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ADVANCED E·N·T Specialists

Leesburg
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Suite 304
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Ph: (703) 737-6930
Fax: (703) 858-5001

www.advancedents.com

Mahesh S. Parameswaran, MD ● Otolaryngologist

LAST NAME	FIRST NAME	MIDDLE INITIAL
SOCIAL SECURITY NUMBER	SEX	PREFIX/SUFFIX
DATE OF BIRTH *(mm/dd/yy)*	STATUS *(please check one)* ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partner	STUDENT *(please check one)* ☐ No ☐ Full Time ☐ Part Time
STREET ADDRESS	CITY/STATE	ZIP CODE
HOME PHONE *(include area code)*	WORK PHONE	CELL PHONE
RACE *(please check one)* ☐ White ☐ Black/African American ☐ Asian ☐ Hawaiian/Other Pacific Islander ☐ Other Race American ☐ Indian/Alaska Native	ETHNICITY *(please check one)* ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown	PREFERRED LANGUAGE *(please check one)* ☐ English ☐ Spanish ☐ Other: _____

EMPLOYER	JOB TITLE/STATUS	EMPLOYER ADDRESS	EMPLOYER PHONE NUMBER

PREFERRED PHARMACY	PHARMACY PHONE NUMBER	EMAIL ADDRESS

PREFERRED METHOD OF CONTACT FOR APPOINTMENT REMINDERS *(please check one)*

☐ Text Message ☐ Email ☐ Cell Phone ☐ Home Phone

CONTACT/GUARANTOR INFORMATION

CONTACT *(please check at least one)* ☐ Emergency Contact ☐ Next of Kin ☐ Insured ☐ Authorized to Seek Treatment	LAST NAME	FIRST NAME	MIDDLE INITIAL

SSN *(social security number)*	DATE OF BIRTH *(mm/dd/yy)*	RELATIONSHIP TO PATIENT	SEX	MARITAL STATUS

HOME ADDRESS	CITY/STATE	ZIP CODE	HOME PHONE

EMPLOYER	WORK PHONE	JOB TITLE

If the Guarantor information is left blank, the patient will be assumed to be the responsible/billed party.

CONTACT *(please check at least one)* **Guarantor** ☐ Emergency Contact ☐ Next of Kin ☐ Insured ☐ Authorized to Seek Treatment	LAST NAME	FIRST NAME	MIDDLE INITIAL

SSN *(social security number)*	DATE OF BIRTH *(mm/dd/yy)*	RELATIONSHIP TO PATIENT	SEX	MARITAL STATUS

HOME ADDRESS	CITY/STATE	ZIP CODE	HOME PHONE

EMPLOYER	WORK PHONE	JOB TITLE

Over

INSURANCE POLICY INFORMATION

POLICY NUMBER	GROUP ID		EFFECTIVE DATE
TYPE *(please check only one)* ☐ Health ☐ Auto ☐ Worker's Comp. ☐ Other	PRIMARY INSURANCE? *(please check one)* ☐ Yes ☐ No	END DATE	COPAYMENT AMOUNT Office: $_____ Specialist: $_____
NAME OF INSURANCE COMPANY/PLAN	INSURANCE COMPANY ADDRESS		PHONE NUMBER
INSURED'S NAME	DATE OF BIRTH *(mm/dd/yy)*		HOME PHONE
INSURED'S MAILING ADDRESS	PRIMARY CARE PHYSICIAN (PCP) &/OR REFERRING PHYSICIAN		

SECONDARY INSURANCE INFORMATION (if applicable)

POLICY NUMBER	GROUP ID		EFFECTIVE DATE
TYPE *(please check only one)* ☐ Health ☐ Auto ☐ Worker's Comp. ☐ Other	PRIMARY INSURANCE? *(please check one)* ☐ Yes ☐ No	END DATE	COPAYMENT AMOUNT Office: $_____ Specialist: $_____
NAME OF INSURANCE COMPANY/PLAN	INSURANCE COMPANY ADDRESS		PHONE NUMBER
INSURED'S NAME	DATE OF BIRTH *(mm/dd/yy)*		HOME PHONE

I authorize my insurance benefits to be paid directly to the physician and I am financially responsible for all charges. I hereby consent to the release and re-disclosure of my medical record to enable or facilitate the collection, verification or settlement of my account for any amounts due from me or any third party payor, health maintenance organization, insurer or other health benefit plan. This consent applies to LMG, PC, or any of its affiliates or agents, lenders, or any third party servicer acting for LMG, PC or any of its affiliates. I also authorize LMG to test my blood for hepatitis and/or the AIDS virus, if in their opinion; an employee has suffered an exposure incident as a result of my treatment, as defined by the Occupational Safety and Health Administration.

_____ _____

Print Name Date

_____

Signature

NOTICE OF DEEMED CONSENT FOR HIV, HEPATITIS B OR C TESTING

LMG is required by § 32.1-45.1 of the Code of Virginia (1950), as amended, to give you the following notice:

1. If any LMG health care professional, worker or employee should be directly exposed to your blood or body fluids in a way that may transmit disease, your blood will be tested for infection with human immunodeficiency virus (the "AIDS" virus), as well as for Hepatitis B and C. A physician or other health care provider will tell you the result of the test. Under Va. Code § 32.1-45.1(A), you are deemed to have consented to the release of the test results to the person exposed.

2. If you should be directly exposed to blood or body fluids of a LMG health care professional, worker or employee in a way that may transmit disease, that person's blood will be tested for infection with human immunodeficiency virus (the "AIDS" virus), as well as for Hepatitis B and C. A physician or other health care provider will tell you and that person the result of the test.

I understand that this consent will remain in effect as long as my dependent or I receive care from LMG or until I withdraw it.

_____ _____

Signature of Patient, Parent/Legal Guardian Date

_____

Relationship (if signature is not of Patient)
Signature of Person Obtaining Consent

LMG LOUDOUN MEDICAL GROUP
Proud Member of Loudoun Medical Group

ADVANCED E·N·T Specialists

LOUDOUN MEDICAL GROUP
Receipt of Notice of Privacy Practices Acknowledgement

_____
Patient's Name

I have a received a copy of Loudoun Medical Group's Notice of Privacy Practices and understand that the notice describes how my/the patient's medical information may be used and how access to this information may be obtained. I have also been given an opportunity to ask questions about the information provided in the Notice.

_____
Signature

Date:_____

_____
Relationship to Patient (if Acknowledgement Form is executed by someone other than the Patient)

FOR OFFICE USE ONLY

I attempted to obtain the patient's/representative's signature in acknowledgement of this Receipt of Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date	Staff Initials	Reason
		Refused to sign (circle if applicable) **Other:**

LOUDOUN MEDICAL GROUP PC
NOTICE OF PATIENT 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.

If you have any questions or comments about this Notice please contact:

Loudoun Medical Group, PC
224-D Cornwall St. N.W., Suite 403
Leesburg, VA 20176

Our Privacy Officer is: Clara McAuley Nussbaum, Director of Compliance, 703-737-6010

Who Does this Notice Apply to?

Loudoun Medical Group, PC ("LMG"), has published this Notice. It applies to everyone who works for Loudoun Medical Group, PC, including our employees, contractors, and volunteers.

Why Do We Publish this Notice?

LMG understands that information about you and your health is sensitive and personal. We are required by law to maintain the privacy of information we gather and use about our patients, and provide them with notices of our legal duties and privacy practices with respect to their information. We are also required to notify affected individuals of any breach of unsecured protected health information.

While we are committed to the privacy of our patients' information, in order to serve them we need to gather, keep and use records of this information. We sometimes also need to share information with other parties. This Notice is intended to let you know how we use and disclose your information.

This Notice is also to let you know about certain legal rights you have with respect to the information we hold about you. You have certain rights to review and obtain a copy of our records of information about you. You may also request that we amend these records, and may ask us to account for certain disclosures we may have made of information about you. Requests for amendments and requests for accountings must be made in writing and directed to the Privacy Officer.

When Is This Notice Effective?

We are required to comply with the terms of this Notice while it is in effect. We reserve the right to change the terms of this Notice, and make the new terms effective for all information to which this Notice applies. This Notice will be in effect from _____ until the date we publish an amended Notice. If we do publish an amended Notice, we will notify you at your next visit. We will also publish the amended Notice in our offices, and will publish it on our web site if we maintain one.

What Information Does this Notice Cover?

This Notice covers all information in our written or electronic records which concerns you, your health care, and payment for your health care. It also covers information we may have shared with other organizations to help us provide your care, get paid for providing care, or manage some of our administrative operations.

When Can We Use or Disclose Information About You?

- ***Treatment***. We may use or disclose information about you for treatment purposes to doctors, nurses, technicians, medical students or other individuals who work in our practice who are involved in providing you with health care. We may also disclose information about you to organizations and individuals involved in your care who are outside of our practice, such as consulting physicians, laboratories, social workers, and so on.

  For example, if we refer you to another physician or a hospital for specialty services, we will provide that physician or hospital with all clinical information, which might be necessary or helpful to help them provide you with the right care. Or, if we need to send a sample of your blood to a laboratory for analysis, we will provide the laboratory with the information they need to process your blood correctly.
  These are only examples, and we may use or disclose information about you to provide you proper treatment in many other ways.

- ***Payment***. We may use or disclose information about you for payment purposes to our clerks and officers involved in billing and claims payment. We may also disclose such information to your health plan or other party financially responsible for your care, or to claims and billing services if necessary.

  For example, if you are covered by a health plan we cannot get paid for the services we provide you unless we submit information in a claim. This might include detailed clinical information, depending on the kind of plan and claim. This is only an example, and there may be many other ways in which we may use or disclose information about you in

connection with payment for your care.

- ***Health care operations***. We may use or disclose information about you for operations in connection with our practice. These activities might include practice quality improvement, training of medical students, insurance underwriting, medical or legal review, and business planning or administration of our practice.

  For example, we may wish to review the quality of care you receive, in order to help us deliver the best care we can. Or, we may audit our management practices so we can become more efficient. These are only examples, and we may use or disclose information about you for health care operations in many other ways.

We may also use and disclose information about you in the following situations, without your prior authorization:

- To a public health agency, for purposes such as controlling disease.
- In case of suspected child abuse, to the appropriate governmental authority.
- In other cases of suspected abuse, neglect or domestic violence, to the appropriate governmental authority, with your agreement or if required by law, or if you are incapacitated or it appears necessary to prevent serious harm to you or others.
- Unless you object, to friends or family members who are involved in your medical care.
- Unless you object, to notify, or to assist in notifying, a family member or friend of your location or condition.
- To health oversight authorities, for regulatory, licensing and other legal purposes.
- In litigation and legal proceedings, subject to certain requirements controlling the terms of the disclosure.
- To law enforcement agencies, subject to applicable legal requirements and limitations.
- We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs established by law.
- To Funeral Directors/Medical Examiners/Coroners in the event of your death.
- When required by Federal, State or Local law.
- For medical research purposes, subject to your authorization or approval by an institutional review board or privacy board.
- If you are in the United States military, national security or intelligence, Foreign Service, to your authorized superiors or other authorized federal officials.

We may contact you for information to support your health care, including appointment reminders, information about alternative treatments, and health-related services, which may be of interest to you. We will routinely contact patients via telephone at home and/or work and, unless otherwise requested, may leave messages on the appropriate voice mail or answering service regarding appoint-ments. *Please advise us if you do not wish to receive such communications*, and we will not use or disclose your information for such purposes. If you wish not to receive this kind of communication, you must advise the Privacy Officer in writing at the address given above.

Most uses and disclosures of psychotherapy notes and most uses and disclosures of your information for marketing purposes will require your written authorization. Further, LMG would typically be required to obtain your written authorization in order to sell your information. Except for uses and disclosures described in this notice, we may not use or disclose information about you for any other purpose without your written authorization.

What Legal Rights Do You Have In Connection With Your Information?

- Right to Inspect and Copy. You have the right to inspect or obtain copies of your medical information. To inspect and copy medical information, you must submit your request in writing to the Privacy Officer at the address set forth above. If you request a copy of the information, there will be a charge based on our costs.

  We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed by another licensed health care professional. We will comply with the outcome of the review.

- Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as we keep the information.

  To request an amendment, your request must be made in writing and submitted to the Privacy Officer at the address set forth above. In addition, you must provide a reason that supports your request.

  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, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by or for LMG;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

You will be informed of the decision regarding any request for amendment of your medical information and, if we deny your request for amendment, we will provide you with information regarding your right to respond to that decision.

- Right to an Accounting of Disclosures. You have the right to request an accounting of disclosures we have made of your medical information. The accounting of disclosures typically would not list disclosures we made of medical information about you that were made for purposes of treatment, payment, or health care operations and that were made in response to a specific authorization from you.

  To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer at the address set forth above. Your request must state a time period for which you want the accounting (which may not be longer than six years prior to the request).

- Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

  We are not required to agree to a requested restriction, unless (i) you are requesting that we not disclose information to a health plan for payment or health care operations of the health plan, and (ii) the information pertains solely to an item or service for which you or someone other than the health plan has already paid in full. If we do agree to a requested restriction, we will comply with your request unless the information is needed to provide you emergency treatment. Additionally, even when we do not agree to a requested restriction, health information about you may only be disclosed to family or friends if, in the exercise of professional judgment, we believe it is in your best interest to have such information disclosed. However, under such circumstances, where practical, you will be given the opportunity to object to any such disclosure.

  To request restrictions, you must make your request in writing to the Privacy Officer at the address set forth above.

- Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

  To request confidential communications, you must make your request in writing to the Privacy Officer at the address set forth above. Your request must specify how or where you wish to be contacted.

- Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

- Complaints. If you believe your privacy rights have been violated, you may file a complaint with LMG or with the Secretary of the Department of Health and Human Services. To file a complaint with LMG, contact the Privacy Officer at the phone number or address set forth above. All complaints to the Department of Health and Human Services must be submitted in writing. We will not retaliate against you for filing a complaint.

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Mahesh S. Parameswaran, MD ● Otolaryngologist

Please take a moment to fill out this medical history form so that your practitioner can get better acquainted with your medical history. We realize that not all of the questions may pertain to you, but please answer all questions that apply. Thank you.

Patient's Full Name: _____ Date of Birth: _____

Today's Date: _____ Height: _____Weight: _____ Blood Type: _____

Primary Care Doctor: _____ Referring Doctor: _____

Reason for Visit: _____

Preferred Pharmacy Name: _____ Pharmacy Address: _____

Pharmacy Phone Number: _____ Pharmacy Fax Number: _____

Allergies: (List all medications, food and environmental)

_____

_____

Medications: (List all current medications including vitamins & supplements)

Date started	*Medication & Dose*	*Directions*	*Reason for Taking*	*Prescribed by*

Past Medical History: (Please check all that apply)

☐ Attention Deficit Disorder	☐ Dizziness/Vertigo	☐ Headache	☐ Leukemia
☐ Anemia	☐ Depression	☐ Herpes	☐ Migraine Headache
☐ Asthma	☐ Easy Bleeding	☐ HIV Infection	☐ Osteoporosis
☐ Alcohol Disorder	☐ Eczema	☐ Heart Disease	☐ Pneumonia
☐ Bronchitis	☐ Emphysema	☐ High Blood Pressure	☐ Rheumatoid Arthritis
☐ Back Problems	☐ Esophageal Reflux	☐ Hodgkin's Disease	☐ Seizure Disorder
☐ Cancer	☐ Fatigue	☐ Insomnia	☐ Sleep Apnea
☐ Concussion	☐ Gastrointestinal Disorder	☐ Lupus	☐ Stroke Syndrome
☐ Diabetes Mellitus	☐ Glaucoma	☐ Lyme Disease	☐ Thyroid Disorder

Please list any other past medical history:

_____

_____

Past Surgical History: (Please check all that apply and include the date)

Surgery	*Date*	*Surgery*	*Date*	*Surgery*	*Date*
□ Appendectomy		□ Hernia Repair		□ Shoulder Surgery	
□ Back Surgery		□ Hysterectomy		□ Sinus Surgery	
□ Breast Surgery		□ Hip Surgery		□ Tonsillectomy	
□ Cataract Surgery		□ Knee Surgery		□ Thyroid Surgery	
□ C-Section		□ Laparoscopy		□ Vasectomy	
□ Colonoscopy		□ Pacemaker Placement		□ Wisdom Teeth	
□ Cosmetic Surgery		□ Prostate Surgery		□ Other: _____	

Family History: (Please check all that apply)

	Father	*Mother*	*Brother*	*Sister*	*P. Grandfather*	*P. Grandmother*	*M. Grandfather*	*M. Grandmother*
Alcoholism								
Asthma								
Bleeding disorder								
Cancer								
Deceased								
Depression								
Diabetes								
Drug Abuse								
Epilepsy								
Heart Disease								
High Blood Pressure								
High Cholesterol								
Migraines								
Stroke								
Suicide								
Thyroid Problems								

Please list any other family medical history:

_____

_____

Prevention Information:

	Date		*Date*		*Yes*	*No*
Flu Vaccine		Meningitis Vaccine		Do you use seat belts?		
Gardasil Vaccine		PPD/TB Test		Do you have smoke detectors in your home?		
Hepatitis A Vaccine		Pneumonia Vaccine		Do you have a loaded firearm in your home? If yes, how is it stored?		
Hepatitis B Vaccine		Tetanus Vaccine				

Review of Symptoms:

Systemic Symptoms	□ fatigue □ fever/chills □ weight change
Head Related	□ headache □ facial pain
Eye	□ trouble with vision □ pain □ redness □ light sensitivity
Ear-Nose-Throat-Mouth	□ earache □ pressure □ ringing □ TMJ □ runny nose □ nose bleeds □ post nasal drip □ sneezing □ snoring □ sore throat □ itchy throat □ hoarseness □ mouth sores □ dryness □ trouble swallowing
Neck	□ swollen glands □ pain □ muscle tightness
Respiratory	□ cough □ wheezing □ shortness of breath
Cardiovascular	□ chest pain □ palpitations □ irregular heart rate □ edema □ fast heart rate
Gastrointestinal	□ abdominal pain □ heart burn □ nausea □ vomiting □ diarrhea □ constipation □ blood in stool □ change of bowel habits
Urinary	□ pain □ frequency □ blood in urine
Skin	□ rash □ lesions □ abnormal hair loss
Musculoskeletal	□ joint pain □ back pain □ muscle pain □ restless legs
Neurological	□ fainting □ numbness □ dizziness
Psychological	□ insomnia □ depression □ anxious □ irritable □ generally not having fun in life
Male	□ slow urine flow □ low libido □ erectile dysfunction
Female	□ pelvic pain □ PMS □ vaginal discharge □ abnormal bleeding

Social/Lifestyle History:

Marital Status: □ Single □ Married □ Widowed □ Divorced □ Separated
If married, spouse's name: _____
Children(s) names and age(s): _____
What is your occupation: _____
What are your hobbies: _____
Who lives at home with you: _____
Where were you born and raised: _____
How long have you been in this area: _____
Do you still drive an automobile: _____Do you ride a motorcycle/bicycle: _____
Do you wear a helmet: _____
Do you smoke or use nicotine products: _____ If yes, for how many years: _____
Cigarettes (# Packs/day): _____ Cigars: _____ Pipe: _____ Chew Tobacco: _____
Have you ever used recreational drugs: _____ If yes, when was the last time: _____
What kind did you use: _____
Do you take over-the-counter medication such as aspirin, antacids, vitamins, herbal products: _____
If yes, which ones and how often: _____
Do you take something to help you sleep: _____ If yes, what and how often: _____
Do you restrict your diet in any way: _____ If yes, how: _____
Do you drink alcohol: □ Never □ Occasionally □ Daily
If yes, how many days per week do you drink alcohol: _____
On a typical day when you drink, how many drinks do you have: _____
Do you drink caffeine: _____ If yes, how much: _____
Ever worked with chemicals, paints, asbestos, or any hazardous material?: _____
If yes, what kind: _____

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Mahesh S. Parameswaran, MD ● Otolaryngologist

Office Policies

Financial Responsibility

We accept most insurance plans and will gladly file insurance claims on your behalf. Ultimately you hold the financial responsibility for your account. We ask that you remit any applicable co-pay, deductible, and co-insurance according to the terms of your insurance contract at the time services are rendered. If you do not have your insurance information available at the time of your visit, we require that you pay 100% of charges rendered prior to the visit.

If you have an outstanding balance due, we appreciate the prompt payment in full. If you are unable to make payment in full, please inquire about arranging a payment plan. Our billing department can be reached at 703-737-6001, Option 2. If multiple attempts to collect payment from you are unsuccessful, we reserve the right to turn the outstanding balance due to over to a collection agency. In addition to the principle balance due, you will also be responsible for any legal or collection agency fees incurred. We accept Visa, MasterCard, Discover and cash. Unfortunately, we do not accept checks.

Referrals/Prior Authorizations

Please be aware of your insurance's requirements for referrals. This is one of the largest hurdles we face when working with our patients that are required to obtain referrals for treatment. It is the patient's responsibility to ensure that a valid referral is on file for the services being rendered. Referrals are usually good for 30 to 60 days depending on the insurance carrier.

Please be courteous to the Primary Care Physicians (PCP) and request the referral early as some of the practices require 3 to 7 days of advance notice. The patient may need to pick up the original referral from the PCP, however, in some cases; the PCP is willing to fax the referral to our office.

Cancellations / Missed Appointments

We will attempt to contact you to remind you of your appointment 24 - 48 hours prior to your appointment. If you are unable to keep your appointment, we require a 48 hour notice of cancellation. If you fail to show for your appointment without notifying us, we reserve the right to charge you a $50.00 no show fee that does not get covered by your insurance.

Audiology / Balance Testing Appointments: If you fail to show for your appointment, you will be charged a $75.00 no show fee.

Surgical Procedure Appointments: If you do not cancel your scheduled surgery at least 10 days in advance or you fail to show for your scheduled procedure, you will be charged a $150.00 no show fee.

Endoscopy / Laryngoscopy Procedures

During your evaluation, your provider may recommend procedures such as; Endoscopy or Laryngoscopy. Before scheduling your procedure, please contact your insurance carrier as you may be subject to additional costs and/or deductibles that are the patient's responsibility.

Prescription Refills

We request 72 hours to refill prescriptions from time of request. The best way to request refills is to call your pharmacy who will contact us.

Emergencies

In the event that an emergency occurs during office hours, call the office and you will be given instructions. If you feel your condition requires immediate medical attention go to the nearest emergency room or visit our Immediate Care Center at 46440 Benedict Drive, #107, Sterling, VA 20164. Their phone number is 703-450-1125.

Release of Medical Records

If at any time you would like to request a copy of your medical records, please fill out a Medical Records Release Form. The processing time is 5-7 days and we will notify you once they are available to pick up. Unfortunately, we do not mail any records. We ask that you bring a photo ID with you when picking up your records. As a courtesy, the first copy will be free of charge. If you need additional copies, it is 0.25 cents per page and a $10.00 processing fee.

By signing this form, I have agreed to the terms and conditions listed above.

_____ _____ _____

Printed Patient Name | Date of Birth | Today's Date

_____

Patient Signature

_____ _____

Printed Name of Personal Representative | Relationship to Patient

_____

Signature of Personal Representative

Thank you for choosing Advanced ENT Associates.

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