FOCUS TOTAL HEALTH | PRIVIA MEDICAL GROUP

Today's Date

Patient Information

Last Name _____
First Name _____
First Name Used _____
Middle Name _____
Former Last Name _____
Legal Sex _____
Gender Identity ☐ Male ☐ Female
☐ Transgender FTM
☐ Transgender MTF
☐ Gender non-conforming
☐ Choose not to disclose
☐ Other, Please specify:_____
Assigned Sex at Birth ☐ Male ☐ Female
☐ Choose not to disclose
☐ Unknown
Preferred Pronouns ☐ he/him ☐ she/her
☐ they/them
DOB _____
Address _____
Address 2 _____
City _____
State _____
Zip _____
Home phone _____
Mobile phone _____
Work phone _____
Contact preference HOME MOBILE WORK
May we text you? YES NO
Email (required) _____
Preferred Pharmacy _____
Preferred Lab _____
Preferred Radiology _____

Marital Status _____
Homebound YES NO
Language _____
Race _____
Ethnicity _____

Guardian

Last Name _____
First Name _____
Middle name _____

Emergency Contact

Name _____
Relationship _____
Home phone _____
Mobile phone _____

Next of Kin

Name _____
Relationship _____
Phone _____

Employment

Employer name _____
Employer phone _____

How did you hear about us? **(please circle options below)**
Advertising Primary Care Physician Specialist Physician Word of Mouth
Insurance Patient in Practice Hospital Insurance Co. Other
Specify (if Other, above)

FOCUS TOTAL HEALTH | PRIVIA MEDICAL GROUP

Primary Insurance Information

Insurance Plan Name _____
ID/Certification No. _____
Policy/Group No. _____

Secondary Insurance Information

Insurance Plan Name _____
ID/Certification No. _____
Policy/Group No. _____

Primary Policy Holder (if other than patient)

Patient's Relationship to policy holder: _____
Last Name _____
First Name _____
Middle Name _____
Address _____
Address (ctd) _____
City _____
State _____
Zip _____
Date of Birth _____
Policy Holder Sex _____
Employer Name _____

Secondary Policy Holder (if other than patient)

Patient's Relationship to policy holder: _____
Last Name _____
First Name _____
Middle Name _____
Address _____
Address (ctd) _____
City _____
State _____
Zip _____
Date of Birth _____
Policy Holder Sex _____
Employer Name _____

Guarantor Information

Last Name _____
First Name _____
Middle name _____
DOB _____
Address _____
Address 2 _____
City _____
State _____
Zip _____

Optional Information

Phone _____

Patient Signature: _____ **Date:** _____

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Name: Insurance: Age: Date:

Drug/Food
Allergies: Reaction:

Reason for Visit:

Medications:

First Day of last menstrual period:

What do you use for contraception?

How old were you when you started having periods?

Is your period regular? Yes No

Is your period painful? Yes No

Frequency: Less than every 20 days 20-25 days 25-30 days 30+days

Duration: Less than 3 days 3-5 days 5-8 days 8+days

Flow: Mild Mild-Mod Moderate Mod-Heavy Heavy

History of abnormal pap? Yes No

History of surgery? Yes No If yes, what type & when?

Personal Medical History:

Asthma	Yes	No	High Cholesterol	Yes	No
Diabetes	Yes	No	Hypertension	Yes	No
Heart Disease	Yes	No	Rheumatic Fever	Yes	No
Blood Clot	Yes	No	Kidney Disease	Yes	No
Thyroid	Yes	No	Seizure	Yes	No
Hepatitis	Yes	No	Blood Transfusion	Yes	No
Depression	Yes	No	Domestic Violence	Yes	No
Major Accident	Yes	No	Cancer	Yes	No
			Type:		

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Family Medical History:

Diabetes	Yes	No	Father/Mother/Sibling/Other:
Hypertension	Yes	No	Father/Mother/Sibling/Other:
Heart Disease	Yes	No	Father/Mother/Sibling/Other:
Lung Disease	Yes	No	Father/Mother/Sibling/Other:
Kidney Disease	Yes	No	Father/Mother/Sibling/Other:
Endocrine Disorder	Yes	No	Father/Mother/Sibling/Other:
Blood Clot	Yes	No	Father/Mother/Sibling/Other:
Malignancy	Yes	No	Father/Mother/Sibling/Other:

Social History:

Your Occupation: _____

Marital Status: Married Single Widowed Divorced

Partner's Name: _____

Smoking:	Yes	No	Amount:
Alcohol:	Yes	No	
Drugs:	Yes	No	

How many pregnancies have you had? _____

How many children do you have? _____

History of sexually transmitted diseases:

Chlamydia	Yes	No	Treated:
Gonorrhea	Yes	No	Treated:
Syphilis	Yes	No	Treated:
Trichomonas	Yes	No	Treated:
Herpes	Yes	No	Treated:

History of preventative care:

Mammogram	Yes	No	Scheduled:
Colonoscopy	Yes	No	Scheduled:
DEXA (Bone) Scan:	Yes	No	Scheduled:

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SYMPTOMS-Female

Name _____ Date _____

Symptoms	**I Feel Bad=1** **I Feel Good=10**
Sleep	1 2 3 4 5 6 7 8 9 10
Anxiety	1 2 3 4 5 6 7 8 9 10
Sex Drive	1 2 3 4 5 6 7 8 9 10
Energy	1 2 3 4 5 6 7 8 9 10
Digestion (Gas/Bloating)	1 2 3 4 5 6 7 8 9 10
Inflammation/Pain	1 2 3 4 5 6 7 8 9 10
Constipation	1 2 3 4 5 6 7 8 9 10
Vaginal Dryness	1 2 3 4 5 6 7 8 9 10
Hot Flashes	1 2 3 4 5 6 7 8 9 10
Foggy Thinking	1 2 3 4 5 6 7 8 9 10
Mood Swings	1 2 3 4 5 6 7 8 9 10
Weight Gain	1 2 3 4 5 6 7 8 9 10
Overeating	1 2 3 4 5 6 7 8 9 10
Hair Loss	1 2 3 4 5 6 7 8 9 10
Retained Fluid	1 2 3 4 5 6 7 8 9 10
Headaches	1 2 3 4 5 6 7 8 9 10
Slump in Energy in PM	1 2 3 4 5 6 7 8 9 10
Frequent Infections/Sickness	1 2 3 4 5 6 7 8 9 10

For Office Use Only

Height:	Weight:	BP:

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Does cancer run in your family? Answer these questions about biological (blood) relatives on both sides of your family:

PARENTS
BROTHERS & SISTERS
HALF SIBLINGS
CHILDREN
GRANDCHILDREN
GRANDPARENTS
AUNTS & UNCLES
NIECES & NEPHEWS

PATIENT NAME

DATE OF BIRTH *(mm/dd/yyyy)*

TODAY'S DATE *(mm/dd/yy)*

1 *Have you or any of your relatives had* BREAST CANCER?

NO ☐ YES ☐ →

N ☐ Y ☐ Do you have 2 or more relatives with any of these cancers? *(Including yourself)*
○ BREAST CANCER ○ PANCREATIC CANCER ○ PROSTATE CANCER

N ☐ Y ☐ Do you have any grandparents who are Ashkenazi Jewish?

Have you or any of your relatives been diagnosed with:

N ☐ Y ☐ Breast cancer at age 45 or younger?
N ☐ Y ☐ Male breast cancer?
N ☐ Y ☐ Triple negative breast cancer at age 60 or younger?
N ☐ Y ☐ Two different breast cancers at age 50 or younger?

these are rare

If **YES** to any, fill out the other side of this form.

2 *Have you or any of your relatives had* LYNCH SYNDROME-RELATED CANCERS? *(see list at right)*

NO ☐ YES ☐ →

N ☐ Y ☐ Do you have 2 or more relatives with any of these cancers? *(Including yourself)*

LYNCH SYNDROME-RELATED CANCERS

○ COLORECTAL CANCER ○ SMALL BOWEL CANCER ○ URETER CANCER
○ UTERINE CANCER ○ BILIARY TRACT CANCER ○ BRAIN TUMORS
○ STOMACH CANCER ○ KIDNEY CANCER ○ PANCREATIC CANCER

Have you or any of your relatives been diagnosed with:

N ☐ Y ☐ Colorectal or uterine cancer at age 49 or younger?
N ☐ Y ☐ Two different types of Lynch syndrome-related cancer in one person?

these are rare

If **YES** to any, fill out the other side of this form.

3 *Have you or any of your relatives had* OVARIAN, FALLOPIAN TUBE, *or* PERITONEAL CANCER?

NO ☐ YES ☐ →

If **YES**, fill out the other side of this form.

If you answered **NO** to all the questions, you don't need to fill out the other side.

OFFICE USE ONLY Reviewed by: _____

Are **outlined** questions checked on front side?
☐ Yes → Turn to other side and count the cancers.
☐ No

Are **shaded** questions checked on front or back side?
☐ Yes → Patient meets NCCN criteria. → Patient accepted testing? ☐ Yes ☐ No
☐ No

Date drawn: _____

progenity® Prepare for life.

CANCER FAMILY HISTORY

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Complete this side if you have relatives with these cancers only

- ○ BREAST
- ○ PANCREATIC
- ○ PROSTATE
- ○ OVARIAN
- ○ FALLOPIAN
- ○ PERITONEAL
- ○ LYNCH SYNDROME-RELATED CANCERS
  - COLORECTAL
  - UTERINE
  - STOMACH
  - SMALL BOWEL
  - BILIARY TRACT
  - KIDNEY
  - URETER
  - BRAIN TUMORS

If you have more affected relatives, use the "other" space in each category.

PATIENT NAME

DATE OF BIRTH *(mm/dd/yyyy)*

Relatives on your mother's side

MOTHER
○ BREAST ○ PANCREATIC ○ LYNCH *specify:* ○ OVARIAN ○ FALLOPIAN ○ PERITONEAL
Age diagnosed: Available to test?*

MATERNAL AUNT/UNCLE
○ BREAST ○ PANCREATIC ○ LYNCH *specify:* ○ OVARIAN ○ FALLOPIAN ○ PERITONEAL ○ PROSTATE ☐ Female ☐ Male
Age diagnosed: Available to test?*

MATERNAL AUNT/UNCLE
○ BREAST ○ PANCREATIC ○ LYNCH *specify:* ○ OVARIAN ○ FALLOPIAN ○ PERITONEAL ○ PROSTATE ☐ Female ☐ Male
Age diagnosed: Available to test?*

MATERNAL GRANDMOTHER
○ BREAST ○ PANCREATIC ○ LYNCH *specify:* ○ OVARIAN ○ FALLOPIAN ○ PERITONEAL
Age diagnosed: Available to test?*

MATERNAL GRANDFATHER
○ BREAST ○ PANCREATIC ○ LYNCH *specify:* ○ PROSTATE
Age diagnosed: Available to test?*

OTHER MATERNAL *relationship:*
○ BREAST ○ PANCREATIC ○ LYNCH *specify:* ○ OVARIAN ○ FALLOPIAN ○ PERITONEAL ○ PROSTATE ☐ Female ☐ Male
Age diagnosed: Available to test?*

Relatives on your father's side

FATHER
○ BREAST ○ PANCREATIC ○ LYNCH *specify:* ○ PROSTATE
Age diagnosed: Available to test?*

PATERNAL AUNT/UNCLE
○ BREAST ○ PANCREATIC ○ LYNCH *specify:* ○ OVARIAN ○ FALLOPIAN ○ PERITONEAL ○ PROSTATE ☐ Female ☐ Male
Age diagnosed: Available to test?*

PATERNAL AUNT/UNCLE
○ BREAST ○ PANCREATIC ○ LYNCH *specify:* ○ OVARIAN ○ FALLOPIAN ○ PERITONEAL ○ PROSTATE ☐ Female ☐ Male
Age diagnosed: Available to test?*

PATERNAL GRANDMOTHER
○ BREAST ○ PANCREATIC ○ LYNCH *specify:* ○ OVARIAN ○ FALLOPIAN ○ PERITONEAL
Age diagnosed: Available to test?*

PATERNAL GRANDFATHER
○ BREAST ○ PANCREATIC ○ LYNCH *specify:* ○ PROSTATE
Age diagnosed: Available to test?*

OTHER PATERNAL *relationship:*
○ BREAST ○ PANCREATIC ○ LYNCH *specify:* ○ OVARIAN ○ FALLOPIAN ○ PERITONEAL ○ PROSTATE ☐ Female ☐ Male
Age diagnosed: Available to test?*

Relatives that belong to both your mother's and father's sides

YOU
○ BREAST ○ PANCREATIC ○ LYNCH *specify:* ○ OVARIAN ○ FALLOPIAN ○ PERITONEAL ○ PROSTATE ☐ Female ☐ Male
Age diagnosed:

YOUR CHILD
○ BREAST ○ PANCREATIC ○ LYNCH *specify:* ○ OVARIAN ○ FALLOPIAN ○ PERITONEAL ○ PROSTATE ☐ Female ☐ Male
Age diagnosed: Available to test?*

YOUR GRANDCHILD
○ BREAST ○ PANCREATIC ○ LYNCH *specify:* ○ OVARIAN ○ FALLOPIAN ○ PERITONEAL ○ PROSTATE ☐ Female ☐ Male
Age diagnosed: Available to test?*

YOUR SIBLING
○ BREAST ○ PANCREATIC ○ LYNCH *specify:* ○ OVARIAN ○ FALLOPIAN ○ PERITONEAL ○ PROSTATE ☐ Female ☐ Male
Age diagnosed: Available to test?*

YOUR NIECE/NEPHEW
○ BREAST ○ PANCREATIC ○ LYNCH *specify:* ○ OVARIAN ○ FALLOPIAN ○ PERITONEAL ○ PROSTATE ☐ Female ☐ Male
Age diagnosed: Available to test?*

OTHER *relationship:*
○ BREAST ○ PANCREATIC ○ LYNCH *specify:* ○ OVARIAN ○ FALLOPIAN ○ PERITONEAL ○ PROSTATE ☐ Female ☐ Male
Age diagnosed: Available to test?*

*AVAILABLE TO TEST?

- **N** Unavailable due to personal reasons
- **D** Deceased
- **E** Estranged; unable to contact
- **Y** Available for testing

Tell us if affected relatives are available for testing by writing the appropriate letter code in the box.

Some health plans require this information to determine eligibility.

OFFICE USE ONLY

If outlined questions are checked on the front, count the affected relatives on the **same side of the family**.

Relatives in the bottom category (**YOU**, **YOUR SIBLING**, etc.) count on **both sides of the family.**

N ☐ Y ☐ 3 people on the **same side of the family** with ☑ **BREAST**, ☑ **PANCREATIC**, or ☑ **PROSTATE CANCER?**

N ☐ Y ☐ 2 people on the **same side of the family** with ☑ **BREAST**, ☑ **PANCREATIC**, or ☑ **PROSTATE CANCER**, with one person diagnosed with breast cancer at age 50 or younger?

N ☐ Y ☐ 3 people on the **same side of the family** with ☑ **LYNCH-RELATED** or ☑ **PANCREATIC CANCER?**

N ☐ Y ☐ 2 people on the **same side of the family** with ☑ **LYNCH-RELATED** or ☑ **PANCREATIC CANCER** with one person diagnosed at age 49 or younger?

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Patient Handbook

Welcome!

This handbook should help you discover how we differ from a traditional medical practice and outlines our office policies. Please feel free to ask our front desk staff if you have any questions.

Making an Appointment

- **KNOW YOUR INSURANCE.** It is the responsibility of the patient to verify that Dr. Miskell is in-network with your insurance policy. Please also know your benefits. We frequently draw labs to ensure that you are healthy inside as well as out (even at annual check-ups), or to ensure that your hormone therapy is working properly. You may have a co-pay or deductible that will be due for your lab work. Please be aware of your financial responsibility before your labs are drawn by knowing your insurance benefits.
- If you have made the appointment for yourself, please don't ask us to see another family member or friend during your appointment time. We would be happy to schedule an appointment for them at another time.
- If your address, phone number, or insurance has changed, please let us know while scheduling your appointment so that we can have the most up-to-date record for you.
- If you are a new patient, please complete your paperwork ahead of time by printing it from the "Forms" section of our website or arrive at least 20 minutes early to complete the packet.

When You Arrive

- When you first arrive, please register with the receptionist. You will be given an update sheet to fill out at every visit. This update sheet will need to reflect your current symptoms & any medication changes, etc.
- If this is your first appointment, plan to arrive a little early to complete your registration and insurance information.
- Please bring your insurance cards and a valid photo ID to your appointment.
- Please be prepared to pay for your visit at the time of service. This includes co-pays and deductibles.

When You Are Late For an Appointment

- Your time is valuable, and so is the doctor's/nurse practitioner's.
- Please be prompt.
- If you arrive 10 minutes or more after your scheduled appointment time, your appointment will have to be rescheduled.

Canceling Your Appointment

- Please give us 24 hours advance notice so that we may offer that appointment to someone on our waiting list.
- We now charge a fee when patients fail to show up for an appointment. The fee is $50 for established patients, and $75 for new patients. However, after three no-shows without notification, we will be forced to release you from our practice. We tend to have a full schedule every day. Late and missed appointments disrupt patient flow and unnecessarily prevent other patients from being able to schedule appointments during those missed slots.
- If you are a new patient and you do not show up for 2 consecutive appointments, and you do not call to cancel, you will be released from the practice.

When You Need Us After Hours

- When you call our office after hours, you will be directed to our answering service or voice mail.
- If you are experiencing a medical emergency or you believe you are experiencing a life-threatening situation, call 911 immediately, or go to the emergency department of your nearest hospital.
- If your urgent medical need is not life threatening, and it is during normal business hours, please call the office. We will help you determine the best plan of care.

Diagnostic/Lab Testing

- Please understand that fees allowed by your insurance for lab work are out of our control. Some companies pay for labs in full, some charge a percentage of the billed rate, and others will charge you for all of your lab work until a deductible has been met. As every insurance policy is different, we ask that you verify your lab benefits prior to your blood draw. Once it has been sent to the insurance company, there is little we can do to adjust a bill. As an alternative to billing your insurance company, we offer discounted cash lab rates for most of the labs we require.
- We know that you want to know the results of your lab tests and other diagnostic testing as soon as you can.
- Our office policy is that all patients must make a follow-up appointment with the doctor or Nurse Practitioner to go over lab results & determine a plan of care.

Prescriptions

- When you need a prescription filled, contact your pharmacy. The pharmacy will notify our office via fax.
- For all patients on hormone or thyroid therapy, our office requires labs at least every 6 months in order to maintain refills.
- Please do not allow yourself to run out of medication. Most of the medications that our office prescribes are specialty or compounded and it can take several days for your pharmacy to fill your prescription.
- Most insurance companies do not pay for compounded medications, although a few are beginning to do so. Occasionally, an insurance company will request a prior authorization form to be filled out before considering the charges. We do NOT do prior authorizations, as there is little evidence this lengthy process increases the likelihood that the prescriptions will be covered. A majority of our patients do find that it is cheaper to pay cash than to pay the insurance rate for these specialty drugs. If compounds are too costly, we will work with you to find an appropriate bio-identical prescription available at a standard pharmacy.

Thank you for choosing our practice for your healthcare needs!

I have read and agree to the above office policies.

Patient Signature: _____ Date: _____

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CONSENT TO TREAT & NOTICE OF OFF-LABEL USE

SAFETY OF HORMONE REPLACEMENT & OFF-LABEL DRUG USE

What is considered off-label drug/prescription use?

1. It is considered off-label use/alternative medicine if you are on any compounded form of medication. Please note that compounded medications do not meet FDA approval and therefore are considered off-label.
2. It is considered off-label use/alternative if you are on a medication which is being used outside of the medication labeling offered by the package insert.

Drug labels are specific to the disease they treat and therefore if the medication is used to treat a disease that is not specified in the label, then the agent is being used off-label. Additionally, any change to the approved dose, frequency or route of administration would constitute an off-label use.

The use of off-label medications is common practice among the medical community and while we are not legally required to obtain a signed written consent it is the belief of this practice that the patient be fully aware of the current treatment plan recommended including its risks, benefits and alternatives to your plan of care. Remember that even over the counter medications carry risks when taken. It is our belief that the treatment of hormone deficiencies can be of great benefit in improving quality of life

Medications and supplements which may be used off-label or as alternative medicine can include but are not limited to the following: armour thyroid, estriol, estradiol, progesterone, DHEA, and/or testosterone via pellets, injections or in compounded formulations. The use of supplements may also be used in an effort to help improve conditions and or symptoms that you may have presented with during your initial consultation and throughout the course of your visit.

If you experience any side effects associated from current prescribed medications please call the office immediately. If it is after usual business hours and you should have severe side effects please proceed to the nearest emergency room or urgent care facility for appropriate treatment.

While hormone therapy will not cause cancer, the use of hormones could potentially make an estrogen and/or progesterone positive cancer grow. Most breast cancers fall into this category.

As a patient you have the right to refuse any off-label use of the medication being prescribed. You also have the right to ask questions regarding the current treatment plan as well as alternatives to what is being prescribed. If you have any questions or concerns please make sure to discuss with your provider during your consultation and any future visits.

FEMALE PATIENTS DESIRING HORMONE REPLACEMENT

The reasonable alternatives to this treatment have been explained to me and they include:

1. Leaving the hormone levels as they are.
2. Treating age related diseases as they appear.
3. Using pharmaceutical agents that are not bio-identical in nature.

Possible side effects for women on estrogen, progesterone and/or testosterone (in any method of delivery) include: breast swelling or discomfort, fluid retention, dizziness, break through bleeding, acne, unwanted hair growth, headaches, increased risk of heart attack, stroke and other cardiovascular problems, increased risk of gallbladder disease, increased risk of blood clots; worsening of: ovarian cysts, uterine fibroids, endometriosis, and fibrocystic disease.

Contraindications: Do not use hormone replacement if you have a known history of reproductive system related cancers such as breast cancer, ovarian cancer, uterine cancer. Exceptions include reproductive system responsive cancer which has been under remission for over 5 years.

I also understand that if I am female and become pregnant, I should stop the entire treatment protocol immediately and notify my primary physician. I understand that this hormone therapy is not for the purpose of preventing pregnancy, and that if I become pregnant on this therapy it could present risk to the fetus (unborn child).

I have provided The Focus with a copy of my most recent pap and mammogram (if these tests were not completed by this office) and the results are within one year of this appointment.

_____(Initial) I understand the possible treatments and side effects

MALE PATIENTS DESIRING HORMONE REPLACEMENT

The reasonable alternatives to this treatment have been explained to me and they include:

1. Leaving the hormone levels as they are.
2. Treating age related diseases as they appear.
3. Using pharmaceutical agents that are not bio-identical in nature.

Possible side effects for men on testosterone replacement are: acne, persistent erections, unwanted hair growth, enlargement of the prostate, enlargement of breast tissue, testicular atrophy (shrinking); and increased risk of heart attack, stroke and other cardiovascular problems.

Contraindications: Do not use hormone replacement if you have a known history of reproductive system related cancers such as prostate cancer. Exceptions include reproductive system responsive cancer which has been under remission for over 5 years.

_____(Initial) I understand the possible treatments and side effects

ALL PATIENTS: OBLIGATIONS & REPRESENTATIONS

Any questions I have regarding this treatment have been answered to my satisfaction. I will comply with the recommended dose and methods of administration. I also agree to participate in the initial and subsequent blood testing as required to monitor my hormone levels.

I have disclosed accurate and true information regarding my medical history, medications, and surgeries.

I certify that I am under the regular care of another physician for all other medical conditions. I will consult my primary care physician(s) for any other medical services I may require (with the exception of gynecology). I understand that this is a specialized practice. I also understand that I will continue under the care of my other physician(s) for any on-going medical condition as well as for any medical consultation that I may need.

I assume full liability for any adverse effects that may result from the non-negligent administration of the proposed treatment. I waive any claim in law or equity for redress of any grievance that I may have concerning or resulting from the therapy, except as that claim pertains to negligent administration of the therapy.

I fully understand the nature and purpose of portions of the aforementioned treatment may be considered experimental because of the lack of adequate scientific evidence or peer-reviewed publications supporting the underlying premise of bio-identical hormone replacement therapy and that such therapy might even be considered by some medical professionals to be medically unnecessary because it is not aimed at treating a particular disease.

I understand that I may suspend or terminate treatment at any time and hereby agree to immediately notify the physician of any such suspension or termination.

I also understand there are possible benefits associated with this therapy but that no guarantee has been made to me regarding the outcomes of this treatment. I also understand that the benefits derived from antioxidant therapy, hormone therapy and drugs that alter hormone levels will cease or reverse if the therapy is discontinued.

ALL PATIENTS: CONSENT

I hereby authorize my physician to evaluate and treat the conditions I specified above. I understand that my physician may be assisted by other health professionals, as necessary, and agree to their participation in my care as it relates to the evaluation and treatment of the conditions this Consent to Treat covers. I am competent to sign this Consent to Treat and have done so of my own free will.

_____ _____

Printed Name of Patient Signature of Patient

_____ _____

Signature of Witness Date