

**CONFIDENTIAL PATIENT INFORMATION**

Date \_\_\_\_\_

Name: \_\_\_\_\_ What would you like to be called? \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Office Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Sex:  M  F Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Social Security No: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Single  Married  Widowed  Divorced  Partnered Name of Spouse \_\_\_\_\_

Spouse's Occupation: \_\_\_\_\_ Spouse's Employer: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Spouse's Work Phone: \_\_\_\_\_ Spouse's Date of Birth: \_\_\_\_\_

How did you hear about our office? \_\_\_\_\_

Have you ever had chiropractic care before?  No  Yes Where? \_\_\_\_\_

How long ago was your last adjustment? \_\_\_\_\_

Reason for not returning: \_\_\_\_\_

Were the results satisfactory?  No  Yes  N/A

Major complaints and symptoms — please be as specific as you can.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How do you believe your problem (pain) began? \_\_\_\_\_

When did you first notice this problem/pain? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Have you lost any work?  No  Yes Day and date you last worked \_\_\_\_\_

Have you ever had this condition before or a similar condition?  No  Yes

When? \_\_\_\_\_

Is this problem due to a work-related injury?  No  Yes

Is this problem due to a motor vehicle collision?  No  Yes

Do you have pain that wakes you out of a sound sleep?  No  Yes

Have you had any changes in bowel or bladder habits?  No  Yes

Do you have night sweats?  No  Yes

Have you lost or gained weight in the past year?  No  Yes

Have you been treated recently by a Medical Physician for this ailment? \_\_\_\_\_

Where? \_\_\_\_\_

Describe the type of treatment: \_\_\_\_\_

\_\_\_\_\_

Family physician's name \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Would you allow us to send a report to your family physician?  No  Yes

Harmony Chiropractic Center, Inc.  
7430 West Central Ave; Suite E  
Toledo, OH 43617  
419-517-5055

CONFIDENTIAL PATIENT INFORMATION

**MEDICAL HISTORY**

Have you been treated for any condition by a physician in the past year?  No  Yes

If yes, what condition? \_\_\_\_\_

Have you ever been in any accidents, auto, fall down stairs, fall from ladder, etc. (even as a child)?

No  Yes When? \_\_\_\_\_

Are you allergic to anything you are aware of?  No  Yes If yes, name them. \_\_\_\_\_

Do you take vitamins supplements or herbs?  No  Yes If yes, please list them \_\_\_\_\_

Are you presently taking any medication, herbs, or over-the-counter products (aspirin included)?  No  Yes

If yes, name them. \_\_\_\_\_

Have you ever broken any bones?  No  Yes Any dislocations?  No  Yes \_\_\_\_\_

What operations have you had? (Please list type and year) \_\_\_\_\_

Give dates you have had any of the following? (if exact date is unknown, give approximate)

Lab Tests (Blood or Urinalysis) \_\_\_\_\_

Imaging (X-Rays, MRI, CT or ultrasound) \_\_\_\_\_

Do you have any health problems not listed above? \_\_\_\_\_

**FAMILY HISTORY**

- Arthritis:  No  Yes
- Asthma:  No  Yes
- Cancer:  No  Yes
- Diabetes:  No  Yes
- Heart Disease:  No  Yes
- Stroke:  No  Yes
- High Blood Pressure:  No  Yes
- Other \_\_\_\_\_

**FEMALE HISTORY**

Beginning date of your last period. \_\_\_\_\_ Do you have pain or cramps?  No  Yes

Date of last pelvic exam. \_\_\_\_\_ Date of last pap test. \_\_\_\_\_

Are you on birth control pills?  No  Yes – For how long? \_\_\_\_\_

Are you currently pregnant?  No  Yes Have you ever been pregnant?  No  Yes

If you have any children, what are their ages? \_\_\_\_\_

Have you ever had a cesarean section?  No  Yes

**SOCIAL HISTORY**

Cigarettes:  Never  Former Smoker – Quit When? \_\_\_\_\_ How many years did you smoke? \_\_\_\_\_  
 Current Smoker - How many packs a day? \_\_\_\_\_ How many years total? \_\_\_\_\_

Coffee? \_\_\_\_\_ Quantity \_\_\_\_\_ cups a day Tea? \_\_\_\_\_ Quantity \_\_\_\_\_ cups a day

Alcohol? \_\_\_\_\_ Quantity \_\_\_\_\_ drinks a week Soda/Pop? \_\_\_\_\_ Quantity \_\_\_\_\_ cans a day

Do you exercise regularly?  No  Yes What kind of exercise? \_\_\_\_\_

Hobbies \_\_\_\_\_

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**PAST HISTORY – REVIEW OF SYMPTOMS**

Mark if you currently have any of the following conditions. Please circle all current problems.

**JOINTS & MUSCLES**

- Arthritis
- Joint pains or aches
- Muscle pains or aches
- Stiffness
- Swollen, tender joints

**DIGESTIVE TRACT**

- Nausea/Vomiting
- Diarrhea/Constipation
- Indigestion
- Bloating feeling
- Belching or passing gas
- Gall bladder trouble
- Ulcers
- Abdominal pain

**EARS**

- Hearing difficulty
- Ringing in ears
- Ear aches
- Ear infections
- Drainage from ear
- Itchy ears

**EYES**

- Glasses/contacts
- Watery eyes
- Itchy eyes
- Dark circles
- Blurred vision
- Pneumonia

**SKIN**

- Acne
- Hives, rashes
- Hair loss
- Flushing, hot flashes
- Excessive sweating

**MOUTH & THROAT**

- Chronic cough
- Gagging
- Often clear throat
- Sore throat
- Canker sores

**NOSE**

- Allergies
- Stuffy nose
- Sinus problems
- Sneezing attacks
- Post-nasal drip

**LUNGS**

- Chest congestion
- Asthma, bronchitis
- Shortness of breath
- Difficulty breathing

**HEART**

- Heart trouble
- High blood pressure
- High cholesterol
- Irregular heartbeat
- Rapid heartbeat
- Chest pains

**HEAD/MIND**

- Headaches
- Fainting
- Dizziness
- Insomnia
- Epilepsy
- Poor memory
- Confusion
- Poor concentration

**ENERGY & ACTIVITY**

- Weakness
- Fatigue
- Apathy, lethargy
- Attention deficit
- Hyperactivity
- Restlessness
- Cravings for sweets
- Anemia

**EMOTIONS**

- Mood swings
- Anxiety, fear
- Irritability, anger
- Depression
- Aggressiveness
- Nervousness

**WEIGHT**

- Binge eating
- Food cravings
- Excessive weight
- Compulsive eating
- Water retention
- Underweight

**OTHER**

- Frequent illnesses
- Allergies
- Diabetes
- Liver trouble
- Thyroid trouble
- Tumors/lumps
- Cancer

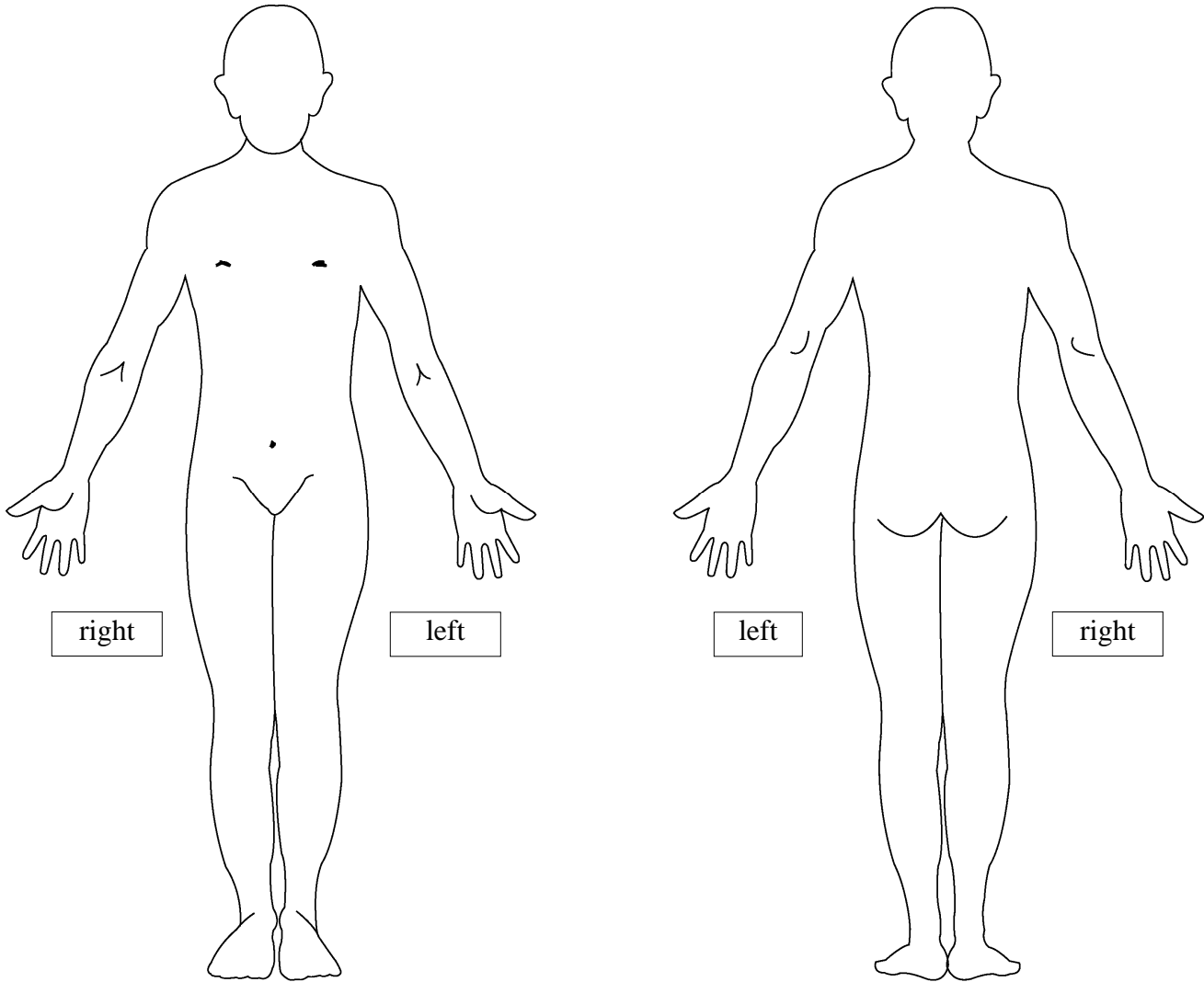
CONFIDENTIAL PATIENT INFORMATION

SHOW AREA(S) OF PAIN OR UNUSUAL FEELING

- Mark the areas on this body where you feel the described sensations.
- Use the appropriate symbols. Mark areas of radiation. Describe in words if the symbols
- Include all affected areas.

Numbness	Pins & Needles	Burning	Aching	Stabbing
-----	00000	xxxxx	*****	//////
-----	00000	xxxxx	*****	//////
-----	00000	xxxxx	*****	//////

**PAIN CHART**



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

Signature \_\_\_\_\_

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## PAIN DISABILITY QUESTIONNAIRE

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

**Instructions:** These questions ask your views about how your pain now affects how you function in everyday activities. Please answer every question and mark the ONE number on EACH scale that best describes how you feel.

1. Does your pain interfere with your normal work inside and outside the home?  
Work normally Unable to work at all  
0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10
2. Does your pain interfere with personal care (such as washing, dressing, etc.)?  
Take care of myself completely Need help with all my personal care  
0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10
3. Does your pain interfere with your traveling?  
Travel anywhere I like Only travel to see doctors  
0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10
4. Does your pain affect your ability to sit or stand?  
No problems Can not sit/stand at all  
0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10
5. Does your pain affect your ability to lift overhead, grasp objects, or reach for things?  
No problems Can not do at all  
0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10
6. Does your pain affect your ability to lift objects off the floor, bend, stoop, or squat?  
No problems Can not do at all  
0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10
7. Does your pain affect your ability to walk or run?  
No problems Can not walk/run at all  
0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10
8. Has your income declined since your pain began?  
No decline Lost all income  
0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10
9. Do you have to take pain medication every day to control your pain?  
No medication needed On pain medication throughout the day  
0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10
10. Does your pain force you to see doctors much more often than before your pain began?  
Never see doctors See doctors weekly  
0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10
11. Does your pain interfere with your ability to see the people who are important to you as much as you would like?  
No problem Never see them  
0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10
12. Does your pain interfere with recreational activities and hobbies that are important to you?  
No interference Total interference  
0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10
13. Do you need the help of your family and friends to complete everyday tasks (including both work outside the home and housework) because of your pain?  
Never need help Need help all the time  
0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10
14. Do you now feel more depressed, tense, or anxious than before your pain began?  
No depression/tension Severe depression/tension  
0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10
15. Are there emotional problems caused by your pain that interfere with your family, social and or work activities?  
No problems Severe problems  
0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10

\_\_\_\_\_  
Examiner

**OTHER COMMENTS:**

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With Permission from: Anagnostis C et al: The Pain Disability Questionnaire: A New Psychometrically Sound Measure for Chronic Musculoskeletal Disorders. *Spine* 2004; 29 (20): 2290-2302.

# HARMONY CHIROPRACTIC CENTER, INC.

## Patient Agreement

Your insurance plan, managed care program, or third party payor provides a *limited* range of benefits compared to the services available at this office. Your carrier provides coverage for “*medically necessary*” services as defined by them, for coverage or “*eligible*” benefits. In other words, no insurance carrier pays for everything. If possible, when the services you receive at this office exceed the covered or eligible benefit limits, or fall outside the payor’s definition of “medically necessary” we will attempt to inform you in advance. Please understand that it is virtually impossible to predict in advance, given the literally hundreds of plans in existence today, what the insurance company will or will not pay. We will certainly comply with our contractual obligations when they exist, and apply the “*appropriate*” write-offs and fee reductions, but we make no representation that all services will be covered. As such you are responsible for anything not covered by the carrier that exceeds the benefits described in the insurance booklet provided by your employer or health carrier. We recommend you become familiar with your benefits so there are no surprises for either of us.

***The following is a list of the services generally available at this office. Most insurances pay for spinal manipulation to some degree, but the benefits vary. The other services may or may not be covered. Again, check your insurance booklet for a listing of available benefits.***

X-rays, exams, therapies, spinal manipulation, supplements, orthotics/pillows/supports, ice packs, x-rays or x-ray interpretation, maintenance or supportive care, physical therapy modalities, rehab, educational classes, and many other services too numerous to list here.

***There are numerous reasons for possible denial by your insurance company. Examples include:*** No referral from primary care provider, care deemed “not medically necessary”, no prior authorization was obtained, treatment extends beyond initial allowance, etc. There are literally hundreds of reasons which your insurance company may give for denial of benefits. As always, we honor our contract with the carriers and apply the appropriate write-offs, but no insurance company pays for everything and you should be come familiar with your benefit package.

### PATIENT AGREEMENT & ACCEPTANCE OF LIABILITY

As you know, our office participates with many third party payor programs and as a result it becomes virtually impossible to predict in advance your available benefits. By signing this agreement you acknowledge that *it remains your responsibility to understand your benefits*, and it remains our responsibility to *comply with any contract we have with certain carriers*. As such, we will apply the appropriate reductions and write-offs for “covered benefits” only. You must pay for all appropriate co-pays, deductibles, and non-covered benefits. Additionally, you agree that you have been notified that your carrier might deny payment for the services identified above. If your carrier denies payment for any reason, you agree to be personally and fully responsible for payment. If you do not have any insurance coverage, you agree that you are personally and fully responsible for payment.

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*Patient Name*

---

*Date*

---

*Patient Signature*

---

*Staff Signature*

Harmony Chiropractic Center, Inc.  
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# HIPAA Notice of Privacy Practices

Harmony Chiropractic Center, Inc. • 7430 W. Central Ave • Suite E • Toledo, OH 43617 • 419-517-5055

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

## **1. Uses and Disclosures of Protected Health Information**

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

**Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

**Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

**Healthcare Operations:** We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

**Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.**

**You may revoke this authorization**, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

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**Your Rights:** Following is a statement of your rights with respect to your protected health information.

**You have the right to inspect and copy your protected health information.** Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

**You have the right to request a restriction of your protected health information.** This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

**You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us,** upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

**Marketing:** We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. We do not provide patient information to other organizations.

**You may have the right to have your physician amend your protected health information.** If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

**You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.**

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

### **Complaints**

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgment that you have received this Notice of our Privacy Practices:

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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## **Informed Consent**

Every type of health care is associated with some risk of a potential problem. This includes chiropractic health care. We want you to be informed about potential problems associated with chiropractic health care before consenting to treatment. This is called informed consent.

Chiropractic adjustments are the moving of bones with the doctor's hands or with the use of a machine. Frequently, adjustments create a "pop" or "click" sound/sensation in the area being treated.

In this office, we use trained staff personnel to assist the doctor with portions of your consultation, examination, physical therapy application, exercise instruction, etc. Occasionally when your doctor is unavailable, another clinic doctor will treat you on that day.

**STROKE:** Stroke is the most serious problem associated with chiropractic adjustments. Stroke means that a portion of the brain does not receive enough oxygen from the blood stream. The results can be temporary or permanent dysfunction of the brain, with a very rare complication of death. Chiropractic adjustments have been associated with strokes that arise from the vertebral artery only; this is because the vertebral artery is actually found inside the neck vertebrae. The most recent studies (Journal of the CCA, Vol. 37 No. 2 June, 1993) estimate that the incident of this type of stroke is 1 per every 3,000,000 upper neck adjustments. This means that an average chiropractor would have to be in practice for hundreds of years before they would statistically be associated with a single patient stroke.

**DISC HERNIATIONS:** Disc herniations that create pressure on the spinal nerve or on the spinal cord are frequently successfully treated by chiropractors and chiropractic adjustments, traction, etc. This includes both in the neck and back. Yet, occasionally chiropractic treatment (adjustments, traction, etc.) will aggravate the problem and rarely surgery may become necessary for correction. Rarely chiropractic adjustments may also cause a disc problem if the disc is in a weakened condition. These problems occur so rarely that there are no available statistics to quantify their probability.

**SOFT TISSUE INJURY:** Soft tissues primarily refer to muscles and ligaments. Muscles move bones and ligaments limit joint movement. Rarely a chiropractic adjustment, traction, massage therapy, etc., may tear some muscle or ligament fibers. The result is a temporary increase in pain and necessary treatments for resolution, but there are no long term affects for the patient. These problems occur so rarely that there are no available statistics to quantify their probability.

**RIB FRACTURES:** The ribs are found only in the thoracic spine or middle back. They extend from your back to your front chest area. Rarely a chiropractic adjustment will crack a rib bone, and this is referred to as a fracture. This occurs only on patients that have weakened bones from such things as osteoporosis. Osteoporosis can be noted on your x-rays. We adjust all patients very carefully, and especially those who have osteoporosis on their x-rays. These problems occur so rarely that there are no available statistics to quantify their probability.

**PHYSICAL THERAPY BURNS:** Some of that machines we use generate heat. We also use both heat and ice, and recommend them for home care on occasion. Everyone's skin had different sensitivity to these modalities, and rarely, either heat or ice can burn or irritate the skin. The result is a temporary increase in skin pain, and there may even be some blistering of the skin. These problems occur so rarely that there are no available statistics to quantify the probability.

SORENESS: It is common for chiropractic adjustments, traction, massage therapy, exercise, etc. to result in a temporary increase in soreness in the region being treated. This is nearly always a temporary symptom that occurs while your body is undergoing therapeutic change. It is not dangerous, but please do tell your doctor about it.

OTHER PROBLEMS: There may be other problems or complications that might arise from chiropractic treatment other than those noted above. These other problems or complications occur so rarely that it is not possible to anticipate and/or explain them all in advance of treatment.

Chiropractic is a system of health care delivery, and, therefore, as with any health care delivery system we cannot promise a cure for any symptom, disease, or condition as a result of treatment in this clinic. We will always give you our best care, and if results are not acceptable, we will refer you to another provider who we feel will assist your situation.

If you have any questions on the above, please ask your doctor. When you have a full understanding, please sign and date below.

\_\_\_\_\_  
Patient's Name Printed

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Parent or Guardian

\_\_\_\_\_  
Staff Signature