Patient Demographic Form

HARBOR PLASTIC SURGERY CENTER
MOHS, AESTHETIC AND RECONSTRUCTIVE SURGERY

Please Print

PATIENT INFORMATION

Last Name | **First Name** | **Middle Initial** | **Nickname/AKA**

Date of Birth | **Social Security Number** | **Gender** ☐ Male ☐ Female

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ LifePartner ☐ Separated ☐ Widowed ☐ Other | **Language** ☐ English Other: _____

Home Address | **Apt #** | **City** | **State** | **Zip Code**

Home Phone | **Work Phone** | **Other Phone** ☐Cell ☐Pager ☐Fax

Email Address | **Employment Status**

Employer | **Employer Phone**

PHYSICIAN REFERRAL INFORMATION

Primary Care Physician | **Referring Physician**

RESPONSIBLE PARTY (GUARANTOR) INFORMATION

Relationship to Patient ☐ Self (If self, skip to Emergency) ☐ Spouse ☐ Parent ☐ Other

Last Name | **First Name** | **Middle Initial**

Date of Birth | **Social Security Number**

Home Address | **Apt #** | **City** | **State** | **Zip Code**

Home Phone | **Work Phone** | **Other Phone** ☐ Cell ☐Pager ☐Fax

Employer | **Employment Status**

EMERGENCY / NEXT OF KIN CONTACT INFORMATION

Last Name | **First Name** | **Relationship to Patient**

Address | **Apt #** | **City** | **State** | **Zip Code**

Home Phone | **Work Phone** | **Other Phone** ☐Cell ☐Pager ☐Fax

OTHER CONTACT INFORMATION – NOT LIVING WITH PATIENT

Last Name | **First Name** | **Relationship to Patient**

Address | **Apt #** | **City** | **State** | **Zip Code**

Home Phone | **Work Phone** | **Other Phone** ☐Cell ☐Pager ☐Fax

- **If copies of insurance cards are not attached, please complete Patient Insurance Form**

HARBOR PLASTIC SURGERY
CENTER
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Patient Name: _____

Date of Birth: _____

GENERAL MEDICAL HISTORY

Check any of the following that apply and use lines for explanations:

- □ Anxiety
- □ Arthritis (Osteo or Rheumatoid)
- □ Arrhythmia/AFIB
- □ Artificial heart valves
- □ Artificial joints _____
- □ Asthma
- □ Bleeding disorder
- □ Blood Clot/DVT/PE
- □ Cancer (Breast/Colon/Lung/Prostate/_____)
- □ Chronic Edema
- □ Congestive Heart Failure/CHF
- □ COPD/Emphysema
- □ Coronary Artery Disease/CAD
- □ Depression
- □ Diabetes
- □ Hay Fever (allergies)
- □ Hearing Loss
- □ Hepatitis (B or C)
- □ Herpes (genital or cold sores)
- □ High Blood Pressure/HTN
- □ High Cholesterol
- □ HIV/AIDS
- □ Intravenous Drug use
- □ Lupus (or other auto immune disease) _____
- □ Kidney/Renal disease/CRF _____
- □ Leukemia
- □ Lymphoma
- □ Organ Transplant _____
- □ Pacemaker (AICD)
- □ Psoriasis
- □ Radiation Treatment _____
- □ Seizures
- □ Sleep Apnea

SKIN HISTORY

Have you experienced:	**In yourself?**		**In your family? (specify who)**
Abnormal scars or keloids	Y	N	_____
Abnormal/atypical moles	Y	N	_____
Actinic Keratosis (Precancers)	Y	N	_____
Basal Cell Skin Cancer	Y	N	_____
Melanoma skin cancer	Y	N	_____
Seborrheic Keratosis (age spots)	Y	N	_____
Squamous Cell Skin Cancer	Y	N	_____

SURGICAL HISTORY

Please list your past surgical history/dates:

_____

_____

_____

SOCIAL HISTORY

Cigarette Smoking:

- ☐ Currently Smokes (pks/day) _____
- ☐ Former Smoker (year quit) _____
- ☐ Never Smoked

Alcohol Use:

- ☐ None
- ☐ Less than 1 drink per day
- ☐ 1 – 2 drinks per day
- ☐ 3 or more drinks per day

FAMILY HISTORY

Please List any Non skin related medical issues within your family: (Only list Parents and Siblings)

Who:	**Medical Issue**:
_____	_____
_____	_____
_____	_____
_____	_____

Use this space for explanations AND any other medical concerns you would like us to know (PLEASE PRINT):

_____

_____

_____

_____

HARBOR PLASTIC SURGERY
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Communication Agreement

May we leave a message regarding your appointment or test results:

On your answering machine/voicemail? **Yes** or **No**
Office/work voicemail? **Yes** or **No**
With another person? **Yes** or **No**

May we periodically email you with additional information from Dr. Piasecki?

Yes or **No**

Please list the person(s) with whom we can discuss your protected health information?

_____
_____
_____
_____

I AGREE that I am making this request for my convenience, without coercion or pressure by my healthcare provider or any other party. I understand that this request may result in someone other than me learning of my personal health information. I also understand that this agreement will be in place until I personally request in writing that it be cancelled. I will be responsible for completing a new request form to update contact numbers should they change. If my contact numbers should change, I give permission to send test results to me by mail.

_____ _____
Signature of Patient or legally authorized individual Date

_____ _____
Printed Name Relationship to patient

HARBOR PLASTIC SURGERY
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Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

The Federal government mandates that you be informed

I understand that as part of my healthcare, this practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand I can be provided with a *Notice of Information Practices* that details a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change its notice and practices and, prior to implementation, will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restriction as how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing to Harbor Plastic Surgery Center located at 5 Canterwood Blvd NW, Suite 310, Gig Harbor, WA 98332 except to the extent that the organization has already taken action in reliance on the consent.

Please read the following information and then indicate your agreement with these statements by circling (yes / no) for each statement.

Please circle

1. yes /no I understand that I will be informed should my medical case be included in any investigational, research, or educational studies.
2. yes /no I would like to receive a copy of my surgeon's medical credentials.
3. yes /no I consent to permit a sample of my blood or body fluid(s) to be tested should any person (surgeon, nursing staff or other personnel) at Harbor Plastic Surgery Center be accidentally contaminated by either or both substances.
4. yes /no Are there other restrictions that you wish to have? If yes, please explain.

_____

_____

I fully understand and **accept/decline** the terms of this consent.

_____ _____

Patient/Guardian Signature **Date**

PATIENT'S RIGHTS & RESPONSIBILITIES

As our patient we would like to make you aware of your rights and responsibilities. You may exercise your rights without being subject to discrimination, reprisal, retribution or denial of care.

Personal Privacy: Your personal privacy and safety are very important. It is your right by virtue of your physical surrounding and respect of dignity by all healthcare workers and business office employees that your privacy and safety be maintained. While in our facility, your spiritual needs will be respected and you may obtain whatever spiritual care that you require. It is the patient's responsibility to indicate to our Facility's Management Team if at any time you feel your privacy or safety is being violated.

Receive care in a safe setting: By virtue of trained, professional healthcare workers and adherence to State, Local and Federal safety standards, Harbor Plastic Surgery Center strives to maintain the highest standards. It is the patient's responsibility to indicate to our facility's management if at any time you feel your safety is being violated.

Be free from all forms of abuse, harassment or neglect: The safety and comfort of our patients is extremely important to us. You have the right to access any protective services you feel are necessary while in our facility. We will strive to protect you against abuse, harassment or neglect. As our patient it is your responsibility to file a grievance with our facility's management if you feel these rights have been violated and to be assured our ASC will respond and take your grievances seriously.

Information Disclosure: You have the right to accurate and easily understood information about your health plan, healthcare professionals and your health care facilities. If you speak another language, have a physical or mental disability, or just don't understand something, help will be provided so you can make informed health care decisions. If you are in need of a translator; a translator will be provided to you upon request.

Choice of Providers: You have the right to choose health care providers. The successful outcome of any patient/doctor relationship requires the patient to be comfortable with their physician and his staff. Therefore, if you wish not to see any physician at Harbor Plastic Surgery Center, please notify our staff immediately. Seeing your physician of choice may not be possible in an emergent situation.

Access to Emergency Services: If you feel your emergent condition is life threatening please call 911 before contacting our office. If you have severe pain, an injury or sudden illness that makes you believe that your health is in serious danger, you have the right to be screened and stabilized using emergency services. Harbor Plastic Surgery Center has a physician on call 24 hours per day/seven days per week. In case of after-hours emergency please contact us at (253) 509-4438.

Participation in Decisions: You have the right to know your treatment options and expected outcomes before treatment begins, and to take part in decisions about your care. Parents, guardians, family members or others can represent you if you cannot make your own decisions.

Respect and Non-Discrimination: You have a right to considerate, respectful care from your doctors and his health care staff. All medical decisions will be based on current medical standards and knowledge.

Confidentiality of Health Information: You have the right to talk privately with your health care provider and to have your health care information protected. You also have the right to read and receive a copy of your own medical record. You have the right to ask the doctor to change his medical record if it is not correct, relevant or complete.

Health Insurance Problems: If you have concerns about your insurance, it is sometimes helpful to start with customer service at your insurance company. Harbor Plastic Surgery Center will provide any required assistance deemed necessary by your insurance carrier in order to process your claims correctly.

Billing and Claim Concerns: Harbor Plastic Surgery Center submits claims to insurance companies as a courtesy to our patients. If you have any questions concerning billing, please call our billing office (253) 358-7988 or the Jill Piasecki at (253) 858-5040.

Advance Directives: It is the policy of Harbor Plastic Surgery Center that in the event a patient goes into cardiac or respiratory distress or any other medical emergency, all emergency care will be provided, including the calling of paramedics and transfer to a local hospital when indicated. Harbor Plastic Surgery Center policy is to make every effort to resuscitate all patients. If a patient wishes are not to be resuscitated (DNR) the patient must bring a copy of his/her POLST (Physicians Orders of Life Sustaining Treatment) to have on our records. This POLST form must be completed by your primary care physician and cannot be completed by Harbor Plastic Surgery Center Physician.

Ownership: Harbor Plastic Surgery Center is a privately owned Corporation by Justin H. Piasecki, MD.

Complaints and Appeals: You have the right to a fair, fast and objective review of any complaint you have against your physician, their staff or the facility. This includes complaints about waiting times, operating hours, the actions of health care personnel, and the adequacy of the health care facilities. Upon receipt of your grievance an investigation will be conducted and you will be sent a written response within 2 days. If you have complaints or concerns you have the right to file them with the following:

Harbor Plastic Surgery Center
Jill Piasecki, Administrator
11511 Canterwood Blvd NW, Suite 310
Gig Harbor, WA 98332
Email: jill@drpiasecki.com

Washington State Department of Health
Health Systems Quality Assurance
Washington State Department of Health
310 Israel Road SE
Tumwater, Washington 98501

Medicare Ombudsman
1-800-Medicare (1-800-633-4227)
http://www.medicare.gov/Ombudsman/resources.asp

PO BOX 47850
Olympia, Washington 98504-7850
(360) 236-4600

Patient Responsibilities – As a patient it is your responsibility to:

Medical History: You are required to provide a complete and accurate history to the best of your ability. This includes, but is not limited to all medications, including over-the-counter products and dietary supplements and any allergies or sensitivities.

Follow Treatment Plan: Your prescribed treatment plan was designed for the best outcomes. If you have any questions or concerns with the treatment plan, you have 24X7 access to your physician. It is your responsibility to contact him if you are confused or do not agree with the plan. Otherwise, we expect that you are following your treatment plan.

Cell Phone Use: For the comfort and privacy of all of our patients, we ask that cell phone use be limited to discrete rooms with the door closed. At no time may our patients photograph another person without their consent.

Service Animals: Because of the sanitary requirements of surgical procedures, no animals are allowed in the Harbor Plastic Surgery Center. If you require a service animal, please talk to our administrator so we can help to make other arrangements.

Transportation: Depending on the treatment performed, you may be required to have a responsible adult to transport you home and remain with you for 24 hours following your procedure. This will be discussed with your doctor.

Advance Directives: It is your responsibility to inform us of your Advance Directive, Living Will or any medical power of attorney.

Respectful Behavior: We expect that our patients will treat our physicians and staff in a courteous, professional and respectful manner.

Termination: We believe that you have an important role in your care. Failure to comply with the patient responsibilities may result in your termination as a patient. If this happens, we will refer you to another provider to continue your care.

Reviewed: July 13, 2022

HARBOR PLASTIC SURGERY
CENTER
MOHS. AESTHETIC AND RECONSTRUCTIVE SURGERY

Financial and Payment Policy

We would like to say "thank you" for choosing Dr. Piasecki and Harbor Plastic Surgery Center for your care! We are very concerned about the cost of your health care and want to inform you of our policies regarding payment.

1. In order to bill your insurance company for your health care costs, **we must obtain complete information about your primary and supplemental insurance plans, including a copy of your insurance cards.** If this information is not provided, you will be required to pay any charges in full at the time of service. We will also use the information you provide to help you with your insurance company's pre-authorization process, if required.
    a. **If your insurance changes, we require a 48-hour notice** to verify benefits and complete any precertification or authorizations required by your plan. Failure to notify our staff within this timeframe may result in a delay in receiving services or require that your visit be rescheduled.
    b. To comply with Washington state law and maintain accuracy in filing your claims, **a copy of your picture ID and your insurance card(s) are required** at your first visit, any time your coverage changes and yearly.
2. At the time of your first appointment in our office, you will meet and discuss your insurance plan with a representative from our office. Our staff will strive to assist you with your understanding of your insurance policy details. However, due to the frequent changes in the specifics of each individual health insurance plan, **HPSC cannot guarantee confirmation of your coverage or benefits by your insurance company.** You are ultimately responsible for the plan that you have.
3. **Payment in full is expected** when services are rendered unless other specific arrangements are made in advance with our office. For your convenience **we accept Visa, MasterCard, and Discover as well as personal checks, money orders and cash.** We can also help you to secure financing from a third party health care lender.

Fees- If you are using insurance to pay for your service, insurance fees are set based on procedures performed, not the level of skill or training of the provider rendering them. If you have the same procedure done by a different physician, your cost would be exactly the same.

We are happy to provide you with an estimate of your cost prior to your procedure. However if we are billing insurance, we cannot guarantee it. Our estimates are based on our knowledge of your insurance company's fee schedule, the elements of your plan and the procedures that will likely be performed. There are times when Dr. Piasecki needs to do different procedures than planned and contracts with insurance companies obligate us to bill exactly the procedures that were performed. Furthermore, we cannot maintain current fee schedules of every insurance carrier. Ultimately when we bill insurance, fees paid to us by patients and the insurance company, are determined strictly by the insurance company.

If you are a private pay patient, you will be given a firm quote. Our private pay fees are based on Medicare rates and published national averages.

Copays/Coinsurance/Deductibles- Our Financial and Payment policy requires **payment for your deductible and/or co-insurance at the time of service for office visits and surgical procedures.** We will file a claim for services on your behalf. In the event there are any additional balances, which may be your responsibility, **you will receive a statement that is to be paid.**

Medicare- We are a participating provider with Medicare. We will submit your claim to Medicare, who will process any payments due directly to us. **You are responsible for your deductible and copays at the time of service.** If you have a Medicare supplement plan, we ask that you complete the coordination of benefits with them so your secondary is billed properly. We will send you a bill for any remaining coinsurance once we receive payment from Medicare and any secondary insurance that you have provided to us and to Medicare.

Referrals- If your insurance carrier requires a referral or authorization for your visit, **it is your responsibility to make sure that our office receives current valid authorization.** If you do not have a valid referral or authorization at the time of service, you may be sent back to your primary care physician to obtain authorization prior to being treated or full payment will be expected at the time of service. **Please remember that it is your responsibility to make sure that we are on your plan's provider listing.** We appreciate your understanding of the ever-changing requirements of managed care plans and our position to adhere to their policies.

Medicaid- We do not participate with Washington Medicaid. If you have a managed plan such as Apple Health, DSHS, Amerigroup or Community Health Plan of Washington these plans are considered Medicaid plans and are not accepted.

Secondary Insurance- As a courtesy to you, our Billing Department will file your claim if we have valid information on file.

HMS, EPO, POS, and PPO Contracted Insurance- We participate with most major insurance carriers and will file your claim for you. **You are responsible for your copay, coinsurance and/or deductible at the time of service and for any amounts not covered by your insurance.** If coverage is denied for any reason, you are responsible for payment of the entire balance.

Non-Contracted Insurance (Out of Network)- If you have an insurance plan that we do not participate with, **you may have out of network benefits. These benefits typically have a higher copay, coinsurance and/or deductible out of pocket cost.** If you choose to have services rendered at HPSC these amounts will be due at the time of service rendered. **You will be considered a self-pay, uninsured patient if you do NOT have out of network benefits.**

Uninsured/Self-pay- Payment in full is expected at your visits. All treatments and care will be reviewed with you in order to make arrangements for payment.

Termination of Benefits- It is your responsibility to contact us within 48 hours of any appointment if you have any changes in insurance coverage.

Returned checks- Returned checks are subject to a $30 service charge. If multiple returned checks are received, we reserve the right to refuse further checks from you and request that all payments be received in cash, money order, cashier's check or credit card.

Non-Payment- If any account becomes delinquent, HPSC reserves the right to have a collection agency take over the account. In matters of dispute of payment, you waive your right to privacy under HIPAA. **If any account is placed with a collection agency, the patient will be responsible for all costs of collection and any legal proceedings.** Timely payment will prevent consequences to your credit rating.

We will work with patients in any way we can to ensure that their medical care is the finest available and that this care does not become a financial burden. If you have any questions about our financial policy or your insurance reimbursement, please contact our office.

Please sign and date this form, acknowledging that you have read and understand our financial policy.

Signature of Patient _____ Date _____

HARBOR PLASTIC SURGERY
C E N T E R
MOHS. AESTHETIC AND RECONSTRUCTIVE SURGERY

Assignment of Benefits

I hereby assign and convey all health care benefits to which I am entitled to **HARBOR PLASTIC SURGERY CENTER, PLLC**, a Washington professional limited liability company ("HPSC"), subject to applicable law. I authorize HPSC to submit claims for medical services on my behalf to my insurance carrier(s), including Medicare, Medicaid, private insurance, and/or any other health care service contractor (each a "Payer"). I authorize and direct my Payer to issue payment to HPSC for medical services rendered to myself and/or my dependents.

I understand that I am financially responsible for all medical services rendered to me and/or my dependents regardless of any applicable insurance or benefit payments. I also understand that my Payer may not pay 100% of the amount of the claim and I may be responsible for any and all amounts not payable by the identified Payer, to the extent allowed by applicable law, including without limitation deductibles, coinsurance, copays, out-of-network charges, and charges for non-covered services.

I certify that the Payer information that I have supplied HPSC is true and accurate as of the date of service. I am fully aware that having health care benefits does not absolve me of my responsibility to ensure that any amount due to HPSC is paid in full, to the extent allowed by applicable law. I understand that HPSC participates with multiple health care service plans but may not contract with my Payer or participate with my specific plan. It is my responsibility to verify with my Payer that my physician at HPSC participates with my plan. I agree that I am individually obligated to pay the full amount for all services rendered to me by HPSC if I belong to a plan with which HPSC does not participate.

Further, I understand that different Payers have different requirements for payment of claims, including, but not limited to, pre-certifications, authorizations or a determination that the services be medically necessary. It is my obligation to know my Payer's requirements and ensure that they have been fulfilled. **I will immediately notify HPSC if any of my insurance or medical benefit information changes.**

I authorize HPSC or its legal representative to release any of my financial records or patient health information, including privileged information regarding mental health, substance abuse or HIV/AIDS, for use in processing my claims, or for use in any audit of the records of HPSC by any health care service contractor or other third party payer. Furthermore, I authorize my plan administrator fiduciary, insurer, representative, and/or attorney to release to HPSC any and all plan documents, summary benefit descriptions, insurance policies, and/or settlement information regarding my benefits or health care service plan.

If my current policy prohibits assignment or direct payment of claims to HPSC, I hereby instruct my Payer to make the payment check payable to me, but to mail it directly to HPSC. I grant HPSC a limited power of attorney to endorse any checks representing payment for services provided by HPSC made out to me individually, or to me and HPSC jointly, from any Payer. In the event that any payments are made directly to me or my representative, I will immediately endorse such payments to HPSC.

In the event that my policy prohibits assignment of certain rights; (such as right to file appeals or to file suit in state or federal court) I expressly designate HPSC as my authorized representative. I intend this assignment and designation to convey to HPSC all of my rights to claim (or place a lien on) the health care benefits related to the services provided by HPSC, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). I authorize HPSC to: (1) submit any and all appeals, when my Payer denies benefits in whole or part to which I may be entitled; (2) submit any and all requests for benefit information from my Payer; and (3) participate in any administrative and/or judicial actions and pursue any claim or

action or right against any liable party, insurer, employee benefit plan, health care benefit plan, or plan administrator. I also agree that any fines, interest, attorney fees, or other awarded damages that may be levied against my Payer will be paid to HPSC for acting as my personal representative in these capacities.

This assignment of benefits will remain in effect until it is revoked by me in writing sent to HPSC. A photocopy of this assignment shall be considered effective and valid as the original.

_____	_____
Signature of Patient/Guardian/Policy Holder	Date
_____	_____
Printed name if signed on behalf of patient	Relationship (parent, legal guardian, etc.)
_____	_____
Witness	Date

HARBOR PLASTIC SURGERY CENTER

AMBULATORY SURGERY CENTER PATIENT CONSENT TO RESUSCITATIVE MEASURES

NOT A REVOCATION OF ADVANCE DIRECTIVE OR MEDICAL POWERS OF ATTORNEY

All Patients have the right to participate in their own health care decisions and to make advance directives or to execute powers of attorney that authorize others to make decisions on their behalf based on the Patient's expressed wishes when the Patient is unable to make decisions or unable to communicate decisions.

However, unlike in an acute care hospital setting, the surgery center does not routinely perform "high risk" procedures. Most procedures performed in this facility are considered to be of minimal risk. Of course, no surgery is without risk. You will discuss the specifics of your procedure with your physician who can answer your questions as to its risks, your expected recovery and care after your surgery.

Therefore, it is our policy, regardless of the contents of any advance directive or instructions from a health care surrogate or attorney that if an adverse event occurs during your treatment at this facility we will initiate resuscitative or other stabilizing measures and transfer you to an acute care hospital for further evaluation. Where further treatment or withdrawal of treatment measures already begun will be ordered in accordance with your wishes, advance directive or health care power of attorney. Your agreement with this policy by your signature below does not revoke or invalidate any current health care directive or health care power of attorney.

If you do not agree to this policy, we are pleased to assist you to reschedule the procedure.

Please check the appropriate box in answer to these questions. Have you executed an advance health care directive, a living will, a power of attorney that authorizes someone to make health care decisions for you?

- □ Yes, I have an advance directive, living will or health care power of attorney
- □ No, I do not have an advance directive, living will or health care power of attorney
- □ I would like to have information on advance directives

If you checked the first box "yes" to the question above, please provide us a copy of that document so that it may be made a part of your medical record.

BY SIGNING THIS DOCUMENT, / ACKNOWLEDGE THAT/ HAVE READ AND UNDERSTAND ITS *CONTENTS AND AGREE TO THE POLICY AS DESCRIBED. IF/ HAVE IND/CATED ƒ WOULD LIKE ADDITIONAL INFORMATION, ƒ ACKNOWLEDGE RECEIPT OF THAT INFORMATION.*

BY:_____

(PATIENT'S SIGNATURE)

PATIENT'S LAST NAME:	PATIENT'S FIRST NAME:	DATE:

If consent to the procedure is provided by anyone other than the Patient, this form must be signed by the person providing the consent or authorization.

/ ACKNOWLEDGE THAT/ HAVE READ AND UNDERSTAND ITS CONTENTS AND AGREE TO THE POLICY AS DESCRIBED.

BY: _____

(SIGNATURE) (PRINT NAME)

_____

RELATIONSHIP TO PATIENT:

- o COURT APPOINTED GUARDIAN
- o ATTORNEY IN FACT
- o HEALTH CARE SURROGATE
- o OTHER _____

MEDICATION RECORD

Patient Name:_____Date of Birth: _____

Pharmacy:_____Pharmacy City/Street: _____

Allergy	What type of Reaction do you have?
MEDICATION	**DOSE DIRECTIONS**