AANEM
Accredited Laboratory
*Exemplary Status

CONSULTANTS IN NEUROLOGY, S.C.
Raymond Rybicki, M.D.

•Neurology • Spine • Peripheral Nerve • Carpal Tunnel Syndrome • Low Back Pain • Neck Pain • Peripheral Neuropathy • Multiple Sclerosis • EMG/NCV Procedures • EEG Procedures • Evoked Potentials •

NEW PATIENT APPOINTMENT NOTICE

Dear Patient:
Your appointment with our office has been scheduled for the following date, time, and location:

Date: _____ Time: _____ a.m. / p.m. Location: _____

Please plan to arrive at your scheduled time. If you arrive late, the doctor may not be able to see you, and your appointment may have to be rescheduled.

Please bring the following items and information with you for your appointment:

1. Insurance cards
2. List of all medications (prescribed and over-the-counter) or bring in the bottles
3. Past medical records
4. Radiology reports (the films are not necessary)
5. Recent blood work
6. Completed Patient Medical History Form and other forms from our office
7. Insurance co-pay or $25 required office fee (see our "Financial Policy")

Your past medical history and your family history are extremely important in diagnosing your present illness. We ask that you fill out the enclosed information packet completely before you arrive and bring it with you to our office for your appointment.

Please answer all questions to the best of your ability. You do not need to go into details. Our Physicians will review the information packet with you during your appointment.

We do not want to duplicate any testing that you already had; therefore, please bring copies of any testing that you have had done. If you cannot get copies, please call our office in advance in order for us to request the records directly from your doctor or test facility.

It's very important that we know all the medications that you are taking so bring a complete list of your medications including over-the-counter or non-prescription drugs that you use. Also indicate the dose amounts and frequency of the medications. As an option, you can bring the prescription bottles with you so medications can be documented in your chart.

If you need any forms completed, bring them to your appointment. Thank you in advance for coming prepared to your appointment.

Consultants in Neurology, S.C.
3805 B Spring Street, Suite 120
Racine, WI 53405

Phone: (262) 631-8550
Fax: (262) 631-8557
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FINANCIAL POLICY

Consultants In Neurology, S.C. is committed to providing quality care and to ensure proper and correct billing is done for services provided in our clinic.
Our staff members will be happy to answer your questions or provide you with more information. The Billing Department can be reached at (262) 631-8550.

When will Consultants in Neurology submit a claim to insurance for me?
As a courtesy to you, we will submit a claim form to your insurance company when complete health insurance information (i.e., a copy of a valid insurance card or other identifying information) is provided at the time of service.

What if I'm covered by Medicare? Does Doctor accept assignments?
The doctors DO accept Medicare assignments and our office will submit a claim to Medicare and your supplemental insurance if we have complete insurance information (i.e., a copy of your Medicare card).

When are patients expected to pay at the time of service?
There are several instances when we will ask the patient for payment. They are as follows:
1 *Patients with Health Insurance*. Patients are responsible to pay the patient co-payment amount indicated on their insurance card or $25 co-payment with commercial insurance at the time of service. Should your insurance pay the full amount, we will send a refund to you.

IMPORTANT NOTE: Patients will also be billed for any additional co-payments or deductibles after we have received payment from their insurance carrier. Consultants In Neurology, S.C. follows the Wisconsin Health law which prohibits us from reducing charges or waiving co-payments or deductibles to patients with health insurance coverage.

2 *Patients without Health Insurance*. Patients without health insurance or patients who choose to be self billed are expected to pay for EACH visit as it occurs.

3 *Other Exceptions*. If your insurance plan does not pay for office visits (i.e., Chrysler Employees BC/BS & Humana), payment is due at the time of service.

4 Consultants in Neurology, S.C. participates in the following HMO and PPO Networks. Patients are responsible for securing the necessary written referral (as required by your managed care plan) from your primary care physician prior to services being rendered. Managed care networks have various IPAs; therefore, we strongly urge our patients to contact their insurance company prior to their initial visit with our clinic.

Managed health care contracts that we are a part of:

AETNA	HEALTH EOS	AHC
HUMANA	AURORA HEALTH NETWORK	UNITED HEALTH CARE
ANTHEM	WEA	CHAMPUS
WPS	CIGNA	

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Our office will allow a maximum of 60 days to receive an insurance payment. We reserve the right to add a re-billing fee of $12 per month on any account 60 days past due.

What type of payments will Consultants in Neurology, S.C. accept?
We will accept payment in cash, personal check, Visa, MasterCard, and money orders (made payable to "Consultants in Neurology."

What is Consultants in Neurology, S.C.'s credit policy?
We understand that sometimes social or economic problems may prevent you from paying on your account. Our Insurance Department is available during office hours to assist you with questions related to billing and to arrange payment plans when needed.

What if I cancel my appointment?
If you cancel your appointment with less than 24 hour notice, we reserve the right to charge you a cancellation fee.

What happens if I'm being seen because of a motor vehicle accident or other injury covered by another party?
It is our policy to treat all patients according to the financial policy listed above. Consultants In Neurology, S.C. will contact the appropriate third party payer for written verification stating they will cover the patient's charges. We will bill your insurance, but we do not accept letters of protection from attorneys promising to pay your bill out of a settlement.

My injury is work related. How is this handled?
Before your visit, you will need to give us the name of a contact person at your place of work so we can call your employer to verify the work injury and get information needed for billing. Any service subsequently rejected by your employer or Worker's Compensation insurance carrier will be your responsibility.

How often will I receive a bill from Consultants in Neurology, S.C.?
Statements are mailed monthly to all patients with outstanding balances. We allow your insurance company 60 days to process the claim. You are responsible for any remaining balance or non-covered service. It is also your responsibility to investigate any delays in payment from your insurance carrier.

Please remember that the patient (parent or legal designated representative) is responsible for the financial obligations of his or her health care. We are here to help you but we cannot do so without your cooperation.
Thank You.

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ASSIGNMENT OF INSURANCE BENEFITS

To Our Patients:

A health insurance policy is a contract between the patient and the insurance carrier. Patients are responsible for all charges whether covered by insurance or not. Our office will submit directly to your insurance if you furnish us with all the necessary information. If you receive a claim from our office, it is your responsibility to submit that claim form to your insurance carrier.

Patients not covered by insurance are expected to pay for services the day they are provided with service. Our office will allow a maximum of 60 days to receive an insurance payment. We reserve the right to add a re-billing fee of $12 per month on any account 60 days past due. We also reserve the right to charge a cancellation fee with less than 24-hour notice.

Payment for any portion owed by the patient is due within 30 days of service. A 1% per month or 12% per year late fee will be assessed on any unpaid balance remaining after 30 days.

We allow a maximum of 90 days for payment in full on all services rendered. If we do not receive payment in full within 90 days, legal action will be started on your past due account. You will be charged and be responsible for all costs of collection. We will increase your balance by 35% to cover collection costs.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize the release of information for the purpose of payment and authorize direct payment to Consultants in Neurology, S.C. the benefits otherwise payable to me by my insurance company. I understand that I am financially responsible for services not covered by Insurance to Consultants in Neurology, S.C.

I have read, I fully understand, and I agree to the above statement.

_____ _____

Patient Signature Date

_____

Employee Witness

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Revised 10/18/17

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PATIENT MEDICAL HISTORY – LONG FORM

Today's Date _____

Last Name _____ First _____ MI _____

Date of Birth _____ Age ___ Ht. ____ Wt. ____ ☐ Male ☐ Female

Address _____ City _____ ST ____ ZIP _____

Home Phone _____ Work _____

Cell Phone _____ Best Number to Call: ☐ Home ☐ Work ☐ Cell

Personal Doctor _____ Referring Doctor _____

Social Security # _____ E-mail Address _____

Employer _____ Occupation _____

Employer Address _____ City _____ ST ____ ZIP _____

Spouse's Name _____ First _____ MI _____

Spouse's DOB _____ (DOB is needed if insurance is through spouse)

Nearest Relative _____ Phone _____ Relationship _____

Relative Address _____ City _____ ST ____ ZIP _____

INSURANCE INFORMATION **Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed**

Insurance Co. _____ Phone _____

Claims Address _____ City _____ ST ____ ZIP _____

Group Number _____ Member Number _____

Policyholder _____ DOB _____ Relationship _____

2nd Insurance _____ Phone _____

Claims Address _____ City _____ ST ____ ZIP _____

Group Number _____ Member Number _____

Policyholder _____ DOB _____ Relationship _____

CURRENT MEDICAL ISSUE (S)

_____

_____

_____

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☆ PLEASE PROVIDE YOUR INSURANCE CARDS TO COPY ☆

Patient Name_____

2 MEDICATIONS AND ALLERGIES

CURRENT MEDICATIONS

List all medications that you are taking (prescriptions and over-the-counter) including aspirin, vitamins, etc.

Medication	Mg	Daily Dose	How Often
1			
2			
3			
4			
5			
6			
7			
8			

ALLERGIES

List medications or injections that have given you bad reactions. List the reaction (hives, welts, rash, itching, headache, nausea, diarrhea, passing out, shock, shortness of breath)

Medication or injection	Reaction	Year
1		
2		
3		
4		

3 PAST MEDICAL HISTORY

Operations/Accidents	Hospital	Year
1		
2		
3		
4		
5		

Hospitalizations	Hospital	Year
1		
2		
3		
4		

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List medical problems not requiring hospitalization such as chronic headaches, rheumatic fever, diabetes, high blood pressure, tuberculosis, hepatitis, kidney stones, gallstones, ulcers, etc.

Problem	Treatment	Year
1		
2		
3		
4		
5		

4 SOCIAL HISTORY

Do you smoke? ☐ No ☐ Yes How Long: _____ How Much: _____

What do you smoke? ☐ Cigarettes ☐ Cigars ☐ Pipe

Have you stopped? ☐ No ☐ Yes When: _____

Do you drink alcohol? ☐ No ☐ Yes How Long: _____

How Much? ☐ 1 drink/day ☐ 2 oz./day ☐ 4 oz./day ☐ More

Have you ever used: ☐ Marijuana ☐ Heroine ☐ Cocaine ☐ LSD/PCP ☐ Other

Have you visited outside the U.S. in the last 6 months? ☐ No ☐ Yes

5 FAMILY MEDICAL HISTORY

	Male	Fem	Age	Health Problems	Age/death	Cause/death
Father						
Mother						
Spouse	☐ M	☐ F				
Siblings	1 ☐ M	☐ F				
	2 ☐ M	☐ F				
	3 ☐ M	☐ F				
	4 ☐ M	☐ F				
	5 ☐ M	☐ F				
Children	1 ☐ M	☐ F				
	2 ☐ M	☐ F				
	3 ☐ M	☐ F				
	4 ☐ M	☐ F				
	5 ☐ M	☐ F				

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IMMEDIATE FAMILY MEDICAL ISSUES – Include relationship to you

☐ Anemia	_____	☐ Alcoholism	_____
☐ Bleeding Disorders	_____	☐ Brain Tumor	_____
☐ Cancer	_____	☐ Diabetes	_____
☐ Heart Problems	_____	☐ High Blood Pressure	_____
☐ Migraines	_____	☐ Multiple Sclerosis	_____
☐ Muscle Disease	_____	☐ Muscular Dystrophy	_____
☐ Seizures	_____	☐ Stroke	_____

6 REVIEW OF SYSTEMIC SYSTEMS

CONSTITUTIONAL

Check Yes or No to any of the following that you have now or have recently had:

☐ Yes	☐ No	Chills	☐ Yes	☐ No	Weakness
☐ Yes	☐ No	Fever	☐ Yes	☐ No	Fatigue
☐ Yes	☐ No	Weight Loss	☐ Yes	☐ No	Weight Gain
☐ Yes	☐ No	Decline in Health			

GENITOURINARY

WOMEN ONLY

☐ Yes	☐ No	Birth Control	☐ Yes	☐ No	Hernias
☐ Yes	☐ No	Change in Periods-Flow	☐ Yes	☐ No	Menopause
☐ Yes	☐ No	Difficult Pregnancy	☐ Yes	☐ No	Menstrual Pain
☐ Yes	☐ No	Postmenopausal Bleeding	☐ Yes	☐ No	Change in Periods-Interval
☐ Yes	☐ No	Sexual Problems	☐ Yes	☐ No	Discharge
☐ Yes	☐ No	Bleeding Between Periods	☐ Yes	☐ No	Itching
☐ Yes	☐ No	Recent Pap Smear	☐ Yes	☐ No	Fertility Problems
☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No	Lesions
☐ Yes	☐ No	Change in Periods-Duration	☐ Yes	☐ No	Pain on Intercourse
☐ Yes	☐ No	DES Exposure	☐ Yes	☐ No	Recent Pregnancy

MEN ONLY

☐ Yes	☐ No	Discharge	☐ Yes	☐ No	Venereal Disease
☐ Yes	☐ No	Impotence	☐ Yes	☐ No	Fertility Problems
☐ Yes	☐ No	Prostate Problems	☐ Yes	☐ No	Lesions

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☐ Yes	☐ No	Scrotal Masses	☐ Yes	☐ No	Pain
☐ Yes	☐ No	Hernias	☐ Yes	☐ No	Sexual Problems

URINARY

☐ Yes	☐ No	Awakening to Urinate	☐ Yes	☐ No	Infections
☐ Yes	☐ No	Burning	☐ Yes	☐ No	Stones
☐ Yes	☐ No	Flank Pain	☐ Yes	☐ No	Urine Odor
☐ Yes	☐ No	Bed Wetting	☐ Yes	☐ No	Pain on Urination
☐ Yes	☐ No	Difficulty Starting Stream	☐ Yes	☐ No	Urgency
☐ Yes	☐ No	Frequency	☐ Yes	☐ No	Blood in Urine
☐ Yes	☐ No	Excessive Urination	☐ Yes	☐ No	Retention
☐ Yes	☐ No	Incontinence	☐ Yes	☐ No	Urine Discoloration

HEAD

☐ Yes	☐ No	Dizziness	☐ Yes	☐ No	Head Injury
☐ Yes	☐ No	Headaches	☐ Yes	☐ No	Sweats
☐ Yes	☐ No	Fainting	☐ Yes	☐ No	Pain

PSYCHIATRIC

☐ Yes	☐ No	Depression	☐ Yes	☐ No	Excessive Stress
☐ Yes	☐ No	Disturbing Thoughts	☐ Yes	☐ No	Mood Changes
☐ Yes	☐ No	Memory Loss	☐ Yes	☐ No	Disorientation
☐ Yes	☐ No	Psychiatric Disorders	☐ Yes	☐ No	Hallucinations
☐ Yes	☐ No	Behavioral Change	☐ Yes	☐ No	Nervousness

NEUROLOGICAL

☐ Yes	☐ No	Loss of Consciousness	☐ Yes	☐ No	Blackouts
☐ Yes	☐ No	Dizziness	☐ Yes	☐ No	Fainting
☐ Yes	☐ No	Headaches	☐ Yes	☐ No	Memory Loss
☐ Yes	☐ No	Paralysis	☐ Yes	☐ No	Speech Disorders
☐ Yes	☐ No	Tingling	☐ Yes	☐ No	Tremors
☐ Yes	☐ No	Burning	☐ Yes	☐ No	Head Injury
☐ Yes	☐ No	Numbness	☐ Yes	☐ No	Strokes
☐ Yes	☐ No	Unsteady Gait			

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RESPIRATORY

☐ Yes	☐ No	Asthma	☐ Yes	☐ No	Coughing of Blood
☐ Yes	☐ No	Bronchitis	☐ Yes	☐ No	Pain
☐ Yes	☐ No	Pleurisy	☐ Yes	☐ No	Positive TB Test
☐ Yes	☐ No	Shortness of Breath	☐ Yes	☐ No	Sputum
☐ Yes	☐ No	Cough	☐ Yes	☐ No	Wheezing
☐ Yes	☐ No	Recent Chest X-Ray	☐ Yes	☐ No	Tuberculosis

CARDIOVASCULAR

☐ Yes	☐ No	Chest Pain	☐ Yes	☐ No	Heart Tests (Not EKG)
☐ Yes	☐ No	Extremities (cool)	☐ Yes	☐ No	Leg Pain-Walking
☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	Shortness of Breath-Exertion
☐ Yes	☐ No	History of Heart Attack	☐ Yes	☐ No	Swelling of Legs
☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No	Varicose Veins
☐ Yes	☐ No	Shortness of Breath-Sleeping	☐ Yes	☐ No	Hair Loss on Legs
☐ Yes	☐ No	Ulcers on Legs	☐ Yes	☐ No	High Blood Pressure
☐ Yes	☐ No	Palpitations	☐ Yes	☐ No	Recent Electrocardiogram
☐ Yes	☐ No	Extremities Discolored	☐ Yes	☐ No	Shortness of Breath-Lying Flat
☐ Yes	☐ No	Thrombophlebitis			

GASTRDINTESTINAL

☐ Yes	☐ No	Abdominal Pain	☐ Yes	☐ No	Change in Stool Color
☐ Yes	☐ No	Heartburn	☐ Yes	☐ No	Excessive Hunger
☐ Yes	☐ No	Rectal Bleeding	☐ Yes	☐ No	Hemorrhoids
☐ Yes	☐ No	Black Tarry Stools	☐ Yes	☐ No	Laxative Use
☐ Yes	☐ No	Swallowing Problems	☐ Yes	☐ No	Change in Frequency of BM
☐ Yes	☐ No	Constipation	☐ Yes	☐ No	Change in Stool Consistency
☐ Yes	☐ No	Jaundice	☐ Yes	☐ No	Excessive Thirst
☐ Yes	☐ No	Abdominal X-Ray Tests	☐ Yes	☐ No	Hepatitis
☐ Yes	☐ No	Nausea	☐ Yes	☐ No	Antacid Use
☐ Yes	☐ No	Vomiting	☐ Yes	☐ No	Change in Stool Caliber

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☐ Yes	☐ No	Diarrhea	☐ Yes	☐ No	Decreased Appetite
☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Gallbladder Disease
☐ Yes	☐ No	Infections	☐ Yes	☐ No	Rectal Pain
☐ Yes	☐ No	Vomiting Blood			

MUSCULOSKELETAL

☐ Yes	☐ No	Arthritis	☐ Yes	☐ No	Back Problems
☐ Yes	☐ No	Muscle Cramps	☐ Yes	☐ No	Restricted Motion
☐ Yes	☐ No	Joint Pain	☐ Yes	☐ No	Deformities
☐ Yes	☐ No	Muscle Stiffness	☐ Yes	☐ No	Weakness
☐ Yes	☐ No	Gout	☐ Yes	☐ No	Joint Stiffness
☐ Yes	☐ No	Paralysis			

ENT

NOSE

☐ Yes	☐ No	Discharge	☐ Yes	☐ No	Nasal Obstruction
☐ Yes	☐ No	Infections	☐ Yes	☐ No	Hay Fever
☐ Yes	☐ No	Sinus Infections	☐ Yes	☐ No	Nose Bleeds
☐ Yes	☐ No	Frequent Colds			

MOUTH

☐ Yes	☐ No	Bleeding Gums	☐ Yes	☐ No	Tongue Burning
☐ Yes	☐ No	Post Nasal Drip	☐ Yes	☐ No	Hoarseness
☐ Yes	☐ No	Change in Dentition	☐ Yes	☐ No	Voice Changes

EARS

☐ Yes	☐ No	Discharge	☐ Yes	☐ No	Dizziness
☐ Yes	☐ No	Hearing Impairment	☐ Yes	☐ No	Infections
☐ Yes	☐ No	Ringing in Ears	☐ Yes	☐ No	Hearing Aid
☐ Yes	☐ No	Pain			

THROAT NECK

☐ Yes	☐ No	Frequent Sore Throats	☐ Yes	☐ No	Lumps
☐ Yes	☐ No	Tonsils Enlarged	☐ Yes	☐ No	Tenderness

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ALLERGIC/IMMUNOLOGIC

☐ Yes	☐ No	Coughing	☐ Yes	☐ No	Sneezing
☐ Yes	☐ No	Itchy Eyes	☐ Yes	☐ No	Wheezing
☐ Yes	☐ No	Runny Nose	☐ Yes	☐ No	Hives
☐ Yes	☐ No	Watery Eyes	☐ Yes	☐ No	Recurrent Infections
☐ Yes	☐ No	Coughing With Exercise	☐ Yes	☐ No	Stuffy Nose
☐ Yes	☐ No	Itchy Nose	☐ Yes	☐ No	Wheezing With Exercise

ENDOCRINE

☐ Yes	☐ No	Weakness	☐ Yes	☐ No	Heat Intolerance
☐ Yes	☐ No	Cold Intolerance	☐ Yes	☐ No	Sweats
☐ Yes	☐ No	Goiter	☐ Yes	☐ No	Weight Loss
☐ Yes	☐ No	Neck Pain	☐ Yes	☐ No	Fatigue
☐ Yes	☐ No	Weight Gain	☐ Yes	☐ No	Increased Thirst
☐ Yes	☐ No	Excessive Urination	☐ Yes	☐ No	Thyroid Trouble

HEMATOLOGIC/LYMPH

☐ Yes	☐ No	Anemia	☐ Yes	☐ No	Bleeding Easily
☐ Yes	☐ No	Easily Bruised	☐ Yes	☐ No	Lumps
☐ Yes	☐ No	Swollen Glands	☐ Yes	☐ No	Transfusion Reaction
☐ Yes	☐ No	Blood Clots	☐ Yes	☐ No	Radiation Exposure

SKIN

☐ Yes	☐ No	Eczema	☐ Yes	☐ No	Hair Dye
☐ Yes	☐ No	Easily Bruised	☐ Yes	☐ No	Lumps
☐ Yes	☐ No	Hives	☐ Yes	☐ No	Nail Texture Change
☐ Yes	☐ No	Nail Appearance Change	☐ Yes	☐ No	Dryness
☐ Yes	☐ No	Skin Color Change	☐ Yes	☐ No	Hair Texture Change
☐ Yes	☐ No	Itching	☐ Yes	☐ No	Mole Increased Size
☐ Yes	☐ No	Rashes			

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EYES

☐ Yes	☐ No	Blurry Vision	☐ Yes	☐ No	Eyeglass Use
☐ Yes	☐ No	Double Vision	☐ Yes	☐ No	Pain with Light
☐ Yes	☐ No	Unusual Sensations	☐ Yes	☐ No	Vision Loss
☐ Yes	☐ No	Cataracts	☐ Yes	☐ No	Discharge
☐ Yes	☐ No	Excessive Tearing	☐ Yes	☐ No	Eye Pain
☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Infections
☐ Yes	☐ No	Recent Injury	☐ Yes	☐ No	Redness

BREASTS

☐ Yes	☐ No	Discharge	☐ Yes	☐ No	Tenderness
☐ Yes	☐ No	Self-Examination	☐ Yes	☐ No	Pain
☐ Yes	☐ No	Lumps			

ADDITIONS, OTHER COMMENTS OR NOTES:

Consultants in Neurology, S.C.
3805 B Spring Street, Suite 120
Racine, WI 53405

Phone: (262) 631- 8550
Fax: (262) 631-8557
www.ConsultantsinNeurology.com

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments?	YES	NO
May we leave a message on your answering machine at home or on your cell phone?	YES	NO
May we discuss your medical condition with any member of your family?	YES	NO

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____