Body By Design

Wellness Chiropractic PLLC

Where Health Begins

Pediatric Patient Application

WELCOME TO OUR OFFICE,

We specialize in assisting our patients to achieve their highest level of health through our spinal and postural corrective programs. Our approach is very unique and advanced from other rehabilitative programs. This allows our patients to achieve far superior results compared to most other systems.

- Please fill out the following information thoroughly so the doctor can let you know if your child is a case we can accept.
- Please note, filling out this form does not guarantee acceptance to this program, the doctor must feel as though your child is a candidate for our specific type of treatment.

Please feel free to ask any questions if you need assistance. We truly look forward to serving you.

Patient Name

Parent Signature

Date

File Number
For Office Use Only

Our Mission

We are here to help as many individuals & families as possible achieve their health needs, wants & goals by providing knowledge, expertise & the support to attain them

Our Commitment

We commit to provide the highest quality care & treatment while always maintaining the drive for excellence as we guide you along your lifelong journey to health & wellness

DATE: _____

PEDIATRIC PATIENT APPLICATION SURVEY

PATIENT INFORMATION

Name: _____ Age _____ Birth Date: ____ / ____ / _____ Gender: ○ Male ○ Female

Home Address: _____ Home Phone: ( ) _____

City, State, Zip: _____ Work Phone: ( ) _____

Email Address: _____ Cell Phone: ( ) _____

Social Security #: ____ - ____ - _____ School: _____ ○ Nursery ○ Pre ○ Elementary ○ M.S ○ H.S

Mother's Name _____ Fathers' Name _____

Mother's Occupation: _____ Fathers' Occupation: _____

Mother's Phone: ( ) _____ Fathers' Phone: ( ) _____

Mother's Email: _____ Fathers' Email: _____

IN CASE OF EMERGENCY, CONTACT

Name: _____ Relationship: _____ Contact Number: ( ) _____

How did you hear about us?: ○ Television ○ Radio ○ Health Talk ○ Friend/Family ○ Online

Who may we thank for referring you to our office: _____

PURPOSE OF THIS VISIT

HOW CAN WE HELP YOUR CHILD?

○ Wellness Checkup – If Wellness, please skip to the next section.

○ Other: _____

Is this purpose related to an auto accident / work injury? ○ Yes ○ No If so, when: _____

When did this condition begin? _____ Did it begin: ○ Gradual ○ Sudden ○ Progressive over time

Is your child already experiencing a symptom, describe it? _____

How bad is it? How intense are the symptoms? (circle) 0 1 2 3 4 5 6 7 8 9 10

0 NO SYMPTOMS — 10 INTENSE SYMPTOMS

How often are they experiencing the symptoms throughout the day? : 100% 75% 50% 25% 10% Only with Activity

Have they experienced this condition before? ○ Yes ○ No If so, please explain: _____

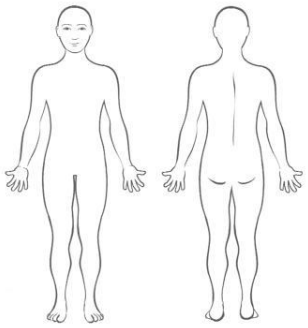
Who have they seen for this? _____ What did they do? _____

How did they respond? _____

Please circle areas to the right where they have pain or other symptoms:

What does it feel like? (check where appropriate)

○ Tingling ○ Shooting
○ Stiffness ○ Burning
○ Dull ○ Throbbing
○ Aching ○ Stabbing
○ Cramping ○ Swelling
○ Nagging ○ Other _____



Pregnancy History

Did you experience any complications during your pregnancy? (check all that apply)

○ Back/Other Pain ○ Gestational Diabetes ○ Pre/Eclampsia ○ Strep B ○ Nausea/Vomiting
○ Pre-Term ○ Fatigue ○ Swelling ○ Other (please describe) _____

Birth History

Type of birth? (check all that apply)

○ Hospital ○ Birth Center ○ Home ○ Normal/Vaginal
○ Cesarean ○ Scheduled/Induced ○ Epidural ○ Breech

Problems during labor/delivery? _____ How long was labor? _____

○ Antibiotics ○ Congenital Anomalies ○ Failure to Thrive ○ Jaundice
○ Respiratory Distress ○ Extended Hospitalization ○ Meconium ○ Other _____

Growth & Development

Infant feeding: ○ Breast ○ Bottle ○ Formula

Number of hours of sleep each night: _____ Quality: _____

At what age did the child:

Respond to sound: _____ Crawl: _____ Hold head up: _____

Stand: _____ Sit unsupported: _____ Walk unsupported: _____

Siblings

How many children do you have? _____ Number of pregnancies: _____

Children's Ages: _____ Are you currently pregnant? No Yes, I'm due _____

Children's health concerns: _____ Health concerns regarding this pregnancy? _____

_____ _____

Childhood Diseases, Illnesses & Vaccinations

Has your child had? (check all that apply)

○ Chicken Pox ○ Measles ○ Rubeola
○ Mumps ○ Rubella ○ Pertussis/Whooping Cough

Has your child ever suffered from? (check all that apply)

○ Allergies ○ Broken Bones ○ Walking Problems ○ Hypertension ○ Orthopedic Problems
○ Anemia ○ Chronic Ear Aches ○ Dizziness ○ Juvenile RA ○ Paralysis
○ Arm Problems ○ Cold/Flu ○ Neuritis ○ Hyperactivity ○ Poor Appetite
○ Asthma ○ Colic ○ Fainting ○ Joint Problems ○ Ruptures/Hernias
○ Back Aches ○ Convulsions/Seizures ○ Headaches ○ Leg Problems ○ Sinus Trouble
○ Bed Wetting ○ Delayed Speech ○ Heart Trouble ○ Neck Problems ○ Tuberculosis
○ Digestive Issues ○ Diabetes – Type 1 / 2 ○ Behavioral Problems

Have you vaccinated your child? ○ No ○ Yes ○ As Scheduled ○ Delayed Schedule

Experience With Chiropractic

Has your childe seen a Chiropractor before? ○ Yes ○ No When? _____

Reason for visits: _____

Did the previous chiropractor take before and/or after x-rays? ○Yes ○No

Did you know posture determines your child's health? ○Yes ○No

Are you aware of any of your child's poor posture habits? ○Yes ○No

Explain: _____

Are you aware of any poor posture habits in your spouse or other children? ○Yes ○No

Explain: _____

The most common postural weakness is Forward Head Syndrome (head and neck starting to bend forward and progressively moving downward weakening your whole body). Even less severe forms of this posture can cause many adverse affects on your overall health. Have you ever been told or felt like you carry your head forward, noticed a rounding of your shoulders or a developing "hump" at the base of your child's neck? ○Yes ○No

Health Lifestyle

Allergies, Surgeries & Medications

ALLERGIES (list)

_____

_____

SURGERIES (list)

_____

_____

MEDICATIONS (list)

_____

_____

FAMILY HISTORY (list)

_____

_____

Health Conditions

Abnormal postural habits or distortions are the result of trauma or stress to the body that have misaligned the vertebrae in your spine. When these vertebrae are twisted from their normal position, they will cause stress to the spinal cord and the delicate nerves that pass between vertebrae. These misalignments are called Subluxations (sub-lux-a-shuns). It has been extensively documented that subluxations, causing stress to your nerves, will weaken and distort the overall structure of your spine. This results in a weakened and distorted POSTURE. Postural distortions have many serious and adverse affects on your overall health. The most common and detrimental postural distortion is called Forward Head Syndrome (a "hunched forward" posture starting in the neck and progressively moving down your spine weakening the entire body).

Nutrition & Weight Loss

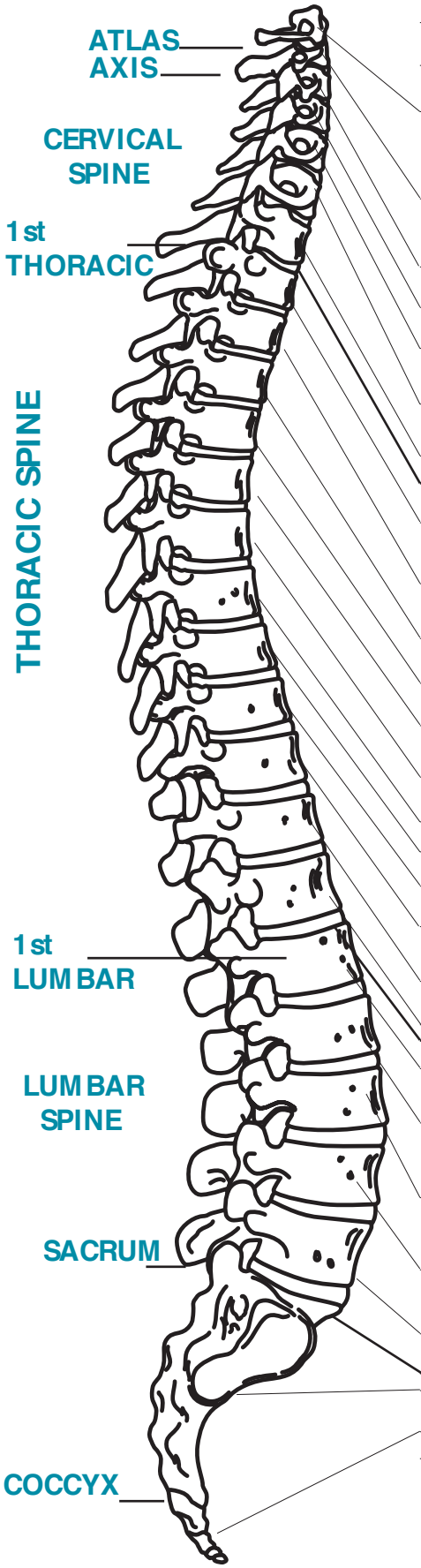
Would you like to set up a Nutritional Consultation for your child? ○ Yes ○ No

Would you like to set up a Weight Loss Consultation for your child? ○ Yes ○ No

Please check any health condition your child may be experiencing, now or in the past below

SYMPTOMS OF SPINAL MISALIGNMENT QUESTIONNAIRE

"The nervous system controls and coordinates all organs and structures of the human body." (Gray's Anatomy, 29th Ed., page 4). Misalignments of spinal vertebrae and discs may cause irritation to the nervous system and affect the structures, organs, and functions which may result in the conditions shown below. Please help us help you by placing a check mark in the appropriate box under the "Possible Effects" column to indicate your symptoms.



Please Check Below

	Vertebrae	Areas Controlled by Nerves*	Possible Effects of a Malfunction
NECK REGION	1C	Blood supply to the head, pituitary gland, scalp, bones of the face, brain, inner and middle ear, sympathetic nervous system.	☐ headaches, ☐ nervousness, ☐ insomnia, ☐ head colds, ☐ high blood pressure, ☐ migraine headaches, ☐ nervous breakdowns, ☐ amnesia, ☐ chronic tiredness, ☐ dizziness.
	2C	Eyes, optic nerves, auditory nerves, sinus, mastoid bones, tongue, forehead.	☐ sinus trouble, ☐ allergies, ☐ crossed eyes, ☐ deafness, ☐ eye troubles, ☐ earache, ☐ fainting spells, ☐ vision difficulties.
	3C	Cheeks, outer ear, face bones, teeth, trifacial nerve.	☐ neuralgia, ☐ neuritis, ☐ acne or pimples, ☐ eczema.
	4C	Nose, lips, mouth, eustachian tube.	☐ hay fever, ☐ hearing loss, ☐ adenoids.
	5C	Vocal cords, neck glands, pharynx.	☐ laryngitis, ☐ hoarseness, ☐ sore throats, ☐ quincy.
	6C	Neck muscles, shoulders, tonsils.	☐ stiff neck, ☐ pain in upper arm, ☐ tonsillitis, ☐ whooping cough, ☐ croup.
	7C	Thyroid gland, bursae in the shoulder, elbows.	☐ bursitis, ☐ colds, ☐ thyroid conditions.
MID-BACK	1T	Arms from the elbows down, including hands, wrists, and fingers; esophagus and trachea.	☐ asthma, ☐ cough, ☐ difficult breathing, ☐ shortness of breath, ☐ pain in lower arm, ☐ pain in hands.
	2T	Heart, including its valves and covering; coronary arteries.	☐ functional heart conditions, ☐ chest conditions.
	3T	Lungs, bronchial tubes, pleura, chest, breast.	☐ bronchitis, ☐ pleurisy, ☐ pneumonia, ☐ congestion, ☐ influenza.
	4T	Gall bladder, common duct.	☐ gall bladder conditions, ☐ jaundice, ☐ shingles.
	5T	Liver, solar plexus, blood.	☐ liver conditions, ☐ fevers, ☐ low blood pressure, ☐ anemia, ☐ poor circulation, ☐ arthritis.
	6T	Stomach.	☐ stomach troubles, ☐ nervous stomach, ☐ indigestion, ☐ heartburn, ☐ dyspepsia.
	7T	Pancreas, duodenum.	☐ ulcers, ☐ gastritis.
	8T	Spleen.	☐ low resistance to colds and disease.
	9T	Adrenal and supra-renal glands.	☐ allergies, ☐ hives.
	10T	Kidneys.	☐ kidney troubles, ☐ hardening of the arteries, ☐ chronic tiredness, ☐ nephritis, ☐ pyelitis.
	11T	Kidneys, ureters.	☐ acne, ☐ pimples, ☐ eczema, ☐ boils.
	12T	Small intestines, lymph circulation.	☐ rheumatism, ☐ gas pains, ☐ sterility.
LOW BACK	1L	Large intestines, inguinal rings.	☐ constipation, ☐ colitis, ☐ dysentery, ☐ diarrhea, ☐ ruptures, ☐ hernias.
	2L	Appendix, abdomen, upper leg.	☐ cramps, ☐ difficult breathing, ☐ acidosis, ☐ varicose veins.
	3L	Sex organs, uterus, bladder, knees.	☐ bladder troubles, ☐ menstrual troubles such as painful or irregular periods, ☐ miscarriages, ☐ bed wetting, ☐ impotency, ☐ change of life symptoms, ☐ knee pains.
	4L	Prostate gland, muscles of the lower back, sciatic nerve.	☐ sciatica, ☐ lumbago, ☐ difficult, painful, or too frequent urination, ☐ backaches.
	5L	Lower legs, ankles, feet.	☐ poor circulation in the legs, ☐ swollen ankles, ☐ weak ankles and arches, ☐ cold feet, ☐ weakness in the legs, ☐ leg cramps.
PELVIS	SACRUM	Hip bones, buttocks.	☐ low back pain, ☐ spinal curvature.
	COCCYX	Rectum, anus.	☐ hemorrhoids (piles), ☐ pruritis (itching), ☐ pain at end of spine on sitting.

* Directly or indirectly controlled

For further explanation of the conditions shown above, and information about those not shown, ask your Doctor of Chiropractic

EXPAND CHIROPRACTIC PRODUCTS Form 021
1-800-548-3676

Terms of Acceptance

When a person seeks chiropractic and rehabilitation health care and is accepted for such care, it is essential for both parties to be working towards the same objective. As a Chiropractic & Rehab facility we have one main goal, to detect and correct/reduce the vertebral subluxation complex and interference on the nervous system. It is important that each person understand both the objective and the method that will be used to attain this goal. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method is by specific adjustments of the spine.

Health: A state of optimal, physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's God-given, innate ability to express it's maximum health potential.

We do not offer to diagnose or treat a disease or condition other than vertebral subluxation. Regardless of what a disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. Our Only Practice Objective is to eliminate a major interference to the expression of the body's innate wisdom and ability to heal. Our only method is specific adjusting to correct vertebral subluxations combined with rehabilitation procedures. NOTE: It is understood and agreed the amount paid to Body By Design Wellness Chiropractic for x-ray, is for examination only and the x-rays will remain the property of this office, being on file where they may be seen at any time while a patient of this office.

Office Usage: at Body By Design we have a semi-open adjusting area so that we can serve as many families as possible. We may use or disclose your health information in the form of patient testimonials. We keep an open environment in the office to create a sense of warmth, family, healing and education. During adjustments, we do not go over private information; however, you will be in an open area where others may see you and/or over-hear conversation. If there is a need to discuss something of a personal or private nature, you may request an appointment in one of our private rooms. The doctor or trained team member will speak with you about your condition or other matters in the private room.

Family and Close Friends Involved in Your Care: Our office has an open, family-centered approach to wellness and we believe it is in all our patient's best interests to have the support and cooperation of their families. Therefore, our office requires that Both Parents if applicable be present when the doctor goes over the patient's report and recommendations for care.

Consent To Care

I do hereby authorize the doctor(s) of Body By Design Wellness Chiropractic to administer such care that is necessary for my particular case. This care may include consultation, examination, spinal adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays or any other procedure that is advisable, and necessary for my health care.

Furthermore, I authorize and agree to allow the doctor of chiropractic named below and/or other licensed doctors of chiropractic or medical assistants who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, to work with my spine through the use of spinal adjustments and rehabilitative exercises for the sole purpose of postural and structural restoration to allow for normal biomechanical motion and neurological function.

I have had the opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinical personnel the nature and purpose of chiropractic adjustments and other procedures related to my health care. I understand that I am responsible for all fees incurred for the services provided, and agree to ensure full payment of all charges. I further understand that a fee for services rendered will be charged and that I am responsible for this fee whether results are obtained or not.

I understand and have been informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to fractures, disk injuries, strokes, burns, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests. The doctor will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another health care practitioner, or are not related to the spinal structural conditions treated at this clinic.

I also clearly understand that if I do not follow the Doctors specific recommendations at this clinic that I will not receive the full benefit from the programs offered, and that if I terminate my care prematurely that all fees incurred will be due and payable at that time. I authorized the assignment of all insurance benefits be directed to the Doctor for all services rendered. I also understand any sum of money paid under assignment by any insurance company shall be credited to my account, and I shall be personally liable for any and all of the unpaid balance to the doctor.

I, _____, have read or have read to me, the above consent. I have also had the opportunity to ask questions about this consent, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my child's present condition and for any future condition(s) for which I seek treatment.

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle: _____

Signature_____ Date _____

Consent to x-ray

I hereby grant Body By Design Wellness Chiropractic and/or Dr Ryan D. Braverman D.C permission to perform/refer for x-ray evaluation if needed. I understand that x-rays are being performed to locate vertebral subluxation, and not to diagnose or treat any other disease or condition. Furthermore it should be noted that these x-rays will be sent to an independent 3rd party to review these films. I hereby consent to an initial course of care before a final diagnostic report has been generated by said 3rd party.

Signature_____ Date _____*(if under 18) Parent's Signature*

Consent to evaluate and adjust a minor child

I, _____ being the parent or legal guardian of _____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Signature_____ Date _____ *(if under 18) Parent's Signature*

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

Uses and Disclosures of Health Information

We use and disclose health information about you for treatment, payment, and healthcare operations, for example;

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Health Care Operations: We may use and disclose your health information in connection with our health-care operations. Health care operations include quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or health care operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your health care or with payment for your health care, but only if you agree that we may do so.

Marketing Health-Related Services: We will not use your health information for marketing communication without your authorization

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

Insurance Information

I clearly understand that all insurance coverage is an arrangement between my insurance carrier and me. If this office chooses to bill any services to my insurance carrier that they are performing these services strictly as a convenience for me. The Doctors office will provide any necessary report or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny any claim and that I am ultimately held responsible for any unpaid balances. Any monies received will be credited to my account. I certify that this office visit is not related to any personal injury or worker's compensation case that is active or that has not been closed and finalized.

INTEREST AND COLLECTION: I acknowledge and agree that, should my account become more than 30 days overdue, I will incur interest on my past balance of seven percent (7%) per annum. I further acknowledge and agree that Dr Ryan David Braverman shall be entitled to reimbursement from me for any legal cost including attorney fees, for all efforts to collect on any past due account with Dr Ryan David Braverman. The assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

Parent's Signature_____ Date _____

body by design wellness chiropractic pllc.
500 Old Country Road, Suite 314, Garden City NY 11530
516-279-6330

Our office is committed to providing the highest quality healthcare while always continuing to do what is best for each and every patient who walks through the door. It is also our goal to always provide the most efficient, safe and effective process every step of the way. With that we wanted to formally let you know that our office is monitored by closed circuit television. We can assure the monitored service is secure and protected and will never be used for anything other than patient safety and efficiency.

Currently we have seven (7) individual security cameras in plain sight (all camera locations are listed below)

Camera 1: Upon entry to the office directly to the right on the ceiling

Camera 2: Upon entry to the office directly to the left on the ceiling

Camera 3: Just behind the front desk above the TV on the right if you are facing the desk

Camera 4: Upon entering the office straight back in the hallway on the ceiling just outside of the rehabilitation room

Camera 5: Above the door frame inside the rehabilitation room

Camera 6: In the open adjusting area on the ceiling above the windows

Camera 7: In the advanced therapy area on the ceiling above the windows

If you would like a personalized tour by someone from our team of all the camera locations please feel free to ask.

Please note by signing the below you openly and freely acknowledge that the above office and any subsidiaries and divisions of the above has provided you will all relevant information with respect to the installation and location of our camera security system.

Patient Name: _____

Patient Signature: _____

Date: _____

BODY BY DESIGN
WELLNESS CHIROPRACTIC PLLC
WHERE HEALTH BEGINS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

500 OLD COUNTRY ROAD, SUITE 314
GARDEN CITY . NEW YORK . 11530
516 – 279 - 6330

I understand and have been provided with the opportunity to review a Notice of Privacy Practices that provide a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- ○ The right to review the notice prior to signing this consent,
- ○ The right to object to the use of my health information for directory purposes, and
- ○ The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations.

APPOINTMENT REMINDERS AND HEALTH CARE INFORMATION AUTHORIZATION

Your chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not at home, a message will be left on your answering machine.

By signing this form, you are giving us authorization to contact you with these reminders and information.

USE OF INFORMATION

We have many success stories in our office and often patients wish to share these stories in an effort to help others. Your picture, written testimonial or video will only be shared with your permission and will only be available when YOU PROVIDE it to us. This is a standard publicity release in accordance with the Federal Trade Commission (FTC).

I hereby grant you, Body By Design Wellness Chiropractic PLLC and Dr. Ryan D Braverman all rights with this my irrevocable explicit approval to use my likeness, voice, etc., as captured or edited, recorded and rendered in various audio, visual and written medium, to be used in commercial, instructional, and promotional activities as Body By Design Wellness Chiropractic PLLC or Dr Ryan D Braverman sees fit. Body By Design Wellness Chiropractic PLLC and Dr Ryan D Braverman shall own 100% right , title and interest in resulting product.

SIGNATURE OF PARENT, PATIENT OR GUARDIAN _____ DATE _____

NEW YORK CHIROPRACTIC ASSOCIATION AUTHORIZATION

Your chiropractor and members of the practice staff may need to disclose your name, address, phone number, billing information and your clinical records to the New York Chiropractic Association (NYCA). This disclosure will be made if we need the NYCA's assistance to receive reimbursement for your services or, we need the NYCA's assistance because the party responsible for reimbursing your services has improperly processed your claim.

By signing this form you are giving us authorization to send the NYCA this information. You are also giving the NYCA authorization to re-disclose your information to the party responsible for the payment of your services, NYCA's legal counsel, and state or federal agencies that may be asked to intercede on your behalf.

SIGNATURE_____ DATE _____

- ○ Parent or guardian of minor patient
- ○ Guardian or conservator of an incompetent patient
- ○ Beneficiary or personal representative of deceased patient

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For Office Use Only:

SIGNED FORM RECEIVED BY: _____