Northeast Natural Medicine, LLC
19 Church Hill Rd., Suite 1
Newtown, CT 06470

ph: 1-800-723-2962
fax: 1-800-957-5421
www.nenaturalmedicine.com

New Patient Registration & Intake Form

Name_____Date_____ Birth date_____ Gender_____

Address_____City_____ State_____ Zip_____

Home Phone_____ Work Phone_____ Cell _____

Email Address_____ May we contact you by email? Y N

Where may we leave messages?: ☐ Home# ☐ Work# ☐ Cell# ☐ Email: is this a work account? Y N

Occupation _____Employer/School_____

Marital Status? _____ Number of Children? _____ Ages_____

Parent/Guardian (if minor)_____ Occupation: _____

Parent/Guardian (if minor)_____ Occupation: _____

Emergency contact: _____Phone #_____Relationship:_____

Insurance Co._____Group#_____ID#_____

Primary Insured Name_____ Birth date_____ Gender_____

How did you hear about our clinic? _____

Responsible Party Information

This section must be completed if someone other than the patient is financially responsible for the patient's account.

Name:_____ Phone: _____

Address_____City_____ State_____Zip_____

Acknowledgement of Receipt

Physicians are required to provide you with a copy of our Notice of Privacy Practices and to obtain written acknowledgement, if possible, that you have received it. The Notice outlines the types of uses and disclosures that may occur involving your protected health information, describes your rights, and explains how you may exercise those rights.

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices. I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by me or my representative or otherwise permitted or required by law.

_____ _____

Patient's Name (PRINT) **Patient's Guardian/Representative (PRINT)**

_____ _____

Signature of Patient Signature of Guardian/Representative

_____ _____

Date Relationship to Patient/Rep. Date

FOR OFFICE USE ONLY: Unable to Obtain Acknowledgement of Receipt

This section serves as a record of Northeast Natural Medicine, LLC's good faith effort to obtain written acknowledgement from the patient of receipt of the Notice of Privacy Practices. Patient was given a copy of the notice on: _____.

❑ Patient refused to sign acknowledgement. ❑ Patient is physically unable to sign acknowledgement.

❑ Other: _____

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Patient Health Questionnaire

Name_____Date_____ Birth date_____ Gender_____

What other health care are you presently receiving? _____

_____

PRESENT HEALTH CONCERNS

Most important health concern: _____
Secondary health concerns:
1. _____
2. _____
3. _____

ALLERGIES

Drugs_____ Foods_____
Environmental:_____
What are your symptoms during an allergy attack? _____
_____
Sensitivities: _____Perfumes _____Cigarette smoke _____Cleaning supplies Other: _____
Past history of long-term antibiotic use? Y N How long? _____
Past history of long-term corticosteroid use? Y N How long? _____

Current Medications	Dose	Times / Day

Current Herbs / Vitamins/ Supplements	Dose	Times / Day

PAST HEALTH HISTORY

Date of last physical exam_____ Where? _____

HEALTH SCREENING HISTORY: List the date of your most recent test or exam.
Mammogram _____ Pap Smear_____ Self Breast Exam _____Breast Exam by Professional _____

Self Testicle Exam _____ Testicle Exam by Professional_____ Prostate Exam by Professional _____

Test for Blood in stool _____ Rectal Exam _____ Scope of Lower Bowel (if over age 50)_____

Blood tests: Cholesterol _____ Blood Sugar _____Other Blood tests_____

Childhood illnesses: Your health as a child was ☐Good ☐Fair ☐Poor
(please circle) Scarlet Fever German Measles Measles Pertussis Strep Mono Ear Infections
Diphtheria Mumps Chicken Pox Rheumatic Fever Polio Pneumonia
Immunizations (check those received): ☐MMR ☐ DTaP ☐ HepB ☐Rota ☐Hib ☐Polio
☐Pneumococcal ☐Varicella ☐ Hep A ☐Meningococcal ☐ HPV

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REVIEW OF SYSTEMS

Circle which applies: **Y** = current condition (during last 3 months) **P** = past condition **N** = a condition you never had

GENERAL
Weight _____ Weight 1 yr ago_____
Maximum weight _____
When _____ Height _____
Fatigue Y P N
Energy Level _____/10 high
Pain Level _____/ 10 high

SKIN
Rashes Y P N
Eczema, hives Y P N
Acne, boils Y P N
Itching Y P N
Color change Y P N
Lumps Y P N
Night sweats Y P N
Nails break easily Y P N
Warts Y P N
Fungal infections Y P N

HEAD
Headache Y P N
Head injury date_____ Y P N
Migraines Y P N
Hair loss Y P N

EYES
Impaired vision Y P N
Glasses or contacts Y P N
Eye Pain Y P N
Tearing or dryness Y P N
Double vision Y P N
Glaucoma Y P N
Cataracts Y P N
Sensitive to light Y P N
Dark circles under eyes Y P N
Puffy eyes Y P N

EARS
Impaired hearing Y P N
Ringing Y P N
Earache Y P N
Dizziness Y P N

NOSE and SINUSES
Frequent colds Y P N
Frequent infections Y P N
Nose bleeds Y P N
Stuffiness Y P N
Hay fever Y P N
Sinus problems Y P N

MOUTH and THROAT
Frequent sore throat Y P N
Sore tongue Y P N
Gum problems Y P N
Hoarseness Y P N
Dental cavities Y P N
Teeth grinding Y P N
Teeth clenching Y P N

NECK
Lumps Y P N
Swollen glands Y P N
Goiter Y P N
Pain or stiffness Y P N

RESPIRATORY
Cough Y P N
Sputum Y P N
Spitting up blood Y P N
Wheezing Y P N
Asthma Y P N
Bronchitis Y P N
Pneumonia Y P N
Pleurisy Y P N
Emphysema Y P N
Difficulty breathing Y P N
Pain on breathing Y P N
Shortness of breath Y P N
At night Y P N
Lying down Y P N
Tuberculosis Y P N

IMMUNE SYSTEM
History of:
- ☐ Epstein Barr
- ☐ Mono
- ☐ Herpes
- ☐ Shingles
- ☐ Hepatitis
- ☐ CMV
- ☐ Lupus
- ☐ Crohn's

How many times have you been sick in the past year? _____

CARDIOVASCULAR
Heart disease Y P N
Angina Y P N
High blood pressure Y P N
Murmurs Y P N
Rheumatic fever Y P N
Chest pain Y P N
Swelling in ankles Y P N
Palpitations, fluttering Y P N

GASTROINTESTINAL
Trouble swallowing Y P N
Heartburn Y P N
Change in thirst Y P N
Change in appetite Y P N
Easy Fullness Y P N
Nausea Y P N
Vomiting Y P N
Vomiting blood Y P N
Bowel movements
How often? _____
Is this a change? _____
Diarrhea Y P N
Constipation Y P N
Blood in stool Y P N
Belching or passing gas Y P N
Bloating Y P N
Stomach Pain Y P N
Jaundice (yellow skin) Y P N
Liver disease Y P N
Hemorrhoids Y P N
Gallbladder attacks Y P N

URINARY
Pain with urination Y P N
Increased frequency Y P N
Frequency at night Y P N
Inability to hold urine Y P N
Frequent infections Y P N
Kidney stones Y P N
Change in urine color Y P N
Change in urine smell Y P N

MUSCULOSKELETAL
Joint pain or stiffness Y P N
Arthritis Y P N
Broken bones Y P N
Muscle spasms or cramps Y P N
Weakness Y P N
Chronic fatigue Y P N
Restless legs Y P N
Chronic low back pain Y P N
Motor Vehicle Accident Y P N

PERIPHERAL VASCULAR
Deep leg pain Y P N
Cold hands/feet Y P N
Varicose veins Y P N
Thrombophlebitis Y P N

NEUROLOGIC
Fainting Y P N
Seizures Y P N
Paralysis Y P N
Muscle weakness Y P N
Numbness or tingling Y P N
Loss of memory Y P N
Tremor Y P N

EMOTIONAL
Depression Y P N
Mood swings Y P N
Anxiety or nervousness Y P N
Tension Y P N
Trauma History Y N

BEHAVIORAL
Bulimia Y P N
Anorexia Y P N
Addiction Y P N
To what?_____
Had counseling Y P N
Was it effective? Y N

ENDOCRINE
Hypothyroid Y P N
Heat or cold intolerance Y P N
Difficulty losing weight Y P N
Difficulty gaining wt. Y P N
Excessive thirst Y P N
Excessive hunger Y P N
Binge eating Y P N

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NOTICE OF PRIVACY PRACTICES

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 BEFORE SIGNING.

Federal law requires us to maintain the privacy of your health information. The Health Insurance Portability and Accountability Act of 1996 (HIPPA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper or orally, are kept confidential. HIPPA gives you, the patient, new rights to understand and control how your health information is used. That law also requires us to give you this explanation of how we maintain the privacy of your health information. We reserve the right to change our privacy practices, provided the changes conform to applicable laws. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available on request.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, heath care operations, health care reminders, and for public benefit. Any other disclosure will require your written authorization.

- Treatment: means providing or managing health care and related services by one or more health providers. An example of this is the disclosure of information between our practictioners to coordinate care for you.
- Payment: means such activities as obtaining reimbursement for services, billing or collection activities and utilization review. An example of this is the disclosure from our staff to a medical insurance company for purposes of billing.
- Health care operations: include the business aspects of running the clinic, quality assessment, and evaluating practitioners. An example of this would be the owners of Northeast Natural Medicine, LLC reviewing with office staff proper data entry operations.
- Reminders: means providing you with appointment reminders or to inform you of changes in the clinic services or hours by such means as postcards, voicemail messages or letters.
- Public benefit: means the disclosure of information for the following types of reasons.: for public health activities including disease and vital statistic reporting; to report abuse, neglect or domestic violence; to health oversight agencies; to law enforcement officers pursuant to subpoenas and other lawful processing; to medical examiners and coroners; to avert a serious threat to health or safety; in connection with certain research activities; and as authorized by state and federal laws.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

Any other uses and disclosures will be made only with **YOUR WRITTEN AUTHORIZATION**. You must give such authorization in writing to disclose it for any purpose, including but not limited to having a copy sent to another physician or receiving a copy for your own personal use. You may revoke such authorization in writing and we are required to honor that written request except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Chief Medical Officer.

- The right to request restrictions on certain uses and disclosures of protected health information, including those related disclosures to family members, relatives, close personal friends or any other person identified by you. We are however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information. You must make a request in writing to obtain access to your health information. If you request copies, we will charge you a reasonable cost-based fee that may include labor, copying costs and postage. If you prefer, we may (but are not required to) prepare a summary or explanation of your health information for a fee.

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NOTICE OF PRIVACY PRACTICES continued

- The right to amend your protected health information. Your request must be in writing and must include an explanation why we should amend your records. We may deny your request under certain circumstances.
- The right to receive an accounting of disclosures of your protected health information.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

You have recourse if you feel your privacy protections have been violated. If you want more information about our privacy practices or have any questions or concerns, please contact us using the information listed at the end of this notice. You may also submit a written complaint to the US Department of Health and Human Services, Office of Civil Rights about violations of provisions of this notice or the policies and procedures of our clinic. We will not retaliate against you for filing a complaint.

I have read and understand the above-stated information.

_____ _____
Patient's Name Legal Gardian (under 16yo)

_____ _____
Patients Signature Relationship to Patient

_____
Date

Please contact us for more information. Provider Contact Office:

Shawn M. Carney, ND, Chief Medical Officer
Northeast Natural Medicine, LLC
33 Main Street, Suite 15
Newtown, CT 06470
Phone: 1-800-723-2962
Fax: 1-800-957-5421

For more information about HIPAA or to file a complaint:

The US Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, SW
Washington, DC 2020
Phone: 202-619-0257
Toll Free: 877-696-6775

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INFORMED CONSENT FOR TREATMENT

I hereby authorize the Naturopathic physicians and other practitioners of Northeast Natural Medicine, LLC to perform the following specific procedure(s) as necessary to facilitate my diagnosis and treatment:

- **Common diagnostic procedures:** e.g., venipuncture, prostate exams, pap smears, radiography, laboratory and x-ray.
- **Minor office procedures:** e.g., dressing a wound, ear cleansing.
- **Medicinal use of nutrition:** therapeutic nutrition, nutritional supplementation of vitamins, minerals, amino acids and other nutritional or therapeutic substances.
- **Botanical Medicine:** botanical substances (herbal medicines) may be prescribed as teas, alcoholic tinctures, capsules, tablets, cremes, plasters or suppositories.
- **Homeopathic medicine:** the use of highly dilute quantities of naturally occurring plants, animals and minerals to gently stimulate the body's healing responses.
- **Lifestyle counseling and hygiene:** diet therapy, fasting, elimination diets, promotion of wellness including recommendations for exercise, sleep, stress reductions and balancing of work and social activities.
- **Psychological counseling, physical medicine, acupuncture and bodywork.**

Practitioners of Northeast Natural Medicine, LLC have discussed and explained to my satisfaction the basic procedures of the above therapies and the risks and benefits of the care I will receive and I have been given the opportunity to ask questions about the treatment plan and procedures. I recognize certain potential risks and benefits of the procedures I am receiving, as they were described to me and as described more generally below:

POTENTIAL RISKS: may include allergic reactions to prescribed herbs and supplements; side effects of natural medications; inconvenience of lifestyle changes; bleeding, bruising or pain with venipuncture; possible prescription drug interaction with prescribed natural supplements or products. Acupuncture may produce temporary numbness, tingling, bruising, bleeding or redness. Physical Medicine may result in temporary pain or discomfort.

POTENTIAL BENEFITS: restoration of health and the body's maximal function capacity, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.

NOTICE TO PREGNANT WOMEN - All female patients must inform the treating doctor if they know or suspect that they are pregnant as some of the procedures and therapies described above may present a risk to the pregnancy.

Please read and sign other side of page

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ALTERNATIVES - I understand that the practitioners at Northeast Natural Medicine, LLC are specialists, not primary care physicians, and the procedures that I will receive at the Northeast Natural Medicine are supplementary care to my primary care physician and/or specialist.
It has been recommended to me that I consult with a primary care physician and/or a specialist to obtain information about all of the conventional medicine treatment alternatives available to me.

CONSENT- With this knowledge, I voluntarily consent to the above procedure(s), realizing that no guarantees have been given to me by the or any of its personnel regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

CONFIDENTIALITY - I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by my lawful representative, or me or unless law permits or requires it. I understand that my request to view or receive a copy of my medical record can only been done with a signed form of records release obtainable at Northeast Natural Medicine, LLC.
I understand that my medical record will be kept for a minimum of seven years after the date of my last visit. I understand that information from my medical record may be analyzed for research purposes, and that my identity will be protected and kept confidential. I understand that my practitioner will answer any questions I have, to the best of his/her ability.
I certify that I have read and fully understand this consent and the matters that have been explained to me. I further certify that I have full authority and accept full responsibility to execute this consent for and on behalf of the above-named patient and that I am signing freely and voluntarily.

_____ _____
Patient Name (Please Print) Signature of Patient

_____ _____
Date Signature of Patient Guardian

Notes_____
_____
_____

Rev 7/13/18

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ACKNOWLEDGEMENT OF FEES & POLICIES

CONSENT: I understand that Dr. Shawn M. Carney directs my care as a patient. I consent to services rendered and provided to me under his instruction.

CONFIDENTIALITY

In the interest of maintaining patient privacy and adhering to HIPPA regulations, Dr. Carney will only discuss medical concerns within an office visit or on the phone. No discussion of your Personal Health Information will occur outside of the clinic.

CONSENT FOR RELEASE OF INFORMATION

Release of information to Referring physician and Insurers: I authorize release of medical and related information, including alcohol, drug abuse, and mental health records obtained in the course of diagnosis and treatment to my insurance carrier(s), agencies and their intermediaries or carriers, if applicable, for the purpose of obtaining care, treatment, or payment for services provided, or to be provided. This information may be released via USPS first class mail, e-mail or facsimile as applicable. Authorization may be withdrawn at any time by written consent. All other medical information requests will require a signed medical release form.

DISPENSARY AND ONLINE ORDERING

Only active patients of this clinic may purchase supplements from the dispensary or order online through our website. In order to be considered "active," patients must have been seen within the last year. In order to better serve our long-distance patients, we will ship dispensary supplement purchases "priority mail" with the USPS. Use of this service requires a credit card on file with the office. If you would prefer to pay by check we will refrain from charging your credit card unless payment is not received within 30 days.

Returning supplements: A full credit or refund will be issued if the supplement is returned unopened, within 30 days. After 30 days there will be no refund or credit issued. Pharmacy refill orders require 24 hr. to be filled. No returns are allowed on tinctures or on special orders.

ONLINE: Patients may purchase supplements online at www.northeastnatmed.com. Supplements purchased through the online store cannot be returned to Dr. Carney's office; please make your purchases wisely.

FEES:

Payment is required at the time of service. As a courtesy, we bill your insurance company if we are in network with them. For all other companies, we will give you a superbill for services rendered upon request, which you can submit yourself. You are responsible for knowing the extent of your insurance coverage, cost of co-pays, and all payments. **You are financially responsible for all the care received from Dr. Carney, or received by family members for whom you are responsible, and agree to pay for any charge or balance your insurance company does not pay, for any reason, upon receipt of a bill from Northeast Natural Medicine, LLC. Co-pays and any deductibles are due at time of service.**

_____
Initial

Cancellation Fees: **Northeast Natural Medicine, LLC reserves the right to charge a fee if in appointment is cancelled with less than 24 hour notice, applicable to business days, or if the patient does not arrive during the appointed time. Fees are $105.00 for new patient appointments and $60.00 for follow-up appointments; however, NNM RESERVES THE RIGHT TO CHARGE THE FULL COST OF THE VISIT, AS $205.00 FOR NEW PATIENT APPOINTMENTS & $140.00 FOR FOLLOW-UP APPOINTMENTS DURING HIGH VOLUME TIMES.**

_____
Initial

Patients are always required to pay for their supplements at the time of purchase; rarely do insurance companies cover the costs of supplements. If you receive a statement for an overdue balance, payment is expected within 2 weeks of the billing date. Payments not received within 30 days of the billing date are considered late and are subject to late charges. Any account that is 45 days overdue may be turned over to a collection service. **Patients are responsible for collection fees and NNM is contracted with a collection's company who reports delinquent debt to credit bureaus.**

_____
Initial

Credit Card authorizations are for the financial settlement of bills for services, insurance copayments, telephone consultations, missed appointment/cancellation of appointments with less than 24-hour notice, and purchases from Northeast Natural Medicine.

_____
Initial

Phone calls: Phone consultations to clarify instructions on an existing treatment plan are encouraged and are free of charge if less than 5 minutes. Phone calls greater than 5 minutes may be subject to being billed as a 'telephone consultation' and may or may not be considered "Covered Services" by my insurance company. If a telephone consultation is not considered a Covered Service, I agree to promptly pay Dr. Carney and Northeast Natural Medicine, LLC in accordance with the fee schedule below.

Telephone Consultation – Complex 1-30 minutes	$90.00
Telephone Consultation – Complex, Extended, 30 + minutes	$140.00

The undersigned agrees to be liable for any property damage incurred by Northeast Natural Medicine, LLC from the patient or their dependents.

The undersigned, jointly and severally, in consideration of services to be rendered as a patient, agrees to pay the provider of service, in accordance with their regular rates and terms, for the services rendered. The undersigned further agrees to pay reasonable attorney fees and expenses incurred in collecting all sums not paid when due, whether or not litigation is actually commenced, as well as all attorney fees and costs on appeal. The undersigned assigns to Dr. Carney all insurance benefits available for their professional and clinic services rendered. The assignment is non-revocable, and the undersigned authorizes carrier of said benefits to make payment directly to Northeast Natural Medicine, LLC. Payments received from insurers will apply to the patient's account balance obligation. The undersigned agrees to promptly pay any charges that are not immediately (within 60 days) covered by insurance.

I agree that the above consents, authorizations to release information, and financial agreement apply to the Naturopathic medical services provided as long as I am a patient of Dr. Carney. I have read, fully understand, and agree to the above statements.

_____ _____
Patient (18 yrs or older) Date

_____ _____
Parent, Guardian, Responsible Party, or Legal Representative Date

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Patient Responsibility Form – Lab Services

This notice is to inform Patients that **it is their responsibility to know** – regarding lab work - whether they have a Deductible, Co-Insurance, No Coverage or if they are Fully Covered. Though we try to be sensitive to a patient's potential lab fees, all patient plans are different and it is always the responsibility of the patient to know if they have to pay for labs or not. We call insurance companies to learn if visits to the doctor are covered, but do not inquire about lab coverage.

Laboratories generally have contracted rates of compensation with different insurance companies and the rates the labs are compensated differ by the health insurance company. These compensation rates are what a patient may be billed, if they have to pay for lab services as part of their insurance plan. The compensation rates differ depending on which health insurance company is being used for a given service.

There are two ways to ascertain how much labs may cost a patient:

1) Call the laboratory and find out what the contracted reimbursement rates are for your insurance company for the specific tests being ordered.

2) Look up the CPT code (procedure code) for each test being ordered by using the internet or asking a laboratory's billing department. Then, call your insurance company to find out how much they compensate and reimburse a laboratory for that procedure.

   Laboratory billing office info:
   Labcorp – 888.365.0129 ext. 4
   Quest Diagnostics – 800.982.5810 ext. 1 or
   questdiagnostics.com

If you elect to not have labs done, we are still able to provide treatment and may be able to so at a more accelerated pace.

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AETNA - Clinical Policy Bulletins (CPBs) explain the medical, dental, laboratory and pharmacy services that AETNA may or may not cover. Some tests relevant to NNM include but are not limited to:

- High-sensitivity C-reactive protein (**hs-CRP**)
- Apolipoprotein B (apo B)
- **Genetic Testing (Notably MTHFR – methylenetetrahydrofolate reductase)**
- **Leptin**
- Lipoprotein remnants: intermediate density lipoproteins (IDL) and small density lipoproteins
- Myeloperoxidase (MPO)
- VAP cholesterol test
- CD57+lymphocyte counts
- Immune complexes
- Polymerase chain reaction (PCR) for identification or quantification of Lyme disease(B. Burgdorferi) spirochetal DNA or RNA
- **Homocysteine**

BCBS - NNM is unaware of any laboratory restrictions at this time.

CIGNA - Below you will find directions on how to access the "Medical Index", this is a PDF document listing all of Cigna's covered and non-covered services. Some tests relevant to NNM include but are not limited to:

•Genetic Testing (Notably MTHFR – methylenetetrahydrofolate reductase)

Directions: Log on to www.cigna.com

- Go to the 3rd tab from the top left – click on **Health Care Professionals**
- Then select **Resources** from the center of the menu and Hover over it until another menu appears.
- Select **Clinical Payments and Reimbursement Policies**
- Once selected – scroll to the 3rd bullet point down labeled **Medical Index.**
- In the search box at the top center of the new page type in Key Words or simply choose the beginning Alphabet letter for the desired test.
- Then select from the list the most applicable category and this will bring you to the PDF Documents listing titled Medical Coverage Policies. This will have all the Tests or Codes in question and will explain whether they are covered or not.

NOTE: Once in the PDF documents – "ctrl F" will allow you to search be CPT Code

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Patient Forms Checklist

Please initial each line stating that you have read and acknowledge the information contained within the Patient Intake Packet.

Forms List (Please Initial)

New Patient Registration: _____

Review of Systems: _____

Notice of Privacy Practices: _____

Informed Consent: _____

Acknowledgment of Fees and Policies: _____

Lab Responsibility Form: _____

Time of Service Fees: (When applicable) _____

Signature: _____ **Date**_____