PATIENT INFORMATION

Name:_____Date:_____Date of Birth:_____Sex:_____Race:_____

Marital Status: Single Partnership Married Widowed. Separated. Divorced

Address:_____ City:_____State_____Zip:_____

Cell #:_____Home #:_____Work Phone:_____Ext:_____

SSN:_____Driver License #:_____

Employer:_____ Address:_____

City:_____State_____Zip:_____

EMERGENCY CONTACT

Name:_____Relationship:_____

Phone #:_____Email:_____

PHARMACY INFORMATION

Pharmacy:_____Address:_____

City:_____State:_____Zip:_____Phone Number:_____

HEALTH INSURANCE INFORMATION

Do you have Medicare? Yes☐ No☐ Do you have a Medicare Supplement? Yes☐ No☐

Are you Medicare eligible? Yes☐ No☐ Do you have a State Program? Yes☐ No☐

Policy Holder's Name:_____

Date of Birth:_____SSN:_____Policy/ID#:_____

Policy Holder's Employer:_____

Insurance Company:_____

Insurance Company Address:_____

City:_____State:_____Zip:_____

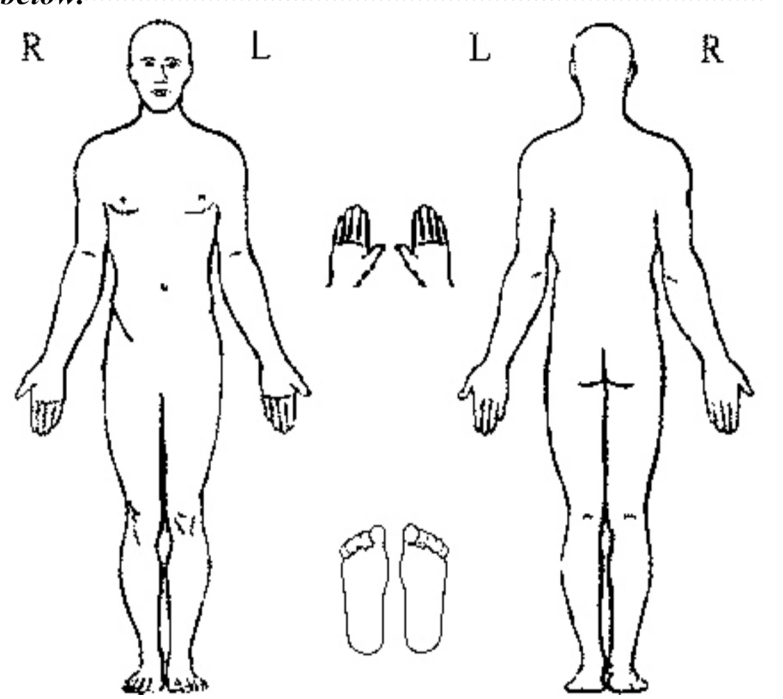
If you have any secondary or additional insurance, please provide the additional information at the front desk.

PAIN AND INJURY

The following information will help us better assess your condition and will enable us to better assist your needs. Please fill out the following forms as accurately as possible.

Name:_____Date of Birth:_____Date:_____

1. When did your pain begin? _____
2. What caused your pain to begin? _____
3. Was your injury: Work related? Yes ☐ No ☐ Accident related? Yes ☐ No ☐
4. Have you pursued/ Are you pursuing legal action for an injury? Yes ☐ No ☐
5. Where is your **worst** pain located?_____
6. ***Please shade the areas with pain on the Pain Chart below.***



7. Circle any of these to describe your pain **quality**:

   Aching Burning Gnawing
   Sharp Shooting Spasm
   *Other:*_____

8. Severity of Pain Scale
   Circle the number on each scale below to answer. (0 being the best, 10 being the worst)

   Level of your pain? 10

   0—1—2—3—4—5—6—7—8—9—10

   How much does the pain affect your activity?

   0—1—2—3—4—5—6—7—8—9—10

9. *The pain is (Please Check one)*:
   Constant ***Comes and Goes***

10. Circle what **aggravates** or makes your pain worse:
    Sitting Standing Walking Bending Lying down Lifting Looking Up/Down
    Other: _____

11. Circle what **relieves** or makes your pain better:
    Sitting Standing Walking Bending Lying down Lifting Looking Up/Down
    Other: _____

12. Is your pain **associated** with any of the following?
    Weakness? Yes ☐ No ☐ If yes, where?_____
    Numbness? Yes ☐ No ☐ If yes, where?_____
    Tingling? Yes ☐ No ☐ If yes, where?_____
    Bowel or bladder problems? Yes ☐ No ☐ If yes, where?_____
    Skin color or temperature change? Yes ☐ No ☐ If yes, where?_____
    Skin sensitive to heat or cold? Yes ☐ No ☐ If yes, where?_____
    Skin sensitive to touch? Yes ☐ No ☐ If yes, where?_____

OTHER MEDICAL ATTENTION/CARE

Name of Referring Physician/ Health Care Provider:_____

Primary Care Physician (PCP):_____

Have you seen ANY other doctors? Yes☐ No☐ *(If yes, please list names below)*

Orthopedist:_____ Neurologist:_____

Psychiatrist:_____ Pain Specialist:_____

Chiropractor:_____ Physical Therapist:_____

General Practitioner:_____ Other:_____

What was the diagnosis given? And who made the diagnosis? :_____

_____

_____

_____

List the treatments that you have received for this problem:

☐ Bed Rest ☐ Back Brace ☐ Medication(s) ☐ Physical Therapy

☐ Chiropractic ☐ Heat/ Ice ☐ Epidural/ Injections ☐ Strengthening Exercises

☐ Osteopathy ☐ Acupuncture ☐ Pain Management ☐ Other:_____

Please explain if or how any of these helped you:_____

_____

_____

_____

List the types of diagnostic testing that were performed on you:

X-Ray Date:_____ Myelogram Date:_____

C.T. Scan Date:_____ EMG/ NCS Date:_____

M.R.I. Scan Date:_____ _____ Date:_____
(other)

Please list any and all tests that were performed that were not listed above:_____

_____

_____

_____

MEDICAL HISTORY

Social History

Please describe the type of work that you do, if you are currently employed:_____

_____

Are you under any type of work restriction by a physician? Yes☐ No☐ If yes, please explain:_____

_____

Cigarette use? Yes☐ No☐ If yes, how many packs per day, week, or month?_____

Alcohol use? Yes☐ No☐ If yes, how many drink(s) per week?_____

Recreational drug use? Yes☐ No☐ If yes, please describe:_____

Medications

List **ANY** and **ALL** medications you are **currently** prescribed (including non-prescribed/herbal medications):

Name of Medication or Supplement	Doctor that manages the prescription (if applicable)	Dosage	When did you start taking this medication?

Please be sure to alert Dr. Moore of any other conditions if there are not enough spaces in the chart above.

Are you taking Blood Thinners? Yes☐ No☐ If yes, please list:_____

_____

List **ANY** and **ALL medications** that you are **allergic** to:_____

_____

Current Conditions:

Please provide the following information for **ANY** past and/or present ***medical condition(s)***, that you have received, or are currently receiving, treatment for from a doctor.

Condition	Doctor responsible for managing your treatment	Treatment Method	When did you receive (or start receiving) treatment for this condition?

Please be sure to alert Dr. Moore of any other conditions if there are not enough spaces in the chart above.

Family History: Please indicate if ANY of your relatives have been affected by particular diseases.

Disease(s)	Family Member(s)

Please be sure to alert Dr. Moore of any other conditions if there are not enough spaces in the chart above.

Is your **father** currently alive? Yes☐ No☐ Unknown☐ If no, cause of death? _____

Is your **mother** currently alive? Yes☐ No☐ Unknown☐ If no, cause of death? _____

Do you have any siblings? Yes☐ No☐ Unknown☐

If yes, indicate how many:_____brother(s) and_____sister(s).

Are any of your siblings deceased? Yes☐ No☐

If yes, indicate how many:_____brother(s) and_____sister(s).

If yes, what was (or were) the cause(s) of death? _____

_____

Surgery

Please acknowledge previous surgeries and year they were performed: No surgeries☐

Neck Surgery:☐_____ Gallbladder:☐_____ Broken Bones:☐_____

Back Surgery:☐_____ Heart surgery:☐_____ Chest/Lung Surgery:☐_____

Hysterectomy:☐_____ Stomach/hernia:☐_____ Appendectomy:☐_____

Previous Hospitalization

Date	Reason(s)

Review of Systems: Please let us know if you are experiencing any of the following symptoms.

General	YES	NO
Change in appetite	☐	☐
Chills	☐	☐
Fatigue	☐	☐
Fever	☐	☐
Weight Gain	☐	☐
EENT		
Blurred vision	☐	☐
Eye discharge	☐	☐
Eye pain	☐	☐
Decreased hearing	☐	☐
Sore throat	☐	☐

Breast	YES	NO
Breast lump	☐	☐
Breast swelling	☐	☐
Nipple discharge	☐	☐
Cardiovascular		
Chest pain at rest	☐	☐
Chest pain on exertion	☐	☐
Irregular heartbeat	☐	☐
Palpitations	☐	☐
Gastrointestinal		
Abdominal pain	☐	☐
Nausea	☐	☐
Vomiting	☐	☐
Diarrhea	☐	☐
Rectal bleeding	☐	☐
Prolonged bleeding	☐	☐
Vomiting	☐	☐

Endocrine	YES	NO
Swollen glands	☐	☐
Cold Intolerance	☐	☐
Excessive thirst	☐	☐
Heat Intolerance	☐	☐
Respiratory		
Cough	☐	☐
Shortness of breath with exertion	☐	☐
Urological		
Blood in urine	☐	☐
Difficulty urinating	☐	☐
Frequent urination	☐	☐
Kidney Failure or Stones	☐	☐
Musculoskeletal		
Carpal tunnel	☐	☐
Painful joints	☐	☐
Swollen joints	☐	☐
Weakness	☐	☐
Peripheral Vascular		
Blanching of skin	☐	☐
Pain/Cramping in legs	☐	☐
Ulceration of feet	☐	☐
Skin		
Itching	☐	☐
Rash	☐	☐
Skin cancer	☐	☐

Hematology	YES	NO
Prolonged bleeding	☐	☐
Recent transfusion	☐	☐
Neurologic		
Balance difficulty	☐	☐
Coordination	☐	☐
Difficulty speaking	☐	☐
Dizziness	☐	☐
Headache	☐	☐
Gait abnormality	☐	☐
Stroke	☐	☐
Tremor	☐	☐
Psychiatric		
Anxiety	☐	☐
Depressed mood	☐	☐

SIGNATURES

By signing below, you are acknowledging that you have provided accurate information to the best of your ability on this form.

_____ _____

Patient Signature Date

_____ _____

Reviewed By Date

For Your Information

(Please read, Sign & Date)

Hours of Operation

Our office is open Monday through Friday from 9:00 a.m. to 5:00 p.m. During these times, members of our staff will be available to take your calls. All non-emergency calls will be forwarded to the appropriate voice mail. Every effort will be made to return the call before the end of the day. ***In case of an emergency after hours, please call our main office number (678) 872-8750 and your call will be handled accordingly.***

Diagnostic Testing

What we need from you:

- Our office must be in possession of **all** documentation needed for a pre-authorization with your insurance carrier before we are able to schedule you for **any** diagnostic testing (MRI, CT scan, X-rays, etc). ***Please note: It may take several days for a pre-authorization to be approved by your insurance provider.***

Scheduling Tests:

- We can schedule you for diagnostic testing with our office, or with a referred physician.
- After we schedule you, we will notify you of the place, date, and the time of your test.
- If the appointment time does not work for you, please ***cancel*** the appointment a ***minimum of 3 days in advance***. In the case of a cancellation, know that ***you are responsible for rescheduling*** another appointment.
- ***Please note: If the you fails to keep the appointment, then the pain medications that you have been prescribed for the time frame leading up to the initial appointment, will not be refilled until after the patient has been seen by the physician.***

Follow-up appointments:

- Once your test has been scheduled, please make it a priority to call this office to schedule a follow up visit, in order to ensure accurate diagnosis, timely treatment, and/or accurate evaluation of the effectiveness of assigned treatment.
- **For diagnostic tests:** (if applicable) **BRING CD'S AND WRITTED RESULTS WITH YOU!** The Doctor will not be able to evaluate your condition without these materials, and we will ask you to go back for the films before seeing the Doctor.

Insurance and Referrals

- We will file your insurance for you, however updates and complete information must be provided.
- If you are a member of a **managed care plan** and your insurance carrier requires a referral, it will be the **responsibility of the patient to obtain the referral.** We will be unable to treat the patient if the referral is not received by the time of visit. Any charges denied because the visit was not approved, will be the responsibility of the patient.

Prescriptions for Lab Work or Physical Therapy

If you have been given a **prescription** for **lab work** or **physical therapy**, please know that you will be required to provide these documents to the facility where you intend to fulfill your perscription. We will be glad to recommend some facilities; however, it is the patient's responsibility to schedule the appointment and confirm that the facility is covered by their insurance. ***Please call this office to schedule a follow up visit after you have completed your physical therapy and /lab work.***

Medical Records Requests

Please call ahead for any medical records and/or films that need to be picked up or mailed. Please allow up to 5 business days for all requests to be fulfilled. **Please be aware that all requests may be subject to a fee. MEDICAL RECORDS MINIMUM FEE = $23.67 (GA. CODE sec 31-33-3)**

Cancellations and Fees

Our office policy states that patients must give **at least 24 hours notice for any cancellations or for the rescheduling or an appointment**. If a **patient misses their appointment**, or if they **fail to cancel or reschedule** their appointment **more than 24 hours in advance**, they will be charged with a "no-show" fee of $$$$$. Please note: If your appointment is scheduled on Monday, please call the Friday before by noon to reschedule.

Appointment Timeliness

Because we are a specialty practice, we often see patients with complex problems or medical histories that have to be thoroughly assessed and may take more time than could have been anticipated. We are also required to see a high volume of emergencies referred from other doctors and area hospitals. As a result, we sometimes have delays in our schedule that are unavoidable. We will make every effort to see you at your appointment time.

_____ _____

Patient/ Legal Guardian Signature Date

Medication Agreement and Refill Policy

As part of your treatment, our physicians may order medications for you. Many of these medications can have serious side effects that can impede your health and safety if they are not managed properly. To avoid any unnecessary risk and to promote the effectiveness of your medical treatment, we ask that you use any prescribed medication(s) as formally directed by the prescribing physician.

It is the patient's responsibility to ask the Doctor at the time of their visit for any prescriptions. We will be unable to honor phone requests unless previously discussed with the Doctor. You may call our office between the hours of 9:00 am and 5:00 pm and leave a message on the prescription line to request a refill. Because the Doctor is in surgery, three days out of the week, we may not be able to get an approval for a couple of days. For this reason, it will be necessary for you to call **3 days in advance** to allow for the delay. **Approved** refills will be called into your pharmacy or the prescription will be available for pick up at our office. ***IMPORTANT*** **NO PRESCRIPTIONS WILL BE HONORED AFTER HOURS.**

1. Upon discharge from Craniospinal Institute, I agree not to request prescriptions for any type of pain medication, sedative antidepressant, etc., form Craniospinal Institute.
2. I agree to follow the dosing schedule prescribed by my doctor.
3. I agree to always keep my medications safeguarded and within my control. Craniospinal Institute cannot replace prescriptions earlier than originally written.
4. I agree to notify Craniospinal Institute if I experience any adverse effects of dosage problems with my prescribed medications. I will not discard any unused medication. Before new medication can be prescribed, I must bring the unused medication to Craniospinal Institute office.
5. I agree to receive all pain-related medications form Craniospinal Institute or an appropriate designated clinic.
6. I agree to use only one pharmacy for my pain-related medications.
7. **I understand that medication refill prescriptions involving opioid medicine requires a scheduled office visit when my Craniospinal Institute physician is on duty in the office. Opioid medication refills will not be called into a pharmacy nor will opioid pain medications be increased over the phone.**
8. I agree to keep all scheduled visits. I am assured of having sufficient medication when I go to all scheduled appointments. If I miss an appointment without prior notification to Craniospinal Institute, I understand that my refill prescriptions will not be issued until my next scheduled appointment.
9. I understand that medication refills cannot be made after hours or on weekends. Please expect a **48-72 hour turnaround** time for prescription referrals.
10. I agree to bring my medications to Craniospinal Institute at the time of my appointment.
11. I understand that I should not drive an automobile or operate heavy equipment while I am taking pain medications or sedatives.
12. I understand that my therapy at Craniospinal Institute may require a regular office visit so my doctor can properly evaluate my progress and/or appropriate opioid medications every 30 days.
13. I understand that abusive behavior or harassment toward any member of the Craniospinal Institute staff will not be tolerated. Harassment includes, but is not limited to, more than **2** telephone calls to the office in one day.
14. I will not come to Craniospinal Institute seeking medication refills.
15. I understand that a forged or falsified prescription will result in immediate dismissal from the Craniospinal Institute practice.
16. I understand that if I do not follow the medication agreement, I may be dismissed form the Craniospinal Institute practice.
17. I willingly choose to come to see Dr. Moore for my medical care at Craniospinal Institute of Gerogia.

_____ _____

Patient/ Legal Guardian Signature Date

FINANCIAL POLICY

The following is a statement of our financial policy. We require that you read and sign prior to any treatment. All patients must complete our patient and insurance information forms before your first appointment with our doctors, nurse, physical therapist, Nerve Conduction Studies, or any medical equipment or supplies are dispensed.

ALL COPAYMENTS ARE DUE PRIOR TO BEING SEEN.

For your convenience, we accept: **Cash, Check, Visa, and MasterCard.**

There will be a 3% transaction fee added to all Credit & Debit cards.

Insurance

We cannot accept assignment of your insurance unless all insurance information is given at the time of each visit. If you have a secondary or supplemental insurance, please provide that information also. It is imperative that we make copies of your current insurance cards for accurate billing. If your insurance has not paid within 45 days, you may receive notification for payment of the balance due. It is your responsibility to contact your individual insurance carrier for benefit information regarding the office visits, ER, hospital, durable medical equipment and other service charges and payments.

It is extremely important that you educate yourself about your individual insurance benefits. **Please be aware that you are responsible for deductibles as well as copayments and co-insurance.**
(Medicare patients do have a yearly deductible and a 20 % copayment each visit. You will be billed when Medicare pays their allowable amount.)

To protect yourself, contact your insurance company prior to any procedure to be certain of your benefits, coverage, and deductibles. Patient balances 90 days past due may be sent to a collection agency.

Referrals

If your insurance requires a referral, it is your responsibility to obtain a current referral from your primary care physician. Please check with our front desk to see if your referral has been received preferably before your scheduled appointment or bring your current referral with the day of your appointment. If your insurance denies payment because of no referral, you will be responsible for payment.

Collection Fee's: Per Georgia Law, a $35.00 service charge will be applied for accounts turned over to collections.

******* IMPORTANT – PLEASE READ*******

***** SELF PAY PATIENT STATUS *****

If you DO NOT have insurance you are expected to pay **PRIOR** to being seen by our PHYSICIANS.

FMLA/Disability and Miscellaneous Forms

There is a charge **$25 and up for FMLA forms and/or Disability forms, PER INSTANCE,** and any other miscellaneous forms payable in advance. (This may be from (1) one page to several pages. The office manager will address additional fee options and policies.)

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns. The Office manager is available to further explain the policy, should the need arise.

I have read and fully understand the Financial Policy laid forth I have been given an opportunity to ask questions for understanding. I agree to adhere to the provisions and requirements of said policy.

_____ _____

Patient/ Legal Guardian Signature Date

ASSIGNMENT OF BENEFITS / RELEASE OF MEDICAL INFORMATION

I,_____, hereby authorize and request that all payments of benefits made by my primary insurance provider,_____, and/ or my secondary insurance provider (if applicable),_____, be made directly to CRANIOSPINAL INSTITUTE OF GEORGIA, LLC, for services furnished to me and/or my dependent.

I understand that my insurance provider(s) may only cover a portion of the financial amounts owed to CRANIOSPINAL INSTITUTE OF GEORGIA, LLC. I further understand that I am personally responsible for 100% of any and all charges not covered by my insurance provider(s). I also understand it is mandatory to notify the health care provider of any other party who may responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information.) *I also recognize that regulations pertaining to Medicare's assignment of benefits apply.*

In addition, I hereby authorize CRANIOSPINAL INSTITUTE OF GEORGIA, LLC, to disclose any and all necessary medical records that my insurance provider(s) need(s) to process claims associated with the treatment and services they furnished to me.

By signing this assignment of benefits and release of information I acknowledge:

1. I am aware and understand that this authorization will not be used unless the above named insurance company(s) or their designated representatives request records of information for reimbursement purposes; or seek to take action reference payment for treatment services.
2. I agree to participate and assist CRANIOSPINAL INSTITUTE OF GEORGIA, LLC, or its designated representatives with any appeal process necessary to collect payments for services rendered.
3. I am aware and have been advised of the provisions of Federal and State Statues, rules and regulations and provide for my right to confidentiality of these records.
4. I understand that this assignment and authorization is subject to revocation at any \time except to the extent that action has been taken in reliance thereof. In any event, this authorization will expire once reimbursement for services rendered is complete.
5. A firm contracted by CRANIOSPINAL INSTITUTE OF GEORGIA, LLC, for billing and collection purposes may do billing.
6. My attorney (if applicable), _____, is appointed by me to act as my representative and on my behalf in any proceeding that may be necessary to seek payment from my insurance carrier. This includes receiving a copy of my insurance plan's documents.
7. Should an overpayment take place, a refund check will be mailed to the authorized party that is due the overpayment.
8. CRANIOSPINAL INSTITUTE OF GEORGIA, LLC shall be entitled to the full amount of its charges without offset.

By signing below, I acknowledge receipt of a completed and signed copy of this assignment and release form:

Patient Signature:_____ Date:_____

Staff Signature:_____ Date:_____

Staff Print Name:_____ Credentials:_____

SURGICAL POLICY

If you are scheduled for surgery all co-pays and deductibles are due 72 hours prior to scheduled date of the procedure(s).

All surgical co-pays and deductibles that are not paid in full 72 hours prior to the scheduled surgical date will be cancelled.

Surgical Procedures must be cancelled 5 days in advance to avoid $300.00 cancellation Fee. Epidural and Trigger Point Injection must be cancelled 3 days in advance to avoid $150.00 cancellation Fee.

We cannot be held responsible or accountable for any claims that have not been filed to your insurance that may reduce your deductible or co-pay. We will require the deductible/co-pay due according to the information that is on file at your insurance company on the day that we call to verify coverage.

If we verify that there is an overpayment or refund due, we will refund you as soon as possible.

_____
Patient Name Printed

_____ _____
Patient/ Legal Guardian Signature Date

HIPAA OMNIBUS RULE
PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for **Craniospinal Institute of Georgia**. A copy of this signed, dated document shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

_____ _____
Please ***print*** name of Patient Please ***sign*** Patient / Guardian of Patient

_____ _____
Legal Representative / Guardian Relationship of Legal Representative / Guardian

Your comments regarding Acknowledgements or Consents:_____

_____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:
☐ First Name Only ☐ Proper Surname ☐ Other _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

☐ Cell Phone Confirmation ☐ Text Message to my Cell Phone
☐ Home Phone Confirmation ☐ Email Confirmation
☐ Work Phone Confirmation ☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

☐ Cell Phone Confirmation ☐ Text Message to my Cell Phone
☐ Home Phone Confirmation ☐ Email Confirmation
☐ Work Phone Confirmation ☐ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

☐ Phone Message ☐ **Any of the Above**
☐ Text Message ☐ **None of the above** (opt out)
☐ Email

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment ☐
I could not communicate with the patient ☐
The patient refused to sign ☐
The patient was unable to sign because ☐
Other (please describe) ☐

_____
Signature of Privacy Officer

_____
Date

PRIVACY PRACTICES

Notice to Patient:
We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

_____
Please print your name here

_____
Signature

_____
Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:
The patient refused to sign.
Due to an emergency situation it was not possible to obtain an acknowledgement.
We weren't able to communicate with the patient.
Other (Please provide specific details)

_____
_____
_____

_____ _____
Employee Signature Date

Submit New Patient Forms