES?** WITH EASE WITH DIFFICULTY UNABLE

**WHAT IS YOUR ACTIVITY LEVEL?** BEDRIDDEN SEDENTARY SEMI-SEDENTARY LIGHT LABOR MODERATE/HEAVY LABOR

WHAT ARE SOME EXAMPLES OF HOW YOUR PAIN IMPACTS YOUR DAILY LIFE? (THINGS YOU CAN NO LONGER DO OR DO COMFORTABLY) \_\_\_\_\_

**CONTINUE TO BACK →**



# MEDICAL AND SURGICAL HISTORY

## HAVE YOU EVER BEEN TOLD BY A DOCTOR THAT YOU HAVE ANY OF THE FOLLOWING?

ANEMIA	ANEURYSM	CARDIAC ARRHYTHMIA	BLOOD CLOTS (DVT/PE)
CAROTID ARTERY DISEASE	CONGESTIVE HEART FAILURE	CARDIAC DISEASE	LUNG DISEASE
DIABETES	GI BLEEDING	GERD/REFLUX	HYPOTHYROIDISM
HEART DISEASE	HIGH CHOLESTEROL	HIGH BLOOD PRESSURE	KIDNEY DISEASE
PEPTIC ULCER DISEASE	PERIPHERAL VASCULAR DISEASE	STROKE/TIA	SEIZURES
ASTHMA	MIGRAINE OR SEVERE HEADACHES	HEPATITIS	HIV
CANCER	EXCESSIVE BLEEDING OR BRUISING	EMPHYSEMA OR COPD	SERIOUS INFECTIONS

PSYCHIATRIC CONDITIONS (DEPRESSION/ANXIETY/OTHER): \_\_\_\_\_

OTHER CONDITIONS: \_\_\_\_\_

### DENTAL HISTORY

ANY ACTIVE DENTAL PROBLEMS?  Y  N WHAT? \_\_\_\_\_ MOST RECENT DENTAL APPOINTMENT \_\_\_\_\_

### PAST SURGICAL TREATMENT (LIST SURGICAL PROCEDURES AND YEAR PERFORMED)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

HAVE YOU HAD ANY MAJOR ISSUES (COMPLICATIONS) WITH PRIOR SURGERIES? \_\_\_\_\_

SIGNIFICANT FAMILY HISTORY \_\_\_\_\_

MEDICATIONS (LIST NAME, DOSAGE, AND FREQUENCY TAKEN. ATTACH LIST IF NECESSARY)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### ALLERGIES (TO MEDICINES OR METALS)

\_\_\_\_\_  
\_\_\_\_\_

### SOCIAL HISTORY

SINGLE MARRIED WIDOWED

Live with Name \_\_\_\_\_

Relationship \_\_\_\_\_

Retired  Y  N Occupation \_\_\_\_\_

Tobacco  Y  N Packs/day \_\_\_\_\_

Alcohol  Y  N Drinks/week \_\_\_\_\_

Drug use  Y  N

Interests/Hobbies \_\_\_\_\_

\_\_\_\_\_

### REVIEW OF SYMPTOMS

Have you experienced any of the following in the past year?

Weight Loss	Weight Gain
Fevers	Vision Changes
Shortness of Breath	Cough
Wheezing	Chest Pain
Irregular Heart Rate	Leg Swelling
Abdominal Pain	Rectal Bleeding
Painful Urination	Difficulty Urinating
Urinary Tract Infections	Severe Back Pain
Leg or Foot Numbness	Leg or Foot Tingling
Easy Bleeding	Skin or Other Infections

Signature \_\_\_\_\_ Date \_\_\_\_\_

## FINANCIAL POLICY

Thank you for choosing Jordan-Young Institute. We are committed to providing you with the best patient care experience possible. As part of this goal, we would like to explain our payment policies before your treatment begins so you have the chance to ask questions before any payment obligation occurs. We feel that helping you understand your payment expectations and obligations ahead of time will help us provide you with the quality of compassion and care you expect from our practice.

For your convenience, we have answered a variety of commonly asked questions about payment policies. If you do not find the answer to your specific questions, please ask to meet with appropriate staff who can help.

### DO YOU ACCEPT MY INSURANCE AS PAYMENT IN FULL?

We are participating providers with Medicare, Cigna, Sentara Optima, Blue Cross Blue Shield and Healthkeepers, Aetna, Humana, Tricare Standard, United Healthcare, VHN, and PHCS. This means that we will accept the insurers allowable as payment in full. **You, however, are still responsible for payment of any deductibles, co-insurance or co-pays as defined by your insurance coverage. Your office visit will be rescheduled if you are unable to pay your co-pay or provide a referral (if necessary) before you are seen.**

We do not participate with Aetna HMO, Today's Option Medicare Advantage or any of the Medicare-Medicaid dual-eligibility programs, however, we will assist you in determining your benefit coverage. We do not offer payment plans but we can refer you to an external agency should you need to make such arrangements.

We do not participate with Healthkeepers Plus and Sentara Family Care.

### WHEN DO I HAVE TO PAY FOR SERVICES?

You are expected to pay all co-pays, co-insurance and unmet deductibles on the day of your visit. We accept VISA, MasterCard, Discover, and American Express as well as payment by cash or check. **If you are unable to pay, your appointment will be rescheduled.**

You are expected to pay for all non-covered services and DME Cash and Carry Items at the time of issue. We will gladly hold an item for you until you are able to pay.

### MAY I STILL BE SEEN IF JORDAN-YOUNG DOES NOT PARTICIPATE WITH MY INSURANCE?

If you do not carry insurance we participate with, your policy may have out-of-network benefits. It is your responsibility to call your insurance carrier to determine and understand your benefit coverage. Jordan-Young will file a claim to your insurance as a courtesy to you; however, we are not obligated to accept your insurance's payment as payment in full. **You may be balance billed for the difference between our charge and the amount your insurance pays.**

### DO I NEED A REFERRAL TO BE SEEN?

Many insurance plans now provide open referral networks; however, **it is your responsibility to determine and understand if your individual insurance coverage requires a referral.** If your insurance requires a referral, you must have the referral available at the time of your appointment. If you do not have the referral with you, you will be asked to either 1) Reschedule your appointment to give you time to obtain the referral or 2) Sign a waiver that will make you responsible for payment in full of the charges incurred on the day's visit.

Tricare Prime patients must obtain a referral before being scheduled for an appointment.

SIGNATURE ON BACK →

## DO I HAVE TO PAY IF I HAVE BEEN INJURED IN AN ACCIDENT?

**Jordan-Young does not accept legal cases or attorney liens.** If you have been injured in a non-work-related accident for which you are seeking legal remedy, you will be required to pay 100% of your billed charges before being seen. **Your medical insurance cannot be billed.**

If you have been injured in a work-related accident, **it is your responsibility to obtain an award number from the state Workers' Compensation Commission** in order to ensure that your claim will be paid in full. If you are treated without the award number from the state and your payment of your claim is denied or only paid in part by your employer, you will be held responsible for the balance of your bill.

Jordan-Young accepts fee schedule payments for injured workers covered under the United States Department of Labor, Jones Act, Longshoreman's Act and Sentara Health Systems.

## MAY I SET UP A PAYMENT PLAN?

Payment is expected in full at the time services are rendered. **If you are not able to pay the patient responsible balance of your bill at the time of service, Jordan-Young retains the right to refer your account to AMC for collection. AMC will attempt to negotiate reasonable payment terms with you and will accept most forms of payment. If you fail to keep the agreed payment terms, further collection activities will ensue. You will be responsible for fees and any other associated costs incurred in collecting on your account.**

Co-insurance and deductible balances after insurance are expected to be paid within 30 days of receiving your first patient statement. If your account balance is still unpaid after 31 days, **your account will be referred to Account Management Company AMC for collections. AMC is not a collection agency, but rather an external bill paying service. However, if you default on your payment arrangements or do not pay your outstanding bill, your outstanding account will be immediately transferred to a collection agency. You will be responsible for the balance due on your account plus any non-negotiable fee assigned by the collection agency in satisfying the payment of your account balance.**

You will be responsible for contacting Credit Control Corporation and AMC at either (757)873-3332 or 1-(800)723-5431 for making time-based payment arrangements or collections payments.

## WHAT HAPPENS IF I MISS AN APPOINTMENT OR HAVE A CHECK RETURNED?

Jordan-Young reserves the right to charge a NO SHOW fee of \$50 for any missed appointment. This fee must be paid before another appointment is scheduled.

Jordan-Young reserves the right to charge a RETURN CHECK fee of \$35 for any payment by check that is returned for insufficient funds.

I have read and fully understand the policies of this office regarding payment. I agree to pay any known patient responsible obligations at the time of service or any obligations identified as my responsibility within 30 days of notification by my insurance or Jordan-Young. I understand that collection of my patient responsible balances outside these terms may be handled by an outside collection agency and I will be responsible for both the balance of the bill and any non-negotiable fees assigned for collection. I understand that I am personally responsible for following the regulations, policies and procedures of my insurance plan.

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Patient Signature

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Date

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Printed Name



# Consent and Acknowledgement of Receipt of Notice of Privacy Practices for Purposes of Payment and Healthcare Operations (HIPAA)

I consent to the use or disclosure of my protected health information by Jordan Young Institute for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Jordan Young Institute.

I have the right to revoke this consent, in writing, at any time, except to the extent that Jordan Young Institute has taken action in reliance on this consent.

My "protected health information" (PHI) means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer, or a health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Jordan Young Institutes' Notice of Privacy Practices (NPP) prior to signing this document. The Notice of Privacy Practices has been offered to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Jordan Young Institute. The Notice of Privacy Practices for Jordan Young Institute is also provided in the lobby and on the group website at [www.jordan-younginstitute.com](http://www.jordan-younginstitute.com). This Notice of Privacy Practices describes my rights and responsibilities and Jordan Young Institutes' duties and actions with respect to my protected health information.

Jordan Young Institute reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing the group's website, calling the office and requesting a revised copy be sent in the mail, or asking for one at the time of my next appointment. I acknowledge I have been told about and offered to receive a copy of the Notice of Privacy Practices.

Release of Information: I hereby give Jordan Young Institute permission to release information on my medical condition to the following people:

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Name and Relationship

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Name and Relationship

---

Name and Relationship

I understand that the areas discussed with these people could include treatment options, side effects, prescriptions, financial information, test results, etc.

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Patient Signature

---

Date

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Printed Name

Parent or Personal Representative  
refused to sign acknowledgment

\_\_\_\_ Staff Initials  
\_\_\_\_ Date

I would like to **RESTRICT DISCLOSURES** "to the insurance company" for services paid for out of pocket.

Patient Signature \_\_\_\_\_

Date of Service \_\_\_\_\_