DATE ________________ **Chatham Dermatology** **Patient Number** __________

PLEASE PRINT

PATIENT INFORMATION FORM

DO NOT LEAVE BLANKS

NAME: Last _______________ First _______________ MI ___ Preferred _______________ SS# ______________________

Date of Birth ___________ Age _____ Gender at Birth: M or F (Gender Identity ____________) Marital Status S M D W

Mailing Address ____ City _______________ State ____ Zip ____________

Occupation _____________ Employer (or school) ________________ ☐ Retired – **PREVIOUS** occupation________________

Do we see any of your family members? Please list: ____

COMMUNICATION: ***The ability to communicate with you is very important.***
We may need to reach you about your appointments, laboratory or pathology results, insurance or billing information, answers to medical questions you requested, or information about products/services of interest to you. By providing the information below, you consent to receiving such communication from our office unless you instruct us otherwise. You also understand the inherent risks of communication by unencrypted e-mail and text messages.

Cell Phone _____________________ Home Phone _______________________ Work Phone _______________________

E-mail Address ____

WHOM MAY WE THANK FOR REFERRING YOU TO US? ____

If a DOCTOR referred you, would you like us to send a letter about your visit? ☐ Yes ☐ No

EMERGENCY CONTACTS
Name ____ Phone _________________ Relationship __________________
Nearest relative/friend not living with you: ____________________________________ Phone: _____________________

SPOUSE or **LIFE PARTNER**
Name: Last ___________ First _____________ MI _____
SS# ____________________ Date of Birth ___________
Address ____
City, State, Zip _____________________________________
Phone: Cell ________ Home________ Work _________
Occupation ________________ Employer ____________

RESPONSIBLE PARENT (IF PATIENT IS UNDER AGE 18)
Name: Last _____________ First ______________ MI ____
SS# ____________________ Date of Birth ______________
Address ____
City, State, Zip ____
Phone: Cell _________ Home _________ Work __________
Occupation _____________ Employer __________________

ALL PATIENTS: ***PRESENT INSURANCE CARD(S), PHOTO ID, & PRESCRIPTION CARDS TO FRONT STAFF.***

PATIENTS OVER AGE 65 – Answer these questions. Are you under Hospice care? ☐ YES ☐ NO

Do you or your spouse have insurance coverage through work? ☐ YES ☐ NO

Did you enroll in a Medicare ADVANTAGE PLAN or HMO ? ☐ YES ☐ NO Which one? _____________________________

Your primary care provider? ____________________ Other important providers _________________________________
Local Pharmacy Name __________________________ Location _______________________ Phone_________________
Mail Order Pharmacy Name __________________________

What laboratory does your insurance specify that you use? ________________________________ ☐ I don't know.

PROTECTED HEALTH INFORMATION
List any family or friends with whom we can discuss all aspects of your health information (results, prescriptions, billing, etc.).

____

____

This information must be updated regularly according to insurance regulations. All above is accurate and up to date. If any changes occur, I will notify the office in writing.
Name ____ Date __________________________________

Chatham Dermatology

MEDICAL INFORMATION

Internal diseases, cancers, genetic issues, and medications can cause and present with *skin problems*. Thus, we need COMPLETE information about your skin, medical conditions, family history, social history, and medications.

Please give this form proper attention.

SKIN INFORMATION / HISTORY

Ethnic / racial heritage ____________________

Natural hair color__________ Eye color__________

Height __________ Weight __________

Is your face? ☐ Dry ☐ Oily ☐ Normal ☐ Combination ☐ Sensitive

Pigmentation problems? ____________________

Products that have irritated your skin? ____________________

☐ Acne ☐ Rosacea ☐ Scalp Dermatitis or Dandruff

☐ Dry Skin ☐ Eczema or Atopic Dermatitis ☐ Hives / Urticaria

☐ Psoriasis ☐ Psoriatic Arthritis ☐ Cold sores/fever blisters

☐ Other skin disorder(s) ____________________

SUN INFORMATION / HISTORY

☐ Excessive sun ☐ Tanning bed usage ☐ Problems with sun

☐ "Precancers" ☐ Atypical or dysplastic or abnormal moles

☐ Skin CANCER(s) – type, location, year, treatment (write on back or separate sheet if needed)

____

____

Outdoor activities (gardening, fishing, sports, etc.)

____

Sun protection used: ☐ UPF clothing ☐ long sleeves ☐ hats

☐ sunglasses ☐ gators/buffs ☐ sunscreen ☐ seek shade

Which best describes your pattern of tanning?

☐ Burn easily; get red and never really tan

☐ Burn easily; light tan with some difficulty

☐ May burn initially but able to tan

☐ Rarely burn; tan easily

☐ Never burn; tan deeply

ALERTS

☐ Blood thinners? ____________________

☐ Bleeding disorder/problems ☐ HIV ☐ Hepatitis

☐ Healing problems ☐ Bad scars/keloids ☐ Staph/MRSA infections

☐ Radiation treatment in past ____________________

☐ **Organ transplant** ____________________

☐ Artificial heart valves ☐ Artificial joint(s)__________

☐ Pacemaker ☐ Defibrillator ☐ Other implanted device __________

☐ Require antibiotics before dental work/surgery

☐ Local anesthesia problems/reactions (lidocaine, epinephrine)

____

☐ Contact Dermatitis / Skin Sensitivities

☐ Latex ☐ Adhesives/tape/bandages ☐ Antibiotic ointment

☐ Nickel ☐ Fragrance ☐ Plants (poison ivy) ☐ Other __________

MEDICAL & FAMILY HISTORY

	Condition	Patient	Family (Who?)	None
SKIN	Skin Cancer	☐	☐ __________	☐
	Melanoma	☐	☐ __________	☐
	Eczema	☐	☐ __________	☐
	Psoriasis	☐	☐ __________	☐
EENT	Eye Disorder	☐	☐ __________	☐
	Hearing disorder	☐	☐ __________	☐
RESPIRATORY	Lung Disease	☐	☐ __________	☐
	Asthma / COPD	☐	☐ __________	☐
	Tuberculosis	☐	☐ __________	☐
	Sinus Problems	☐	☐ __________	☐
	Allergies	☐	☐ __________	☐
CARDIOVASCULAR	Blood Clots	☐	☐ __________	☐
	Stroke	☐	☐ __________	☐
	Heart arrythmia	☐	☐ __________	☐
	Heart valve issues	☐	☐ __________	☐
	Heart attack	☐	☐ __________	☐
	Hypertension	☐	☐ __________	☐
IMMUNOLOGIC	Thyroid Disease	☐	☐ __________	☐
	Diabetes	☐	☐ __________	☐
	Arthritis	☐	☐ __________	☐
	HIV/AIDS	☐	☐ __________	☐
	Lupus	☐	☐ __________	☐
	Multiple Sclerosis	☐	☐ __________	☐
	Crohn's Disease	☐	☐ __________	☐
	Ulcerative Colitis	☐	☐ __________	☐
GU	Kidney Disease	☐	☐ __________	☐
	Enlarged Prostate	☐	☐ __________	☐
GI	Liver Disease	☐	☐ __________	☐
	Reflux	☐	☐ __________	☐
	Hepatitis	☐	☐ __________	☐
CNS	Seizures	☐	☐ __________	☐
	Mental Illness	☐	☐ __________	☐
	Dementia	☐	☐ __________	☐

OTHER DISORDERS

____

SURGERIES

____

CANCERS

____

SOCIAL HISTORY

Hours of sleep nightly _______

Smoking ☐ No ☐ Yes Amount__________

Alcohol ☐ No ☐ Yes Amount__________

Exercise ☐ No ☐ Yes Amount__________

Pets ☐ No ☐ Yes Type__________

Children ☐ No ☐ Yes __________

FEMALES

Sexually active ☐ Yes ☐ No

Birth Control __________

☐ Tubal ligation

☐ Hysterectomy

Signature

____

Print Name ____________________

☐ Patient ☐ Parent ☐ Legal Guardian

Date: __________

Chatham Dermatology

OFFICE POLICIES

The following are internal policies adopted by Chatham Dermatology. Signature is required before services can be provided. No revisions to this form will be accepted, and any attempted changes shall be null and void.

HOW TO PREPARE FOR VISITS

We are honored to have you as a patient. For visits to go smoothly, you must prepare for *each* visit properly.

ALWAYS BRING: √ ***current*** insurance card
√ photo ID
√ **written/typed list of medications / supplements**
√ payment.

Many patients bring a helpful typed list of all medical information: medicines, allergies, medical problems, past surgeries, and family history. Pathology reports (previous skin cancers and/or abnormal moles) are also important. *Please limit your visit to the concern(s) you expressed when making your appointment.* Do *not* wear make-up if you have facial concerns/lesions. Please call during office hours for questions/concerns/refills – NOT after hours.

FINANCIAL POLICY

FULL PAYMENT is due at time of service. We accept cash, local checks, debit cards and credit cards (Visa, MC, Discover and AMEX). Patients/guardians assume financial responsibility for services rendered and agree to pay the reasonable costs and expenses incurred to collect amounts owed (including collection fees, legal fees/attorney fees, and court costs). Unpaid charges shall bear the current allowable interest rate accrued monthly from the date of service. A service charge of $35.00 shall be applied each time a check is dishonored. Any concerns about the cost or coding of any services should be discussed with the office manager.

HEALTH INSURANCE COVERAGE

Insurance coverage is a contract between the insurance company and the patient. Responsibility for payment of fees is the patient's obligation. If we are participating providers for your insurance company, we will file your claim. It is YOUR responsibility to be sure our office participates with your *specific* insurance plan. Any unmet deductible or copay is due *at the time of service*. **Be aware that "COPAYS" usually cover office visits. Surgical procedures (common in this office) usually fall under deductible.** If we do not "participate" with your insurance company, you will be given a statement of office services to send to your company for possible reimbursement. If your insurance carrier requests information from you, you agree to comply *promptly* with such requests.

MEDICARE

We accept assignment of benefits from Medicare. Claims will be filed in accordance with Medicare regulations; payment will be accepted from Medicare. Medicare patients are responsible for unmet deductibles as well as 20% of Medicare's allowable charge (unless secondary insurance is a Medicare approved Medigap). Medicare considers some services "non-covered/not medically necessary" (e.g. cosmetic services, removal of benign lesions). You will be informed before such services are provided. If you desire such services, YOU are responsible for full payment.

MISSED/CANCELLED APPOINTMENTS

The practice discourages missed appointments and being late for appointments. If you are unable to keep an appointment, notify us at least **2 *working* days** (M,T,W,Th) in advance by confirming with office staff. This courtesy allows someone else to be treated - a courtesy you would want if the circumstances were reversed. If you miss or cancel scheduled appointments without proper notification, you will be responsible for a $50.00-$100.00 charge (for the missed visit). Higher charges will apply for surgeries, skin cancer screening appointments, and *multiple* missed visits. These fees are not covered by your insurance; you will **not** be rescheduled until the fees are paid in full. You will be discharged from the practice for repeated offenses.

RECORDS/FORMS

Records/Forms can be copied and/or "filled out" for a small fee depending on the type of form and size of your chart. Our office will gladly give you **one** free copy of your chart. A fee will be charged for repeated requests.

PRESCRIPTIONS

Prescriptions will be sent electronically to your preferred pharmacy. Submit refill requests through your pharmacy. If it has been over a year since your last visit, prescriptions cannot be refilled until your follow-up visit. If you missed your last appointment without proper notification, no refills will be authorized. Certain serious medicines require lab tests; these meds will not be refilled without lab results. It is YOUR responsibility to schedule visits and to obtain orders for necessary labs. Prescriptions will only be refilled during office hours when your chart may be reviewed properly (NOT on weekends). IF THERE IS A PROBLEM with a prescription (too expensive/not covered), notify our office about the problem. Many dermatology medications require prior authorization (PA). If you need a written prescription to shop around for the best price (e.g. using GoodRx), we can prepare one for you.

AUTHORIZATION FOR SERVICES AND RELEASE OF INFORMATION

The signature below serves as authorization for treatment by Chatham Dermatology. I authorize the release of any medical or other information about me/patient (including psychiatric, drug and alcohol abuse, or HIV information) to my insurance company or the Social Security Administration and Health Care Financing Administration (or its intermediaries) to process this or future claims or for utilization review or quality assurance. I also authorize release or receipt of information to/from other healthcare providers, pharmacies, insurers, consultants, and family to coordinate proper medical care, process insurance claims, and obtain prescriptions. I hereby assign benefits and authorize payment under my insurance program to Chatham Dermatology for services rendered to me. Regulations pertaining to Medicare and Medicaid assignment of benefits apply. For those under age 18, parent**s** or legal guardian**s** are financially responsible for payment.

DOCTOR–PATIENT RELATIONSHIP

The relationship between a doctor and a patient is very important. Our office is very proud of our reputation for excellence and our mission to offer the very best care for our patients. However, things in any relationship are not always perfect. If you ever have any questions, issues, or concerns about any aspect of our office or your care, please contact the office manager and/or the physician about the situation. Let us all work together to resolve any problems. If you ever decide to put negative information online, the doctor-patient relationship will be violated resulting in your official discharge from the practice and possible legal action as well.

DOCTORS IN TRAINING

Please be advised that Dr. McCullough is on clinical faculty for The Medical College of Georgia, Mercer University Medical School, and Memorial Health University Medical Center. She will sometimes have a resident physician or student physician following her to learn the art of medicine.

Chatham Dermatology wants to help patients with all their skin care needs. The high demand for dermatology care and our commitment to addressing each patient's needs can occasionally lead to longer than anticipated wait times. If you believe the best care is worth a little flexibility, we promise to do all we can to get you the best quality care.

Signature signifies assumption of full financial responsibility as detailed on this sheet.
Signature below acknowledges receipt of a copy of Chatham Dermatology Notice of Privacy Practices.
Signature below acknowledges understanding, authorizations, and compliance with ALL the above stated policies (on front and back of this form).

****Do not sign this form until you have read it and understand it.****

Signature ____ Date ________________________

If signing for a patient, please detail your guardian relationship: ______________________________________
GUARDIAN OR ADULT SIGNATURE IS REQUIRED *IF PATIENT IS UNDER 18.*

(A copy of this signature is as valid as the original.)

Chatham Dermatology

Toni Lewis McCullough, M.D.
820 East 67th Street
Savannah, Georgia 31405
(912) 355-9818
Fax: (912) 356-9878

Chatham Dermatology Notice of Privacy Practices

Date of Last Revision: April 14, 2003
Effective Date: April 14, 2003

WHAT IS THIS NOTICE OF PRIVACY PRACTICES?

This notice describes ways in which your medical information may be used and disclosed. This notice also explains *your* rights and the obligations *we* have regarding the use and disclosure of medical information. This notice applies to ALL of your records generated and used by Chatham Dermatology, whether made by the practice or another facility. This notice describes our policies which extend to all areas of our practice, all who work for or with our practice, and any business associates involved in the handling of your medical information. Please review carefully.

YOUR PERSONAL MEDICAL INFORMATION - "PROTECTED HEALTH INFORMATION" (PHI)

Your medical/health information is personal, and we are committed to protecting the information about you. At Chatham Dermatology, we create paper and electronic records of the care and services/items you receive at our office. We must keep such records to provide you with quality care and to comply with certain legal requirements.

OUR OBLIGATIONS REGARDING YOUR PROTECTED HEALTH INFORMATION (PHI)

By law, we are required to:

- Make sure that your protected health information (PHI) is kept private;
- Provide you with our Notice of Privacy Practices that details how we use and disclose your PHI;
- Advise you of the laws about PHI and your legal rights with respect to your PHI;
- Follow the conditions of the notice that is currently in effect.

Changes to this Notice: We reserve the right to change this notice at any time. We will always have a copy of the current notice available in the office. The notice will contain the date of last revision and effective date on the first page (top right hand corner). Each time you visit the office you may request a copy of the current notice in effect.

Handling of Protected Health Information (PHI): This notice will detail how the law allows us to use and disclose your PHI. Other uses and disclosures of PHI *not* covered by this notice or the laws that apply to us will be made *only with your written permission.* Examples of requests requiring written authorization include release of PHI to:

- Another physician,
- Yourself or a family member,
- A life insurance company.

If you have provided us with your permission to use or disclose your PHI, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose your PHI for the reason covered by your written authorization.

HOW WE ARE ALLOWED TO USE & DISCLOSE YOUR PROTECTED HEALTH INFORMATION (PHI)

The following categories describe different general ways (with examples) that the law allows us to use and disclose PHI without a special written authorization from you.

▶ Medical Treatment: We may use your PHI to provide you with medical treatment or services. We may disclose your PHI to other health care professionals who are, were, or may become involved in taking care of you. Examples include sharing your information with: your family doctor that referred you here initially, a friend or family member involved in your care, a doctor we refer you to for a special treatment or someone who helps pay for your care.

▶ Payment: We may use and disclose your PHI so that the treatment and services that you receive may be billed to and payment may be collected from you, an insurance company, or a third party. For example, we may need to give your current or previous health plan information about treatment you received at our office so your plan will pay us for the visit. We may also tell your health plan and/or referring physician about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

▶ Billing: We may use and disclose medical information to our electronic billing company who submits our insurance claims to insurance companies electronically. This is necessary because many insurance companies no longer accept "paper claims" and require electronic claims submissions.

▶ Operational Uses: We do many things that any business would do. We may use and disclose PHI so that we can run our practice more efficiently and make sure that our patients receive quality care. Such uses may include those associated with evaluating the quality of care we give (via internal or external review/audit), training our staff, complying with legal requirements/ lawyers, and other such business operations. When business associates are used, we shall advise them of their continued obligation to maintain the privacy of your medical records.

▶ Appointment, Treatment, Recall Reminders: We may use and disclose PHI to contact you as a reminder that you have an appointment with us or that you are due for an appointment with us. This contact may be via telephone, e-mail, postcards, or other means and may involve leaving a message on e-mail, voice mail, an answering machine, or with family, etc. Others could pick up such communications.

▶ Marketing/ New and Special Treatments: We may use and disclose PHI to keep you posted about procedures, treatments, or products that you might find of interest. We may also use PHI to inform you about our upcoming events, seminars, and discounts on products/services.

▶ Pathology / Blood work: We may use and disclose PHI to diagnostic labs/ pathology labs in order to send specimens and receive results for you.

▶ Laser Services: If you choose to have laser treatments, we may need to share your medical information with our laser technician

▶ Required By Law: We will disclose PHI when required to do so by federal, state or local law. We may also release PHI to a law enforcement official to report or solve crimes and in response to a court order, subpoena, warrant, summons, or similar process.

▶ Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose PHI in response to a court or administrative order. We may also disclose PHI in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute. We shall attempt in these cases to tell you about the request so you may obtain an order protecting the information requested if you so desire. We may also disclose PHI to defend any member of our practice in any actual or threatened action.

SPECIAL SITUATIONS

▶ To Avert a Serious Threat to Health or Safety: We may use and disclose PHI when necessary to prevent a serious threat either to your specific health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may share PHI with federal officials for national security reasons.

▶ Organ and Tissue Donation: If you are an organ donor, we may release PHI to appropriate organizations to facilitate organ or tissue donation and transplantation.

▶ Disaster relief: We may disclose PHI to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

▶ Workers Compensation: We may release PHI for workers compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.

▶ Public Health Risks: Law or public policy requires us to disclose medical information about you for public health activities. These activities generally include the following:

- To prevent or control disease, injury, or disability;
- To report births and deaths;
- To report child abuse or neglect;
- To report reactions to medications or problems with products;
- To notify a people of recalls of products they may be using;
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

▶ Investigation and Government Activities: We may disclose PHI to a local, state or federal agency for activities authorized by law. These oversight activities may include audits, investigations, inspections, and licensure. These activities are necessary for the government, health plans, and other regulatory agencies to monitor the health care system, government programs, and compliance with laws.

▶ Coroners, Medical Examiners and Funeral Directors: We may release PHI to a coroner or medical examiner, for example, to help identify a deceased person or determine the cause of death. We may also release PHI to funeral directors as necessary to carry out their duties.

PATIENT RIGHTS REGARDING PROTECTED HEALTH INFORMATION (PHI)

You have the following rights regarding medical information we maintain about you:

♦ **Right to Inspect and Copy:** You have the right to inspect and have copies of your PHI (including medical and billing records but not psychotherapy notes). Upon proof of an appropriate legal relationship, records of others related to you or under your care (guardian or custodial) may also be disclosed.

To inspect and have a copy of your medical record, you must submit your request in writing to Chatham Dermatology - Attn: HIPAA Compliance Officer. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other supplies (tapes, disks, etc.) associated with your request. We may deny your request in certain very limited circumstances. If we deny your request, we will explain why, and you may request that the denial be reviewed.

♦ **Right to Amend:** If you feel that the medical information we have about you in your record is incorrect or incomplete, then you may ask us to amend the information, following the procedure below. You have the right to request an amendment for as long as the practice maintains your medical record.

To request an amendment, submit the request in writing to Tonya McCullough, M.D. You must identify your intended amendment and a reason that supports your request to amend. The information must be dated, signed by you, and notarized.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us;
- Is not part of our records;
- Is not part of the information which you would be permitted to inspect;
- Is accurate and complete.

If we deny amending your PHI, we will tell you why, and we will explain other steps you can take.

♦ **Right to an Accounting of Disclosures:** You have the right to request this "accounting" or list of the disclosures we have made of your PHI to others. The list will *not* include the disclosures detailed above that are allowed by law for purposes of treatment, payment, healthcare operations, public safety, and governmental policy/law enforcement (i.e. those disclosures *not* requiring special authorization from you).

To request this list, you must submit your request in writing to Chatham Dermatology – Attn: HIPAA Compliance Officer. You may ask for the "accounting" of those who have seen your PHI in the past 6 years (but we can only give information about the time since April 14, 2003). The first list you request within a twelve (12) month period will be free. For additional lists, we may charge you a fee.

♦ **Right to Request Restrictions:** You have the right to request *in writing* a restriction or limitation on the medical information we use or disclose about you. *We are not required to agree to your request and we may not be able to comply with your request.* For example, you may request a limit on the information we disclose about you to a family member or friend. If we do agree to honor your request, we will comply with your request except in the case of an emergency.

♦ **Right to Request Confidential Communications:** You have the right to request *in writing* that we communicate with you in certain ways or at certain locations. For example, you can ask that we contact you at work instead of home. Or, you may request that we not leave messages on voice mail, e-mail, or the like. We will attempt to accommodate all *reasonable* requests.

♦ **Right to a Paper Copy of This Notice:** You may ask us to give you a copy of this notice at any time.

♦ **Right to Complain:** If you believe your privacy rights have been violated, you may file a complaint with the practice and/or with the Secretary of the Department of Health and Human Services. To file a complaint with the practice, submit your complaint *in writing* to Tonya McCullough, M.D. All complaints shall be investigated without repercussion to you. You will not be penalized for filing a complaint.

Chatham Dermatology provides this Notice to comply with the Privacy Regulations issued by the Department of Health and Human Services in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

ACKNOWLEDGEMENT OF RECEIPT OF CHATHAM DERMATOLOGY PRIVACY NOTICE

I have received a copy of Chatham Dermatology's Notice of Privacy Practices, detailing how my protected health information may be used and disclosed as permitted under federal and state law. The Notice contains a section describing my rights under the law. I have the right to review the Notice before signing this acknowledgement. The terms of the notice may change. If the Notice is revised, I may obtain a revised copy at the office.

I have the right to request restrictions on how protected health information is used or disclosed. The practice is not obligated to agree to such restrictions, but if the practice agrees to any restrictions, it will honor the agreement.

I request the following restriction(s) concerning the use of my personal protected health information:

____

____

____

____

Signature: ______________________________ **Date:** ______________________________

Patient Name: ____________________________ **Witness:** ___________________________

If not signed by patient, please indicate relationship to patient: ______________________

If a patient or patient's representative refuses to sign acknowledgement of receipt of notice, please document date and time the notice was presented to patient and sign below.

Presented on (date and time): ____

By (name and title): ____