

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

<u>Symptoms</u>	<u>X</u>	<u>Sleep Habits</u>	<u>Time</u>
Loud snoring		At what time do you usually get in the bed?	
Breathing or snoring stops in my sleep		How long does it take you to fall asleep after you have turned out the lights?	
Awaken gasping for breath		How often do you awaken each night?	
Become sleepy during the day		Total time I spend awake in bed?	
Difficulty falling asleep		I usually wake up from sleep at?	
Difficulty remaining asleep		What time do you get out of bed from sleep?	
Awaken too early		Indicate total length of naps daily?	
My mind races with many thoughts when I try to fall asleep		If you do rotating shift work, or have other work schedule changes and need more space to describe?	
I often worry whether or not I will be able to fall asleep		<b><u>Epworth Sleepiness Scale</u></b>	
Fatigue			
Awaken with a dry mouth			
Vivid or lifelike visions (people in room, etc) as you fall asleep or wake up		How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the <b>most appropriate number</b> for each situation. 0 = would never doze; 1 = slight chance of dozing; 2 = moderate chance of dozing; 3 = high chance of dozing	
Irritability/ Depression			
Memory impairment or Inability to concentrate		<b><u>Situation</u></b>	<b><u>Score</u></b>
Sinus trouble, nasal congestion or post-nasal drip interfering with sleep		Sitting and reading	
Heartburn, sour belches, regurgitation, or indigestion which disrupts sleep		Watching TV	
Pain which delays, prevents, or awakens me from sleep		Sitting, inactive, in a public place (e.g., a theater or a meeting)	
Inability to move as you are trying to go to sleep or wake up		As a passenger in a car for an hour without a break	
Morning headaches		Lying down to rest in the afternoon	
Sudden weakness or feel your body go limp when you are angry or excited		Sitting and talking with someone	
Irresistible urge to move legs or arms		Sitting quietly after a lunch without alcohol	
Creeping or crawling sensation in your legs before falling asleep		In a car, while stopped for a few minutes in traffic	
Legs or arms jerking during sleep			
Frequent urination disrupting sleep		<b>Total*</b>	
Sleep talking or Sleep walking		*Greater than 10 indicates sleepiness	

**Patient Name:** \_\_\_\_\_

**DOB:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**MEDICATIONS: PLEASE LIST THE NAME(S) AND DOSAGE(S) OF ALL MEDICATIONS YOU CURRENTLY TAKE.**

Check here for  NO Medications

_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you currently take any medication to fall asleep?  NO  YES what type? \_\_\_\_\_ how long? \_\_\_\_\_

Have you ever used sleep medications?  NO  YES what type? \_\_\_\_\_ how long? \_\_\_\_\_

**ALLERGIES: PLEASE LIST ALL ALLERGENS AND YOUR REACTION TO THEM.**

Check here for  NO Allergies

_____	_____	_____
_____	_____	_____
_____	_____	_____

**SOCIAL HISTORY:** Please answer all questions below

Do you smoke?  NO  YES  Cigarettes  Cigars  Pipe How often/How long? \_\_\_\_\_

Do you drink alcohol?  NO  YES  Beer  Wine  Liquor / Mixed drinks How often? \_\_\_\_\_

Do you use street drugs?  NO  YES What Type(s)? \_\_\_\_\_ How often? \_\_\_\_\_

Employment  Employed  Retired  Not working at this time.

Are you Married?  NO  YES  Divorced  Separated



Neurodiagnostic  
Sleep Centers

**SLEEP STUDY CONSENT**  
**PSG, CPAP, BiPAP, MSL T and/or MWT**

I have been referred to American Medical Diagnostics (AMDx, Ltd.) I NeuroDiagnostic Sleep Centers (NDL, LLC) for a diagnostic sleep study as requested by my physician, to further understand my medical condition.

Diagnostic sleep studies involve the placement of electrodes on your scalp, face, neck, chest, hand(s) and leg(s) to measure and record brain activity, heart activity, respiration, body movement, blood oxygen content and Rapid Eye Movement (REM) in order to determine the levels of sleep. You will be monitored, for both audio and video, using an infra-red video camera and an intercom system.

The sleep technologist will not be able to share any information about your study with you, until the physician has reviewed all of the data collected. The sleep study results are typically available within one (1) week of the date of the study. Please keep in mind, every patient and their condition(s) are unique therefore not every sleep study will result in a confirmed diagnosis. There are no known side effects of this type of testing. The alternative to this type of testing is to not have it performed, where the information regarding a potential sleep disorder will not be obtained.

**I HAVE BEEN ADVISED OF AND UNDERSTAND THE DEFINITIONS AND PROCEDURES DESCRIBED WITHIN THIS DOCUMENT AND AGREE TO PROCEED WITH THE SLEEP STUDY**

**Patient Name (printed):** \_\_\_\_\_ **Patient Signature:** \_\_\_\_\_

**If the patient is a minor, please print the name of the patient's representative:**

\_\_\_\_\_, Relationship to the Minor \_\_\_\_\_

**Representative Signature:** \_\_\_\_\_



**FINANCIAL POLICY**

As a courtesy to our patients, our facility will provide the service of billing your insurance carrier. However, practical benefits are not determined until a claim is received by your insurance company. When requested, our group can provide an estimate of your cost share, as determined by your insurance carrier. Therefore, as the patient and/or responsible party, you are responsible for providing us with the most current and complete information regarding your insurance coverage. This includes but is not limited to; Health Plan Name, Policy ID and Group ID (when applicable), Cardholder Name (if different than the patient) and providing a copy of your insurance card at the time of service. It is also your responsibility to pay any amounts determined to be patient responsibility by your insurance carrier, at the time service is rendered. Any service(s) denied by your insurance for reasons that cannot be appealed by our medical group, will become the financial responsibility of the patient and/or responsible party.

For patients without coverage by an insurance carrier, an initial payment equal to no less than one half (1/2) of the total cost for the ordered test(s) is due at the time service is rendered. Failure to make payment, within the agreed time(s) allotted will result in collection activity. The patient and/or responsible party will assume all financial costs assigned by the collection agency, attorney and/or court, in addition to the original patient balance with AMDx, Ltd. (dba: NeuroDiagnostic Laboratories, LLC).

A Non-sufficient Funds (NSF) Fee of \$25.00 will be applied to the patient and/or responsible party balance for any returned check(s). At that point, any/all future payments must be made in cash, money order or credit/debit transactions.

**ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION**

I authorize direct remittance of insurance benefit payment(s) including Medicare (when applicable) to AMDx, Ltd, (dba: NeuroDiagnostic Laboratories, LLC) and/or the affiliated entities or otherwise at its direction.

I further authorize the release of any information pertaining to the Health Care Financing Administration, My Insurance Carrier(s) and/or other entities necessary in the determination of benefit payment and coverage for services and/or supplies provided to me by AMDx, Ltd (dba: NeuroDiagnostic Laboratories, LLC).

**AUTHORIZATION TO APPEAL ON PATIENT'S BEHALF**

I further authorize AMDx, Ltd., (dba: NeuroDiagnostic Laboratories, LLC) and/or the affiliated entities to submit appeals on my behalf, including submissions to Medicare, if I am a Medicare beneficiary. I understand that in the even of an adverse decision made by my insurance carrier as it relates to coverage, authorization or payment(s), AMDx, Ltd., (dba: NeuroDiagnostic Laboratories, LLC) is not obligated to file an appeal on my behalf and that by signing this authorization I am not released from any financial obligation resulting from the determination(s) made by my insurance carrier.

**I HAVE BEEN ADVISED OF, UNDERSTAND AND AGREE TO THE FINANCIAL POLICY AND SUBSECTIONS WITHIN.**

Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**Patient Name** (printed): \_\_\_\_\_ **Patient Signature:** \_\_\_\_\_

**If the patient is a minor, please print the name of the patient's representative:**

\_\_\_\_\_, Relationship to the Minor \_\_\_\_\_

Representative Signature: \_\_\_\_\_



## **Acknowledgement of Receipt of Notice of Privacy Practice And Patient Rights Form**

This document provides acknowledgement of receipt of the American Medical Diagnostics Ltd (AMDx, Ltd.) / NeuroDiagnostic Laboratories, LLC (AMDx) Notice of Privacy Practices and Patient Rights Form. AMDx maintains strict compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the guidelines set therein.

Any questions you have regarding the information provided in the AMDx Notice of Privacy Practices or Patient Rights Forms should be directed to AMDx Administrative staff or the Privacy Officer indicated on the Privacy Practice.

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I understand that certain disclosures are required under federal law and may be released by AMDx, upon request from an authorized entity, as outlined below:

- Public Health Activities
- Health Oversight Activities
- Law Enforcement
- Coroners, Medical Examiners and Funeral Directors
- Organ and Tissue Donation
- Certain research projects
- Disclosures necessary to prevent serious threats to health or safety
- Military Command Authorities; if you are a member of the armed forces or foreign military authority
- National Security and Intelligence
- Worker's Compensation Payers; and
- Disclosures necessary to initiate and complete health care treatment
- Payment and operations or functions by business associates

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I further understand that the disclosures outlined below may be considered optional and that I may choose to 'opt out' of these types of disclosures by selecting '*decline*' for any or all circumstances below.

- Family members or close friends who are involved in your care or payment for treatment  DECLINE
- Disaster Relief Agencies; if you are involved in a disaster relief effort; and  DECLINE
- Information provided to you regarding alternative treatments for your health care  DECLINE

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I have been given, and have read and understand my rights under the Notice of Privacy Practices.  
I have been given, and have read and understand my rights under the Patient Rights Form.

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

**Patient Name (printed):** \_\_\_\_\_

If applicable, please print the name of the Patient's Representative: \_\_\_\_\_

Relationship to the patient: \_\_\_\_\_ Representative Signature: \_\_\_\_\_



## Patient Rights

As an individual receiving services through NeuroDiagnostic Labs, you have the right:

- To receive services regardless of your race, national origin, religion, gender, sexual orientation, age, disability, marital status, or diagnosis.
- To receive services that support and respect the patient's individuality, choices, strengths, and abilities.
- To receive privacy in care for personal needs.
- To review, upon written request, the patient's own medical record according to A.R.S. §§ 12-2293, 12-2294, and 12-2294.01;
- To receive a referral to another health care institution if the provider is unable to provide physical health services or behavioral health services for the patient.
- To receive assistance from a family member, representative, or other individual in understanding, protecting, or exercising the patient's rights.
- To be treated with consideration, respect and dignity, including privacy in treatment.
- To not be subjected to: Abuse; Neglect; Exploitation; Coercion; Manipulation; Sexual abuse; Sexual assault; Seclusion; Restraint, if not necessary to prevent imminent harm to self or others; Retaliation for submitting a complaint to the Department or another entity; or Misappropriation of personal and private property by a unclassified health care institution's personnel members, employees, volunteers, or students; and A patient or the patient's representative
- To be informed of the patient compliant process.
- To be given the opportunity to give consent to photographs of the patient before a patient is photographed except that a patient may be photographed when admitted to a health care institution for identification and administrative purposes.
- To provide written consent to the release of patient's medical records and financial records.
- To express complaints about the care and services provided and to have the health center investigate such complaints. NeuroDiagnostic Labs is responsible for providing you or your designee with a written response within 30 days, if requested, indicating the findings of the investigation. NeuroDiagnostic Labs is also responsible for notifying you or your designee that if you are not satisfied by our response, you may complain to the Arizona Department of Health Office.

Submit complaints in writing to:

NeuroDiagnostic Labs  
Attn: Mike McCloskey  
2423 W. Dunlap Ave #175  
Phoenix, AZ 85021



## **NOTICE OF PRIVACY PRACTICES**

### **THIS NOTICE IS INTENDED TO DESCRIBE HOW YOUR HEALTH INFORMATION MAY BE USED OR DISCLOSED AND HOW YOU MAY OBTAIN ACCESS TO THIS INFORMATION**

**\*\* PLEASE REVIEW THIS INFORMATION CAREFULLY \*\***

1) **PURPOSE:** American Medical Diagnostics, Ltd (AMDx, Ltd.), NeuroDiagnostic Laboratories, LLC (NDL) and their employees follow the privacy practices described within this notice. AMDx, Ltd. / NDL maintain your health information and confidential records, as required by law. AMDx, Ltd./ NDL may use, disclose or share your health information as pertains to your treatment, payment of services and the general healthcare operations, necessary to provide you with quality health care.

2) **WHAT ARE TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS?** **Treatment** may include sharing information with the other health care providers who are involved in your care. For example, your health care provider may need to share information about your condition with a pharmacist in order for you to receive medications. **Payment** may include use of your health information as required by your insurance carrier to obtain prior authorization, when applicable, and payment for services rendered. **Health Care Operations** may include limited use of your health information to help improve the quality of your care and/or for educational purposes as it relates to the training of AMDx, Ltd. / NDL employees and staff.

3) **HOW WILL AMDx, Ltd. /NDL USE OR DISCLOSE MY HEALTH INFORMATION?** Your health information may be used for the following reasons or disclosed to the following individuals and entities. *Note: You may refuse any/all communications outlined below, when shown with an asterisk (\*).*

- Family members or close friends who are involved in your care or payment for treatment, or to family members, a personal representative or another person responsible for your or regarding your location, general condition or death. (\*)
- Disaster Relief Agency, if you are involved in a disaster relief effort (\*)
- Information provided to you, regarding alternative treatments or services related to your health (\*)
- Appointment Reminders
- Public Health Activities, such as; disease prevention, injury or disability, reporting of births/deaths, reporting adverse reactions to medications or product concerns, notification of recalls, infectious disease control, and notification to government agencies for suspected abuse, neglect or domestic violence
- Health Oversight Activities, such as; audits, inspections, investigation and licensure
- For Public Safety and Law Enforcement Activities, such as reporting crime in an emergency, a death that we suspect may have resulted from criminal conduct, to report a crime at one of our facilities, or to report information about a victim of a crime
- Marketing involving treatment, case management or care coordination, to direct or recommend alternative treatments, therapies, health care providers or settings, to describe a health related product or service included in a plan or benefits. AMDx Ltd./NDL will obtain your authorization prior to using or disclosing your health information for purposes of marketing items or services to you if it is paid to make the communication. You may revoke your authorization by making a written request to **[insert contact info]**
- To assist Coroners, Medical Examiners and Funeral Directors in carrying out their job duties
- Organ and Tissue Donation
- Certain Research Projects or for reviews preparatory to research
- Disclosures necessary to prevent or lessen a serious and imminent threat to health or safety of a person or the public
- If the disclosure is required by federal or state law, such as in the case of child neglect or abuse reporting
- Military Command Authorities, if you are a member of the armed forces or a member of a foreign military authority
- National security and intelligence activities to authorized person who use the disclose to conduct special investigations
- Worker's Compensation Payers, as it relates to any injury and/or illness reported to or by a worker's compensation office
- For judicial or administrative proceedings if ordered by a court or in response to a subpoena
- To a correctional institution or law enforcement official if you are in inmate of a correctional facility or are under the custody of a law enforcement official to provide you with health care or to protect your health and safety or the health and safety of others, including the correctional institution.



- Use or disclosure necessary to initiate and complete health care treatment, payment and operations or functions by business associates, such as; installation of a new computer software system

**Note: Information with Additional Protection:** Certain types of medical information have additional protection under Arizona law. In some circumstances, we will require your consent to disclose information about communicable disease and HIV/AIDS, drug and alcohol abuse treatment, genetic testing, and mental health treatment.

4) **YOUR AUTHORIZATION IS REQUIRED FOR OTHER DISCLOSURES:** Except where otherwise described, use and/or disclose of your medical information will be not be released by AMDx, Ltd. / NDL. If you would like us to release your medical information to a party/parties not otherwise mentioned, your request must be provided in writing and will only be effective as of the date you indicate. In addition, AMDx Ltd./NDL require your written authorization to use or disclose your psychotherapy notes or to sell your health information. You may revoke any authorization to use or disclose your health information at any time by contacting [**insert contact info**], however, you understand that AMDx Ltd./NDL may have already acted on your authorization to use or disclose your health information.

5) **WHAT ARE MY RIGHTS REGARDING MY HEALTH INFORMATION?** You have the following rights, when requested on the form(s) provided by AMDx, Ltd. / NDL:

- **The Right to Request Restrictions:** You may request certain limitations on the usage or disclosure of your health information in relation to your health care, treatment, payment or operations. However, we are not required to comply with these types of requests, unless you request that we do not share your health information with your health insurer about a service for which you (or someone other than your insurer) has paid us in full and the disclosure is for the purpose of carrying out payment or health care operations and the disclosure is not otherwise required by law.
- **The Right to Confidential Communications:** You may request that communication regarding your health information be provided in a certain way or at a location, other than the personal address you provided. When submitting such a request, you must also provide a written method of contact for yourself; i.e., alternate phone number or address.
- **The Right to Inspect and Copy:** You may review and request a copy of your medical or health record(s). For certain requests, an administrative fee to cover the cost of the request may be applied. Under limited circumstances, your request may be denied. You then have the right to request review of the denial by another licensed health care professional, as selected by AMDx, Ltd. / NDL. After the review is completed, AMDx, Ltd. / NDL will comply with the outcome.
- **The Right to Request Amendment:** You may request an amendment to your medical or health record(s), if you believe that information maintained by AMDx, Ltd. / NDL is incorrect or incomplete. However, we are not required to accept the amendment.
- **The Right to Accounting of Disclosures:** You may request a list of some of the disclosures made by AMDx Ltd./NDL of your health information. AMDx, Ltd. / NDL may apply an administrative fee for any request received after the initial request.
- **The Right to a Copy of This Notice:** You may request a paper copy of this notice at any time, even if you have been provided with an electronic copy. To obtain an electronic copy of this notice, please refer to our website, at: [www.ndxlabs.com](http://www.ndxlabs.com).
- **To Be Notified in the Event of a Breach.** In the event AMDx. Ltd./NDL determine that the confidentiality of your health information has been breached, you have the right to be notified.

6) **WHAT REQUIREMENTS APPLY TO THIS NOTICE?** AMDx, Ltd. / NDL is required by law to provide you with this notice and will continue to comply with the provisions outlined within, for as long as it is required by law. AMDx, Ltd. / NDL reserves the right to change the terms outlined within this notice and any such changes will be effective for all information that may be in our health records for you, as well as for all future information we receive for or by you. All revisions to this notice will be available on our website, at [www.ndxlabs.com](http://www.ndxlabs.com). Revised paper copies will also be available, upon request. A copy of the notice may be provided to you, each time you register to receive services by AMDx, Ltd. / NDL.

7) **WHAT IF I HAVE A COMPLAINT REGARDING PRIVACY PRACTICES?** If you believe your privacy rights have been violated, you may file a complaint with the AMDx, Ltd. / NDL Privacy Officer or with the Secretary of the United State Department of Health and Human Services. All complaints must be submitted in writing and must describe the details / situation that caused the complaint. You will not be penalized or retaliated against for filing a complaint to AMDx, Ltd. / NDL or to the Department of Health and Human Services.

AMDx, Ltd. / NDL  
**ATTN: Privacy Officer**  
2423 W. Dunlap Ave | Suite 175  
Phoenix, AZ. 85021-5818  
(P) 602.424.4450 | (F) 602.424.4451

Effective: 9/23/13





APPOINTMENT DATE ____ / ____ / ____
----------------------------------------

## Bedtime Questionnaire

Patient name: \_\_\_\_\_

DOB: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

PLEASE COMPLETE ALL SECTIONS AND PRINT CLEARLY

Did you take any naps today?  NO  YES

Did you have any caffeinated beverages today?  NO  YES

If yes, at what times? \_\_\_\_\_ What time and how many: \_\_\_\_\_

Did you have any alcoholic beverages today?  NO  YES

If yes, at what times? \_\_\_\_\_ How much / how many: \_\_\_\_\_

Did you take any medications to help you stay awake?  NO  YES

If yes, what type? \_\_\_\_\_ At what time? \_\_\_\_\_

Did you take any sleep aids today?  NO  YES

If yes, what type? \_\_\_\_\_ At what time? \_\_\_\_\_

**Patient Name** (printed): \_\_\_\_\_ **Patient Signature:** \_\_\_\_\_

**If the patient is a minor, please print the name of the patient's representative:**

\_\_\_\_\_, Relationship to the Minor \_\_\_\_\_

Representative Signature: \_\_\_\_\_



## **DRIVING RECOMMENDATION AND ACKNOWLEDGEMENT**

Driving while groggy, sleepy and/or under the influence of any medications that may cause drowsiness can be dangerous, potentially leading to serious injuries or even death. It is the opinion and strong recommendation of the management, staff and/or other affiliates of American Medical Diagnostics (AMDx, Ltd.) and NeuroDiagnostic Sleep Centers (NDL, LLC) that if you feel too groggy in the morning that you call for alternative transportation home from the lab. Please note: we are not be responsible for any adverse actions or events that you may be subject to, should you choose to decline alternate transportation options.

As a courtesy to our patients, we provide a small selection of coffee at each sleep lab center for your use. However, we do not have other breakfast items or food of any kind. If you would like something to eat before leaving the center, please bring a snack(s) with you.

I HAVE BEEN ADVISED OF AND FULLY UNDERSTAND THE DRIVING RECOMMENDATIONS MADE BY THE MANAGEMENT, STAFF AND/OR OTHER AFFILIATES OF AMDx, Ltd. | NDL, LLC, AND HAVE MADE THE FOLLOWING DECISION REGARDING MY TRANSPORTATION:

- I have arranged for alternative transportation (i.e., friend/family member, taxi/cab, bus)
- I have DECLINED to arrange alternative transportation\*

By DECLINING to arrange alternative transportation, I accept full responsibility for any adverse actions and/or events that may result from my decision\*

Patient Name (printed): \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_



## **Sleep Study Cancellation Policy**

Each patient is scheduled with a specific sleep technologist for the entire night of observation. Therefore, if the patient does not show up for his/her scheduled appointment the technologist may be without work. This is unfair to staff and other patients needing a sleep study who may have wanted to schedule appointment date / time.

If 3 full-business days' notice is not provided and/or you arrive more than 15 minutes late for your appointment there is a \$250.00 cancellation/ no show fee that you will be responsible for. Confirmation of cancellation must be received by verbal conversation with one of our staff members. By providing your credit card information you are authorizing NeuroDiagnositic Labs to charge the card on file if this policy is not followed.

\*Further documentation may be required in the event your appointment is canceled outside of the policy guidelines.

Thank you in advance for your understanding and cooperation with the outlined policy.

I HAVE READ, UNDERSTAND AND AGREE TO THE SLEEP STUDY CANCELLATION POLICY OUTLINED WITHIN THIS DOCUMENT.

Patient Name (printed): \_\_\_\_\_ Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

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



APPOINTMENT DATE ____ / ____ / ____
----------------------------------------

## Morning Questionnaire

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

### PLEASE COMPLETE ALL SECTIONS AND PRINT CLEARLY

How long do you think it took for you to fall asleep last night? 0-30 Minutes \_\_\_\_\_ 30-60 \_\_\_\_\_ Longer \_\_\_\_\_

Compared to your normal sleep, how did you sleep last night?  Better  Same  Worse

Compared to your normal sleep, how much sleep did you get last night?  More  Same  Less

Do you feel last night's sleep was adequate?  NO  YES

How many times do you think you woke up last night?  Unsure  Not at all  \_\_\_\_ times

Please make **ONE** selection that best describes how you felt when you woke up this morning:

Active, vital, alert and awake  Foggy, not able to concentrate

Relaxed, awake, but not at full alertness  Sleepy, fighting to stay awake

Did anything bother you during the night?  NO  YES

Explain: \_\_\_\_\_

**Patient Name** (printed): \_\_\_\_\_ **Patient Signature:** \_\_\_\_\_

**If the patient is a minor, please print the name of the patient's representative:**

\_\_\_\_\_, Relationship to the Minor \_\_\_\_\_

Representative Signature: \_\_\_\_\_