Multi-Care Medical
"Of SW Florida"

13701 CYPRESS TERRACE CIRCLE
FORT MYERS, FL 33907
PHONE: (239) 277-1655 FAX: (239) 277-1255

ABOUT YOU

TODAY'S DATE: _____/_____/_____ PATIENT NAME: _____

☐ MALE BIRTHDATE: _____/_____/_____ AGE: _____ SS#: _____
☐ FEMALE

ADDRESS: _____CITY:_____STATE:_____ZIP:_____

HOME #: ___ ___ ___- ___ ___ ___- ___ ___ ___ ___ WORK #: ___ ___ ___- ___ ___ ___- ___ ___ ___ ___

CELL #: ___ ___ ___- ___ ___ ___- ____ ____ ____ ___ EMAIL ADDRESS: _____

EMPLOYER: _____OCCUPATION: _____

STATUS: ( ) Minor ( ) Single ( ) Married ( ) Divorced ( ) Separated ( ) Widowed

SPOUSE'S NAME: _____

DO YOU HAVE CHILDREN? ____ YES ____ NO HOW MANY: _____

REASON FOR VISIT

THE REASON FOR THIS VISIT IS A RESULT OF: __AUTO __ WORK __SPORTS ___TRAUMA __CHRONIC

DATE OF THE ACCIDENT (IF APPLICABLE): _____

EXPLAIN WHAT HAPPENED: _____

_____

_____

PLEASE DESCRIBE THE PAIN & LOCATION:_____

_____

WHEN DID THE CONDITION BEGIN? _____/_____/_____

IS THIS CONDITION GETTING WORSE? ___YES ___NO ____CONSTANT ____COMES AND GOES

IS THE CONDITION INTERFERRING WITH YOUR: _____WORK _____SLEEP _____DAILY ROUTINE

HAVE YOU HAD SIMILAR CONDITION IN THE PAST? _____ YES _____ NO

HAVE YOU BEEN TREATED BY A MEDICAL PHYSICIAN FOR THIS CONDITION? _____YES _____NO

HAVE YOU BEEN TREATED BY A CHIROPRACTOR BEFORE? ___YES ___NO

IF SO, WHOM? _____

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HEALTH HISTORY

ARE YOU TAKING ANY OF THE FOLLOWING MEDICATIONS?

☐ Nerve pills ☐ Pain killers(aspirin) ☐ Muscle relaxers ☐ Stimulants ☐Blood Thinners

DO YOU HAVE OR EVER HAD ANY OF THE FOLLOWING DISEASES OR CONDITIONS?

☐Heart Attack/Stroke	☐Heart Surg/Pacemaker	☐Heart murmur
☐Congenital Heart Defect	☐Asthma	☐Mitral Valve Prolapse
☐Artificial Valves	☐Alcohol/Drug Abuse	☐Chemotherapy
☐HIV/Aids	☐Hepatitis	☐Shingles
☐Venereal Disease	☐Diabetes/Tuberculosis	☐Fainting/Seizures
☐Cancer	☐Emphysema/Glaucoma	☐Artificial Bones
☐Frequent Neck Pain	☐Anemia	☐Difficulty Breathing
☐Sinus Problems	☐Arthritis	☐Rheumatic Fever
☐High/Low Blood Pressure	☐Psychiatric Problems	☐Lower Back Problems
☐Frequent Headaches	☐Kidney Problems	☐Ulcers/Colitis

LIST ANY OTHER SERIOUS MEDICAL CONDITION(S) YOU HAVE OR EVER HAD:

_____

PLEASE LIST ANYTHING YOU MAY BE ALLERGIC TO:

_____

LIST PREVIOUS SURGERIES/TREATMENTS WITH DATES:

_____

LIST ANY PAST SERIOUS ACCIDENTS WITH DATES:

_____

FAMILY HEALTH HISTORY:

_____

DO YOU: TAKE SUPPLEMENTS OR VITAMINS ☐YES ☐NO EXERCISE? ☐YES ☐NO

SPECIAL DIET? ☐YES ☐NO DO YOU SMOKE? ☐YES ☐NO **WOMEN:** PREGNANT? ☐YES ☐NO

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AUTO RELATED ACCIDENT

DATE & TIME OF ACCIDENT: _____ ☐AM ☐PM

WERE YOU THE: ☐DRIVER ☐FRONT PASSENGER ☐REAR PASSENGER

WHO WAS CITED? _____ NUMBER OF PEOPLE IN VEHICLE? _____

DID THE POLICE COME TO THE ACCIDENT SITE? ☐YES ☐NO POLICE REPORT? ☐YES ☐NO
WITNESSES? ☐YES ☐NO WERE YOU WEARING SEATBELT? ☐YES ☐NO
WAS THIS VEHICLE EQUIPPED WITH AIRBRAGS? ☐YES ☐NO DID AIRBAGS DEPLOY? ☐YES ☐NO

IN RELATION TO THE BASE OF YOUR SKULL, WHERE WAS THE HEADREST?

☐ABOVE ☐BELOW ☐AT THE BASE OF SKULL

WHAT DID YOU IMPACT? ☐ANOTHER VEHICLE ☐OTHER _____

ANY BODY PART STRIKE VEHICLE? ☐YES ☐NO_____

MAKE & MODEL OF THE VEHICLE YOU WERE OCCUPYING? _____

NAME OF THE LOCATION/STREET ON WHICH YOU WERE TRAVELING? _____

IN WHICH DIRECTION WERE YOU HEADED?

☐NORTH ☐SOUTH ☐EAST ☐WEST APPROX SPEED OF VEHICLE: _____

DID THE IMPACT TO YOUR VEHICLE COME FROM THE:

☐FRONT ☐REAR ☐RIGHT SIDE ☐LEFT SIDE ☐OTHER

DURING THE IMPACT, WERE YOU FACING: ☐RIGHT ☐LEFT ☐FORWARD

WERE YOU: ☐AWARE ☐SURPRISED BY IMPACT?

MAKE & MODEL OF THE OTHER VEHICLE: _____

DIRECTION OTHER VEHICLE WAS HEADED?

☐NORTH ☐SOUTH ☐EAST ☐WEST APPROX SPEED OF OTHER VEHICLE? _____

IN YOUR WORDS, PLEASE DESCRIBE THE ACCIDENT:

_____

_____

_____

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AFTER INJURY

WERE YOU RENDERED UNCONSCIOUS? ☐YES ☐NO IF YES, FOR HOW LONG? _____

PLEASE DESCRIBE HOW YOU FELT IMMEDIATELY AFTER THE ACCIDENT:

_____

DID YOU GO TO THE HOSPITAL? ☐YES ☐NO

WHEN DID YOU GO? ☐JUST AFTER ACCIDENT ☐THE NEXT DAY ☐2 DAYS PLUS

HOW DID YOU GET THERE? ☐AMBULANCE ☐PRIVATE TRANSPORTATION

NAME OF HOSPITAL? _____

WERE X-RAYS TAKEN? ☐YES ☐NO **WAS MEDICATION PRESCRIBED?** ☐YES☐NO

HAVE YOU BEEN ABLE TO WORK ?☐YES ☐NO

INDICATE ☑ THE SYMPTOMS THAT ARE A RESULT OF THIS ACCIDENT:

☐DIZZINESS	☐DIFFICULTY SLEEPING	☐JAW PROBLEMS
☐NAUSEA	☐MEMORY LOSS	☐IRRITABILITY
☐ARM/SHOULDER PAIN	☐BACK PAIN	☐HEADACHES
☐FATIGUE	☐NUMB HANDS/FINGERS	☐LOW BACK PAIN
☐BLURRED VISION	☐TENSION	☐CHEST PAIN
☐BACK STIFFNESS	☐BUZZING IN EAR	☐NECK PAIN
☐SHORTNESS OF BREATH	☐LEG PAIN	☐EARS RINGING
☐NECK STIFF	☐STOMACH UPSET	☐NUMB FEET/TOES

☐OTHER _____

IS YOUR CONDITION GETTING WORSE? ☐YES ☐NO ☐CONSTANT ☐COMES AND GOES

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INDICATE YOUR DEGREE OF COMFORT WHILE PERFORMING THE FOLLOWING ACTIVITIES:

	COMFORTABLE	UNCOMFORTABLE	PAINFUL
LYING ON BACK	☐	☐	☐
LYING ON SIDE	☐	☐	☐
LYING ON STOMACH	☐	☐	☐
SITTING	☐	☐	☐
STANDING	☐	☐	☐
STRETCHING	☐	☐	☐
WALKING	☐	☐	☐
RUNNING	☐	☐	☐
SPORTS	☐	☐	☐
WORKING	☐	☐	☐
LIFTING	☐	☐	☐

TO EVALUATE THE EFFECT THAT CONTINUING WORK WILL HAVE ON YOUR RECOVERY PLEASE COMPLETE THE FOLLOWING:

☐STANDING	☐DRIVING	☐OPERATE EQUIPMENT	☐SITTING
☐TWISTING	☐WORK W ARMS	☐WALKING	☐CRAWLING
☐LIFTING	☐BENDING	☐STOOPING	☐OTHER_____

- How many hours are in your normal workday? _____
- Prior to the injury were you capable of working on an equal basis with others your age? ___Y ___N
- Do you work with other who can help you with any heavy lifting? ___Y ___N
- While in recovery, is there any light duty work you could request? ___Y ___N

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and or managed care organization to release any information required to process insurance claims. I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

SIGNATURE: _____DATE: _____

ASSIGNMENT OF INSURANCE BENEFITS, RELEASE, & DEMAND

I, the undersigned patient/insured knowingly, voluntarily and intentionally assign the rights and benefits of my automobile Insurance, a/k/a Personal Injury Protection (hereinafter PIP), Uninsured Motorist, and Medical Payments policy of insurance to **Multi Care Medical of SW Florida**. I understand it is the intention of the provider to accept this assignment of benefits in lieu of demanding payment at the time services are rendered. I understand this document will allow **Multi Care Medical of SW Florida** to file suit against an insurer for payment of the insurance benefits or an explanation of benefits and to seek 627.428 damages from the insurer. If the provider's bills are applied to a deductible, I agree this will serve as a benefit to me. This assignment of benefits includes the cost of transportation, medications, supplies, over due interest and any potential claim for common law or statutory bad faith/unfair claims handling. If the insurer disputes the validity of this assignment of benefits then the insurer is instructed to notify **Multi Care Medical of SW Florida** in writing within five days of receipt of this document. Failure to inform **Multi Care Medical of SW Florida** shall result in a waiver by the insurer to contest the validity of this document. The undersigned directs the insurer to pay the health care provider the maximum amount directly without any reductions & without including the patient's name on the check. To the extent the PIP insurer contends there is a material misrepresentation on the application for insurance resulting in the policy of insurance is declared voided, rescinded, or canceled, I, as the named insured under said policy of insurance, hereby assign the right to receive the premiums paid for my PIP insurance to **Multi Care Medical of SW Florida** and to file suit for recovery of the premiums. The insurer is directed to issue such a refund check payable to this provider only. Should the medical bills not exceed the premium refunded, then **Multi Care Medical of SW Florida** is directed to mail the patient/name insured a check, which represents the difference between the medical bills and the premiums paid.

DISPUTES: The insurer is directed by **Multi Care Medical of SW Florida** and the undersigned to not issue any checks or drafts in partial settlement of a claim that contain or are accompanied by language releasing the insurer or its insured/patient from liability unless there has been a prior written settlement agreed to by the health provider (specifically the office manager) and the insurer as to the amount payable under the insurance policy. The insured and **Multi Care Medical of SW Florida** hereby contests and objects to any reductions or partial payments. Any partial or reduced payment, regardless of the accompanying language, issued by the insurer and deposited by **Multi Care Medical of SW Florida** shall be done so under protest, at the risk of the insurer, and the deposit shall not be deemed a waiver, accords, satisfaction, discharge, settlement or agreement by the provider to accept a reduced amount as payment in full. The pay claims at 200% of Medicare then the insurer is instructed & directed to provide **Multi Care Medical of SW Florida** with a copy of the policy of insurance within 10 days**. Any effort by the insurer to pay a disputed debt as full satisfaction must be mailed to the address above, after speaking with the office manager, and mailed to the specific attention of the Office Manager. See Fla. Stat. 673.3111.**

EUOs and IMEs: If the insurer schedules a defense examination r examination under oath (hereinafter "EUO") the insurer is hereby INSTRUCTED to send a copy of said notification to **Multi Care Medical of SW Florida**. The provider or the provider's attorney is expressly authorized to appear at any EUO or IME set by the insurer. The health care provider is not the agent of the insurer or the patient for any purpose. This assignment applies to both past and future medical expenses and is valid even if undated. A photocopy of this assignment is to be considered as valid as the original. I agree to pay any applicable deductible, co payments, for services rendered after the policy of insurance exhausts and for any other services unrelated to the automobile accident. **Multi Care Medical of SW Florida** is given the power of attorney to: endorse my name on any check for services rendered by the above provider; and to request and obtain a copy of any statements or examinations under oath given by patient.

Release of Information: I authorize **Multi Care Medical of SW Florida** to: furnish an insurer, an insurer's intermediary, the patient's other medical providers and the patient's attorney via mail, fax, or email, with any and all information that may be contained in the medical records; to obtain insurance coverage information (declaration sheet & policy of insurance) in writing and telephonically from the insurer; request from any insurer all explanation of benefits (EOBs) for all providers and non-redacted PIP payout sheets; obtain any written and verbal statements the patient or anyone else provided to the insurer; obtain copies of the entire claim file, the property damage file, and all medical records, including but not limited to, documents, reports, scans, notes, bills, opinions, X-rays, IMEs, and MRIs, from any other medical provider or any insurer. **Multi Care Medical of SW Florida** is permitted to produce my medical records to its attorney in connection with any pending lawsuits. The insurer is directed to keep the patient's medical records from this provider private and confidential. The insurer is not authorized to provide these medical records to anyone without the patient's and provider's prior express written permission.

Demand: Demand is hereby made for the insurer to pay all bills within 30 days without reductions and to mail the latest non-redacted PIP payout sheet and the insurance coverage declaration sheet to the above provider within 15 days. The insurer is directed to pay the bills in the order they are received. However, if a bill from **Multi Care Medical of SW Florida** and a claim from anyone else are received by the insurer on the same day the insurer is directed to not apply this provider's bill to the deductible. If the insurer receives a bill from this provider and claim from anyone else on the same day then the insurer is direct to pay this provider first before the policy is exhausted. In the event the provider's medical bills are disputed or reduced by the insurer for any reason, or amount, the insurer is to: set aside the entire amount disputed or reduced; escrow the full amount at issue; and not pay the disputed amount to anyone or any entity, including myself, until the dispute is resolved by a Court. Do not exhaust the policy. The insurer is instructed to inform, in writing **Multi Care Medical of SW Florida** of any dispute.

I authorize **Multi Care Medical of SW Florida** to release any information pertinent to my case to any insurance company, adjuster or attorney to facilitate collection under this Assignment, Lien and Authorization. I agree that **Multi Care Medical of SW Florida** be given a Special Power of Attorney to endorse/sign my name on any and all checks and claim forms for payment of my bill.

Certification: I certify that: I have read and agree to the above; I have no been solicited or promised anything in exchange for receiving health care; I have not received any promises or guarantees from anyone as to results that may be obtained by any treatment or service; and I agree the provider's treatment and supplies are medically necessary and pertaining to my injuries. **Caution: Please read before signing. If you do not completely understand this document please ask us to explain it to you. If you sign below we will assume you understand and agree to the above.**

Patient Name: _____ Patient Signature: _____Date:_____

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PHYSICIAN'S LIEN

To: Attorney_____

Re: Patient: _____ Date of Accident: _____

I hereby authorize the above doctor for furnish you, my attorney, with a full report of his examinations, diagnosis, treatment, prognosis, etc. of myself in regard to the accident in which I was involved.

I hereby authorize and direct you, my attorney, to pay directly to **Multi Care Medical of SW Florida** such sums as may be due and owing him for professional services rendered me both by reason of this accident and by reason of any other bills that are due office and withhold such sums from any settlement, judgment or verdict as may be necessary adequately to pay said doctor. I hereby further give a lien on my case to said doctor against any and all proceeds from any settlement, judgment or verdict which may be paid to you, my attorney or myself a result of the injuries in connection therewith.

I fully understand that I am directly and fully responsible to said doctor for all professional bills submitted by him for services rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which may eventually recover said fee.

Dated: _____ Patient's Signature_____

Address _____

The undersigned being attorney of record for the above patient does hereby agree to

Observe all the terms of the above and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary adequately to protect the said doctor named above.

Dated: _____ Attorney Signature: _____

Attorney, please sign and return to doctor's office as soon as possible. Keep one copy for your records.

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AUTHORIZATION FOR MEDICAL TREATMENT

I the undersigned, patient in this office hereby authorize **Multi Care Medical of SWL Florida** and/or the physicians of **Multi Care Medical of SWL Florida** (and whomever they designate as their assistants) to administer such treatments as is necessary and to perform the following therapy and manipulation and such additional therapy or procedures as are considered therapeutically necessary on the basis of findings during the course of said treatment.

I hereby certify that I have read and fully understand the above Authorization for Medical Treatment, the reason why the above-named treatment is considered necessary, its advantages and possible complications, if any as well as possible alternative modes of treatment which are explained to me by **Multi Care Medical of SWL Florida** and/or the physicians of **Multi Care Medical of SWL Florida**.

I also certify that no guarantee or assurance has been made as to the result that may be obtained.

Date: _____ Signed: _____

Witness: _____ Patient's Name: _____

APPLICATION FOR FLORIDA "NO FAULT" BENEFITS

NAME OF INSURANCE COMPANY

DATE	OUR POLICY HOLDER	DATE OF ACCIDENT	FILE NUMBER

TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS UNDER THE FLORIDA PERSONAL INJURY PROTECTION LAW, PLEASE COMPLETE THIS FORM AND RETURN IT PROMPTLY.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURANCE COMPANY MAKES A STATEMENT OF CLAIM CONTAINING ANY FALSE INCOMPLETE OR MISLEADING INFORMATION, IS GUILTY OF A FELONY OF THE THIRD DEGREE.

YOUR NAME	PHONE NO.	HOME	BUSINESS

YOUR ADDRESS (NO, STREET, CITY OR TOWN, STATE AND ZIP CODE)	DATE OF BIRTH	SOCIAL SECURITY NO.

PERMANENT ADDRESS, IF DIFFERENT	HOW LONG HAVE YOU LIVED IN FLORIDA?

DATE AND TIME OF ACCIDENT	PLACE OF ACCIDENT (STREET, CITY OR TOWN AND STATE)

BRIEF DESCRIPTION OF ACCIDENT AND VEHICLES INVOLVED:

DESCRIBE MOTOR VEHICLE YOU OWN -	DESCRIBE MOTOR VEHICLE OWNED BY ANY MEMBER OF YOUR FAMILY-

AS A RESULT OF THIS ACCIDENT, WERE YOU INJURED? IF YOUR ANSWER IS YES, COMPLETE THE REST OF THIS FORM. IF NO, SIGN HERE AND RETURN THIS FORM TO US.

SIGNATURE: **DATE:**

DESCRIBE YOUR INJURY

WERE YOU TREATED BY A DOCTOR?		DOCTOR'S NAME AND ADDRESS
IF YOU WERE TREATED IN A HOSPITAL, WERE YOU AN IN PATIENT ____ OUT PATIENT _____		HOSPITAL'S NAME AND ADDRESS

AMOUNT OF MEDICAL BILLS TO DATE	WILL YOU HAVE MORE MEDICAL EXPENSE?	AT THE TIME OF YOUR ACCIDENT, WERE YOU IN THE COURSE OF YOUR EMPLOYMENT?

DID YOU LOSE WAGES OR SALARY AS A RESULT OF YOUR INJURY?	IF YES, AMOUNT OF LOSS TO DATE	WHAT IS YOUR AVERAGE WEEKLY WAGE OR SALARY?

IF YOU LOST WAGES:	DATE DISABILITY FROM WORK BEGAN	DATE YOU RETURNED TO WORK

HAVE YOU RECEIVED, OR ARE YOU ELIGIBLE FOR, PAYMENTS UNDER ANY WORKMEN'S COMPENSATION OR EMPLOYMENT LAW?	IF YES, AMOUNT PER WEEK PER MONTH

LIST NAMES AND ADDRESSES OF YOUR PRESENT EMPLOYER(S) AND GIVE YOUR OCCUPATION AND DATES OF EMPLOYMENT FOR EACH

EMPLOYER AND ADDRESS	YOUR OCCUPATION	FROM	TO
EMPLOYER AND ADDRESS	YOUR OCCUPATION	FROM	TO
EMPLOYER AND ADDRESS	YOUR OCCUPATION	FROM	TO

AS A RESULT OF YOUR INJURY HAVE YOU HAD ANY OTHER EXPENSES? SIGNATURE: DATE:	IF YES, EXPLAIN ON REVERSE SIDE

IMPORTANT: 1. TO BE ELIGIBLE FOR BENEFITS COMPLETE AND SIGN THIS APPLICATION
2. SIGN AND ATTACH AUTHORIZATION(S)
3. RETURN PROMPTLY WITH ANY MEDICAL BILLS YOU HAVE RECEIVED TO DATE

OFFICE OF INSURANCE REGULATION
Bureau of Property & Casualty Forms and Rates

Standard Disclosure and Acknowledgement Form
Personal Injury Protection - Initial Treatment or Service Provided

The undersigned insured person (or guardian of such person) affirms:

1. The services or treatment set forth below were **actually rendered.** This means that those services have **already been provided.**

_____

_____

2. I have the right and the **duty to confirm** that the services have already been provided.

3. I was **not solicited** by any person to seek any services from the medical provider of the services described above.

4. The medical provider has **explained** the services to me for which payment is being claimed.

5. If I notify the insurer in writing of a billing error, I may be entitled to a portion of any reduction in the amounts paid by my motor vehicle insurer. If entitled, my share would be at least 20% of the amount of the reduction, up to $500.

Insured Person (patient receiving treatment or services) or Guardian of Insured Person:

Name *(PRINT or TYPE)*	Signature	Date

The undersigned licensed medical professional or medical director, if applicable, affirms the statement numbered 1 above and also:

A. I have **not solicited** or caused the insured person, who was involved in a motor vehicle accident, to be solicited to make a claim for Personal Injury Protection benefits.

B. The treatment or services rendered were explained to the insured person, or his or her guardian, **sufficiently** for that person to sign this form with informed consent.

C. The accompanying statement or bill is **properly completed** in all material provisions and all relevant information has been provided therein. This means that each request for information has been responded to **truthfully, accurately**, and in a **substantially complete** manner.

D. The coding of procedures on the accompanying statement or bill is proper. This means that **no service has been upcoded, unbundled**, or constitutes an invalid **or not medically necessary diagnostic test** as defined by Section 627.732(14) and (15), Florida Statutes or Section 627.736(5)(b)6, Florida Statutes.

Licensed Medical Professional Rendering Treatment/Services or Medical Director, if applicable *(Signature by his/ her **own hand**)*:

Name *(PRINT or TYPE)*	Signature	Date

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of Claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree per Section 817.234(1)(b), Florida Statutes.

Note: The **original** of this form must be furnished to the insurer pursuant to Section 627.736(4)(b), Florida Statutes and may **not** be electronically furnished. Failure to furnish this form may result in non-payment of the claim.

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDEGMENT

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your **Notice of Privacy Practices** containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its **Notice of Privacy Practices** from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the **Notice of Privacy Practices**.

I understand that I may request in writing that you restrict how my private information is used or disclose to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: ____ Self _____Other _____

Signature: _____Date: _____

OFFICE USE ONLY

WITNESS: _____