Synergique Healing, PA

Behavioral Health & Functional Medicine

Welcome

We would like to take this opportunity to thank you for your confidence in choosing Synergique Healing, PA for professional services. Since our goal is to provide you with the best and most effective service possible, we ask that you read the following information relevant to treatment, confidentiality and office policies.

Aims & Goals

At Synergique Healing, PA, we believe in a gentle, collaborative partnership with our patients to help them reach happiness and true well being. Our main goal is to treat each individual as a whole by identifying unique needs before setting forward a treatment plan tailored to your specific needs. This goal is accomplished by:

- Increasing personal awareness
- Increasing personal responsibility and acceptance to make changes necessary to attain your goals.
- Identifying personal treatment goals

You are responsible for providing necessary information to facilitate effective treatment. You are expected to play an active role in your treatment by attending ALL of your scheduled appointments on time and working with your provider to outline your treatment goals and assess your progress. There may also be negative consequences if you do not follow through with the recommended treatment(s).

You may be asked to complete questionnaires and random multi panel urine drug tests will occur. Your progress often depends much more on what you do between sessions, than on what happens during the session.

Synergique Healing, PA

Behavioral Health & Functional Medicine

Patient Demographics

First Name:_____ Middle Initial:_____ Last Name:_____

Preferred Name:_____ Date of Birth:_____ Age:_____

Sex at Birth: _____ Driver License/ID Number:_____

Gender Identity:_____ Pronouns:_____

Social Security Number:_____ Marital Status:_____

Home Address & Apt/Unit/ Suite#:_____

City, State, Zip:_____

Home Phone:_____ Cell Phone:_____

Email Address:_____

Occupation:_____ Employer Name:_____ Work #:_____

Emergency Contact Name:_____ Phone #:_____

Email:_____ Relationship to the patient:_____

Does this person know you are a patient of Synergique Healing? ☐ Yes ☐ No

*_____**Opt. Out Emergency Contact:** Would like to not have an emergency contact at this time. I am aware I may add an emergency contact if I wish to do so at a later time.

Race: ☐ Asian ☐ Other Pacific Islander ☐ White ☐ Native Hawaiian ☐ Native American ☐ Alaska Native ☐ Black/African American ☐ Other ☐ Decline

Ethnicity: ☐ Hispanic ☐ Non Hispanic ☐ Other: _____ ☐ Decline

Preferred Language:_____

U.S. Military Veteran: ☐ Yes ☐ No ☐ Decline

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If a minor, Parent, Legal Guardian or Legal Representative

First Name:_____ Middle Initial:_____ Last Name:_____

What is your relationship with the patient?_____

Driver License/ID Number:_____

If applicable, do you have the custody paperwork?_____

Other Contacts: (Name, Relationship to patient and contact number)

Legal Guardian:_____

Primary Care Giver:_____

Power of Attorney: _____

Other Provider:_____

Pharmacy Information

Preferred Pharmacy Name:_____ Phone Number:_____

Address:_____

City, State, Zip:_____

Insurance

(If none, skip to the following section)

Type of Insurance: ☐ PPO ☐ HMO ☐ Other ☐ Selfpay/None

Insurance Name:_____

Member ID:_____ Group#:_____

Provider/ Customer Service Number:_____

Policy holder's Name:_____ Their date of birth:_____

Social Security Number:_____ Relationship to patient:_____

By signing this document, I attest that all the statements I have made to all the questions are true and correct to the best of my knowledge and belief.

Signature:_____ Date:_____

Name and relationship to Patients (If differ.):_____

**If signed electronically*, Date of Birth of signer:_____ Phone#:_____

Witness Name: _____ Witness Signature: _____

Office Policies and Procedures

*____ ***Regarding Urgent/Crisis*** matters emails,voicemails and faxes ***ARE NOT AN ACCEPTABLE*** method to manage these situations. In the event of a crisis you will call 911 and contact the office **AFTER** the crisis has been controlled. ***We are a psychiatric outpatient office.*** We ***DO NOT*** have the necessary equipment or items needed to address urgent/crisis matters as effectively as a hospital or emergency room would.

*____ **After Hours Contact:** In the event of an **URGENT/CRISIS** matter outside of business hours you may contact 911 or go to the closest emergency room. We ***DO NOT*** offer after hours services at this time. Once the matter is under control contact us to make us aware of the events the following business day. Other resources you may use are for urgent care are:

Sun Behavioral Houston Healthcare Hospital
Phone#: 713-796-2273
7601 Fannin St, Houston, TX 77054

If you only need to talk to someone regarding suicidal thoughts you are experiencing you may also use the following contacts:

The Suicide Prevention Hotline
Phone#: 800-273-8255

988 Suicide & Crisis Lifeline
Phone#: 988

*____ **Confidentiality:** Issues discussed with your provider are important and are generally legally protected as both confidential and privileged. However, there are limits to the privilege of confidentiality. The following are those limits:

- Suspected abuse or neglect of a child, elderly or disabled person.
- When the medical provider believes you are in danger of harming yourself or another person.
- If you are not able to care for yourself.
- If you report you intend to physically injure someone, by law the medical provider must make that person and the legal authorities aware.
- If the court orders the medical provider to release information.
- When you involve your insurance company. (For filing claims, insurance audits,case reviews or appeals e.t.c.)
- Or when otherwise required by law.

You may be asked to sign a Release of information so that your provider may speak with other mental health professionals or to family members. If you are concerned about some of your information, you have a right to ask us to not use or share some of your information for treatments, payment or administrative purposes. Such requests must be submitted in writing, After you have signed you have the right to revoke it at any time, by writing a letter stating you no longer consent to the use and disclosure of your personal health information. On receipt of your letter, we will comply with your wishes from that time on.

*____ **Record Keeping**: A clinical chart is maintained describing your condition, treatment, progress in treatment, dates of appointment, fees for sessions and notes describing each session. **Your records will not be released without your written consent, unless in situations as outlined in the *Confidentiality Agreement.***

*____ **Treatment of Minors:** Minors 17 years and younger of age must be accompanied by a parent/s or legal guardian. Under no circumstances will medication changes be authorized without the parent/s or legal guardian present.

- Regarding treatment of minors of divorced parents the most recent legal custody order must be presented ***before*** an appointment is scheduled. The office can and will enforce what is only authorized by the court.

*____ **Picture Consent:** Your picture will be taken on your first visit and will be renewed every year. The images taken will only be used for your medical record as an adjunct to clinical care. No images will be shared in any way or form outside the use of this agreement.

*____ **Forms, Letters, & Other Professional Services:** Any other professional services that require longer than 5 minutes such as: telephone conversations (non emergency), any form of report writing (preparation of treatment, summaries, 504 Letters, Accommodation Letters, Medication Letters, all other forms or letters) or time spent on performing any other services will be charged $95.00 for every 10 minute increment, like the fee for treatment.

*_____ **FMLA & Temporary Disability Forms**: **ONLY** with the prior medical physician's approval would these forms be considered for review. If the medical physician has not recommended any of these services those documents ***will not*** be considered for review.

- If approved for review, the paperwork will be charged a fee starting at $250.00 and be charged $95.00 for every 10 minute increment spent on completing the document.

*____ **Payments:** All office fees are due at the time of service. This office accepts cash, debit and credit cards through Mastercard, Visa, Discover,and American Express for your convenience. ***OUR OFFICE DOES NOT ACCEPT CHECKS.***

- In the event your account has a payment overdue for 60 days, we have the option of using legal means to secure payment. (Collection agencies or small claim courts.) The only information provided to these agencies is your name, the nature of the services and amount due.

*____ **Cancellations, Missed, Same Day Re-Scheduling, Telemed Appointment** : Once your appointment is scheduled, you are expected to attend whether in person or telemedicine. Please be aware insurance companies do not cover missed ,rescheduling or late cancellation appointment fees. In the event you are not able to attend your appointment, your medication/s can not be refilled until you are seen at an appointment.

*____ You understand in the event that the patient were to miss 2 appointments your medical provider will have to terminate your care and our provider - patient relationship due to failure to maintain scheduled continuity of care.

If the patient is not compliant with this policy the following costs are due:

- **New Patients**: If not compliant with this policy the full cost of the appointment is due. $400 would be due and charged to the card on file.

- **Established Patients:**If not compliant with this policy the following would be charged to the card on file:

    - Established Patient: Missed scheduled appointment fee:
        - 20 minutes - $150.00
        - 30 minutes - 40 minutes $225.00
        - 1 Hour-$250.00

    - **Telemedicine Appointments:** Services rendered as telemedicine are a courtesy & a privilege. Even though your insurance may cover this method if the patient were to miss an appointment or fail to connect, they will lose this privilege and only be seen in person for all appointments. Same charges as listed above apply to this service.

- **Late Arrivals to the appointment are not permitted:** If you arrive more than 10 minutes late to your scheduled appointment you may be:

    - 1. Reschedule for another time and day. The missed appointment fee will apply before rescheduling the appointment.

    - 2. You may be seen for the remaining amount of time of what would have been your scheduled time slot.

- 3. You may be asked to be seen by another medical provider or nurse practitioner for that appointment day.

We request that all patients adhere to the above; however, most importantly please give the necessary importance to your mental health, as you would give importance to other physical health conditions. If you can not make your scheduled appointment, please show compassion and courtesy by canceling your appointment with adequate timing to allow another patient to occupy your place. Please contact us 2 business days (*48 business hours*) **BEFORE** the appointment. **(WEEKENDS AND HOLIDAYS DO NOT COUNT.)** ***All appointments will require a minimum of 2 business days (48 business hours) notice to avoid cancellation fees.***

We realize no one can predict emergencies or disasters. We do work with patients when it comes to matters outside of one's control.(e.i. Going to the emergency room, death of a loved one, a flat tire, e.t.c.) But your appointments must also be a priority. We do ask you to give a courtesy call or email in these types of events. You will be asked for documentation of the event to avoid the missed fee and not terminate your care with our medical providers and office.

*____**Appointment Reminders:** Appointment reminders are a courtesy service provided. You are responsible for your appointment regardless if a reminder was received

- In an effort to help remind you of your scheduled appointments our automated system will send you a total of 4 reminders. You will receive these reminders 3 business days, 2 business days, 1 business day and 1 hour before your appointment. ***Please be aware that you must call 2 business days in advance to make any changes in order to avoid the late cancellation fee. Weekends and holidays do count as business day since the office will be closed on those days.***

- You will receive your automated appointment reminders from the following email and phone numbers. Please save the following information in your contacts to avoid disregarding the reminders as spam.

    - Automated Email: no-reply@valant.io
    - Automated Text Messages: 928-985-4438
    - Automated Phone Call: 833-731-2799

*____ **Appointments Rescheduled by the Clinic:** At times our clinic may call you to reschedule your appointment due to unforeseen circumstances. The medical doctor/s at our clinic authorize their Nurse Practitioner/s or Psychiatrist to see the patient in this situation. If

you wish to reschedule and not get seen by the Nurse Practitioner/s or other psychiatrist please check your medications to be sure you have enough to last until the date of your return. The following are valid methods to cancel or reschedule your appointments:

Monday - Thursday 9 am to 5 pm
Fridays 9 am - 3 pm

Email: admin@synergiquehealing.com
Phone: 713-840-7956
Fax: 281-972-834

____ Communication** ***(Review previous page for contact information)

- **Emails:** Please remember emails have the privacy of a postcard. Before sending an email, be cautious with what you're disclosing. Emails are intended for non immediate matters.

- **Voicemails:** Please be aware we are not in the office everyday. But we do commit to returning your voicemail. Please allow us 2 business days to return your message.

- **Faxes:** Faxes are reviewed during normal business hours and are responded within 72 hours. The priority of requested medications from the pharmacy are taken into consideration when responding to each fax. Medication changes will not be accepted.

***____ Insurance Changes, Billing & Payments**

- ***ANY CHANGES*** to your insurance require 2 business days notice and are REQUIRED prior to your appointment. The office cannot verify your insurance for mental health benefits the same day of your appointment. Even if your insurance requires "no-precertification" or there is no deductible, the office cannot verify benefits on the same day of your visit. If notification is not given to the office before 2 Business days of your appointment, the "full fee" for your visit will be due. Unless, the office manager modifies this policy. This will be the only notification that will be received.

- Our office accepts several commercial insurances only. Our office ***DOES NOT*** file insurance claim forms for insurances we are not contracted and or credentialed with. We will be glad to give you an itemized receipt, which includes all the information necessary for filing claims with your insurance company.

- As a courtesy to you, for insurance we are contracted with, we will bill your primary insurance company directly for medical services rendered. While we make a good faith attempt to verify coverage, we are not able to guarantee that the information given to us by your insurance is correct. We encourage you to call your insurance plan directly if you have any questions about covered services.

- In addition, you will be responsible for payment of all non-covered services at the time they are rendered. If your insurance subsequently pays for services that were

first treated as non-covered, you will be reimbursed. Know that it is your responsibility to notify our office if you have any insurance changes.

*____ **Prior Authorizations:** Prior authorizations are courtesy services. While we do our best to secure coverage for prescriptions medications; it is ultimately the patient's responsibility to contact their insurance company to determine which medications are covered or request appeals for potential coverage.

*____ **Termination of Care:** At times termination of care between the patient and the provider is necessary. Termination of care may occur at any given time and may be initiated by either the patient or the provider.

Credit Card Authorization

I,_____, am authorizing Synergique Healing, PA to charge my card listed below if I fail to show, cancel or reschedule an appointment late. I am aware I need to provide notification at least 48 business hours (2 business days) in advance. I am aware that reminder calls, texts and emails are a courtesy. I am responsible for my own appointment regardless if a reminder was received or not. I further authorize Synergique Healing, PA, to disclose information about my attendance or cancellation to my card company if I dispute a charge. *(Patient or financially responsible party name on card,) *This document will be securely stored in your clinical file and may be updated upon request at any time.*

Credit/Debit Card Type: ☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

Credit/Debit Card Number:_____

Expiration Date:_____ **CVV Security Code:**_____

Full Name on Card:_____

Complete Billing Address :_____

City, State, Zip code:_____

By signing below I acknowledge that I read and understand the above terms and consent for Synergique Healing, PA to place and keep my card information in my patient file. I understand my card will be charged the applicable fees in the events I do not show to my appointment or I cancel / reschedule within the 48 business hours of my appointment.

Signature:_____ Date:_____

Name and relationship to Patients (If differ.):_____

**If signed electronically*, Date of Birth of signer:_____ Phone#:_____

Witness Name: _____ Witness Signature: _____

Informed Consent for Telemedicine Based Services

*_____ You understand the current method of telemedicine services is **a courtesy & privilege** offered to you at the discretion of the medical provider. You are aware at any time in your treatment your medical provider, if they deem it necessary, can revoke this method if needed for the patient's well-being and continuation of treatment.

*_____ You understand Telehealth appointments are given the same priority as an in person appointment. When your Telehealth appointment is scheduled to begin, you are expected to be logged in and waiting for the medical provider to start the session. In the event your medical provider were to fall behind and is unable to see you at your scheduled time the patient is to remain logged in until your appointment starts. Any requests to cancel on the same day, reschedule for a different day or the patient could not wait any longer for the session to begin, will result in getting charged as a missed appointment fee to the card on file, for not attending the appointment.

*_____ You understand that Telehealth is a mode of delivering health care services, including psychotherapy, via communication technologies (e.g. Internet or phone) to facilitate diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care.

*_____ You have a right to confidentiality with regard to your treatment and related communications via Telehealth under the same laws that protect the confidentiality of your treatment information during in-person psychotherapy. The same mandatory and permissive exceptions to confidentiality outlined in the [Informed Consent Form or Statement of Disclosures] I received from Synergique Healing also apply to my Telehealth services.

*_____ You understand that there are risks associated with participating in Telehealth including, but not limited to, the possibility, despite reasonable efforts and safeguards on the part of Synergique Healing, that my psychotherapy sessions and transmission of my treatment information could be disrupted or distorted by technical failures and/or interrupted.

*_____ You understand that miscommunication between myself and my provider may occur via Telehealth.

*_____You understand that there is a risk of being overheard by persons near you and are responsible for using a location that is private and free from distractions or intrusions.

*_____ You understand that at the beginning of each Telehealth session my provider is required to verify my full name and current location.

*_____ You understand that in some instances Telehealth may not be as effective or provide the same results as in-person treatment or care. You understand that if your provider believes

you would be better served by in-person treatment or care, your provider will discuss this with you and refer you to in-person services as needed. If such services are not possible because of distance or hardship, you will be referred to another psychiatrist who can provide such services.

*_____ You understand that while Telehealth has been found to be effective in treating a wide range of mental and emotional issues, there is no guarantee that Telehealth is effective for all individuals. Therefore, you understand that while you may benefit from Telehealth, results cannot be guaranteed or assured.

*_____ You understand that some Telehealth platforms allow for video or audio recordings and that neither you nor your provider may record the sessions without the other party's written permission.

*_____ You have discussed the fees charged for Telehealth with Synergique Healing administration staff and agree to them.

*_____ You understand that your provider will make reasonable efforts to ascertain and provide you with emergency resources in your geographic area. You also understand that your provider may not be able to assist you in an emergency situation. If you require emergency care, you understand you will call 911 or proceed to the nearest hospital emergency room for immediate assistance.

Your signature below indicates that you have read the office policies documented in full. You understand all its provisions and you agree to abide by these policies throughout the course of your professional relationship with Synergique Healing and any of its associates. I have discussed my questions with the administration staff and or the medical provider, and understand that I have the right to have all my questions answered regarding this information.You understand that the violation of any of these policies is grounds for termination of care.

Signature:_____ Date:_____

Name and relationship to Patients (If differ.):_____

**If signed electronically*, Date of Birth of signer:_____ Phone#:_____

Witness Name: _____ Witness Signature: _____

Controlled Substance Policy

Please be advised that it is extremely hazardous to obtain prescription medication for controlled substances from numerous medical providers. Be aware that if you are prescribed a controlled substance the doctor may utilize the following resources to obtain a history of prescribed medications: ***requesting information from your past/current treating physician, requesting information from your current/previous pharmacy and conducting a DPS report.***

*____ You acknowledge and agree to notify our clinic of any new medications as well as any medical conditions and or adverse effects you experience from any of the medications that you consume. You shall utilize the prescribed dosage for the prescribed controlled substance. You will not share, sell, trade, exchange your prescription(s) for revenue, product services or in any other manner enable other individuals to possess use of this (or these) prescription(s). You consent to keep and or maintain this (or these) prescription(s) in a secure and safe location.

*____ Refills are exclusively provided as determined by your doctor. **Absolutely no premature refills will be provided regardless of the circumstances (i.e. Stolen, misplaced. Mislaid, exceeding dosage prescribed, e.t.c)**

*____ Changes and or alterations in prescriptions shall ONLY be made in the course of clinic visits and NEVER, emails, or non business hours.

*____Urine drug screening may be requested to track your consumption of prescribed controlled substances and to screen for the use of illegal substances. Refusal to consent to such testing shall subject you to a medication taper schedule and may result in the discontinuing of your prescription.

Altering the date, quantity and or strength of medications or altering a prescription by any means is prohibited. Forging prescriptions and or physcian's signature is prohibited and violates state and federal law.

Our clinic fully cooperates with local, state and federal law enforcement agencies as well as the Drug Enforcement Agency (DEA) and the Department of Public Safety (DPS) regarding infractions involving prescription medications.

The patient's pharmacy, local authorities, and DEA will be notified if the treating physician believes the law has been violated in any manner by the patient.

If it is determined that any of the above policies have been violated, all orders for these prescriptions will cease and the patient will be dismissed from the care of the doctor and office.

*____ **Prescriptions & Refills:** Please allow a maximum of 2 business days to complete the medication refill requests. Our office does not refill medications on the weekends or holidays. If you notice that you are running out of medication and you do not have refills remaining or an appointment pending, you must call and schedule an appointment as soon as possible.

Please allow 2-3 weeks to schedule your follow up appointment in order to guarantee medication refills are dispensed on time. The medical providers can authorize phone requests for medication refills at their discretion. The medical providers go based on the patient's best interest and safety. If you recently saw the doctor and need a refill, please contact your pharmacy and request a refill.

Medications will only be refilled for current patients who maintain their regularly scheduled appointments. Your refill will be denied if you have not been seen within the time frame recommended by your provider or if you are too early for a refill.

- To request a same day refill, there will be a charge of $55.00.
- To resend an expired prescription, there will be a charge of $55.00.

If your current pharmacy informs you "your medication/s are out of stock" the patients are responsible for contacting their local pharmacies to confirm if they have the medication/s in stock. Once you have spoken to the pharmacist's and received their confirmation the patient will contact the office via phone or email with the following information:

- The patient's full name, date of birth & the name and strength of the medication/s.
- The pharmacy's name, complete address and phone number.

*____ In the event the patient fails to confirm with the pharmacy after submitting their request to change to another pharmacy, be aware there is a $25 fee per request that must be collected before being able to change to another location again.

I have read and understood the policies regarding controlled substances. I agree to the terms and received a copy of this policy. I understand if any of the above policies are violated or I choose not to adhere to them; I will be discharged from the clinic and will not receive further refills from the treating physician.

Signature:_____ Date:_____

Name and relationship to Patients (If differ.):_____

**If signed electronically*, Date of Birth of signer:_____ Phone#:_____

Witness Name: _____ Witness Signature: _____

Notice of Privacy Practices

**This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully. The privacy of your health information is important to us.*

Uses and Disclosure of Health Information

We use and disclose health information about your treatment, payment and healthcare operations. *The following are examples of why and when this information is disclosed.*

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you. Or to family or friends you approved.

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

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare options include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare 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, payments, or healthcare operations, you may give us written consent to use or disclose your health information to anyone for any purpose. You also have the right to request restrictions on disclosure of PHI (Personal Health Information) or alternative means of communication to ensure privacy.

Marketing Health Related Services: We will notice your health information for marketing communications without your written consent.

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

Abuse or Neglect: We may disclose your health information to appropriate authorities when we suspect abuse or neglect.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (Such as voicemail messages, text messages, postcards or letters.)

Patient Rights

Access: You have the right to look at or get copies of your health information with limited exceptions. **If you request copies, we will charge a reasonable fee to locate, copy your information, and postage if you want copies mailed to you.**

Amendment: You have the right to request that we amend your health information.

Questions and Complaints

If you are concerned we violated your privacy rights, or you disagree with a decision we made regarding the access to your health information or in response to a request you made to amend or restrict or disclose your health information, or to have us communicate with you by alternative means, you may submit a complaint to us using out contact information listed at the bottom of all the pages. You may also submit a complaint to the U.S. Department of Human Services. We will provide you with that information upon request.

We support your right to the privacy of your health information, We will not retaliate in any way or form if you choose to file a complaint with us. A Privacy/ Contact Officer has been designated for this office. They may be contacted by simply requesting to speak to the office manager.

Informed Consent for Treatment

The risks, benefits, side effects and alternatives of treatment as well as the consequences of non compliance with treatment have been discussed with me and I will or have had the opportunity to ask questions. No promises have been made to me regarding the results of treatment.

I understand that I need to provide accurate information about myself to my medical provider so that I will receive effective treatment. I also agree to play an active role in my treatment. I understand that I may terminate my treatment at any time.

My signature below shows that I understand and agree with all the above statements and have given consent for evaluation and treatment. I will or have had the opportunity to ask questions regarding the treatment process. I also agree to guarantee payment for the provider's services.

If the patient is a minor or has a legal guardian appointed by the court, the patient's parent or legal guardian must sign this consent and provide the court documents that allow the guardian to seek treatment for the patient. If the patient is a minor and lives with one of the divorced parents, then the signed divorced document must be presented before the patient is scheduled for an appointment.

Agreement

By signing below, I acknowledge that I have received and agreed to this Notice of Privacy Practices and Consent for Treatment. ***Without the signature on this Consent Agreement, that went over Notice of Privacy Practices and Consent to Treatment, we cannot evaluate or treat you.***

Signature:_____ Date:_____

Name and relationship to Patients (If differ.):_____

**If signed electronically*, Date of Birth of signer:_____ Phone#:_____

Witness Name: _____ Witness Signature: _____

Thank you for your cooperation and welcome to our practice!