# WELCOME TO LOW COUNTRY PHYSICAL THERAPY

Your appointment is scheduled on _____/_____/_____ at_____ :_____ AM/PM.

It is the mission of Low Country Physical Therapy and its staff to provide therapeutic and restorative services to patients for the rehabilitation of the injured, disabled, or sick; to assist each patient in reaching his/her maximum performance so he/she may resume his/her rightful place in the society while learning to live within the limits of his/her capabilities. Low Country Physical Therapy shall provide state-of-the-art health care that strives to significantly improve the wellbeing of each patient, while recognizing their capacity of being responsible for their own health.

All patient co-pays and balances are due prior to treatment. We accept the following forms of payment: cash, check, Visa, MasterCard, Discover, and American Express.

Enclosed you will find your new patient paperwork you will need to complete in blue or black ink only, and bring with you the day of your appointment. Make sure you also bring the following items:

1. **Driver's license**
2. **Insurance card(s)**
3. **A current list of medications including anything that is over the counter. Please be prepared to provide us with the dosage (i.e. Milligrams), how many times a day you take each one, how each one is taken, and the reason you are taking each medication.**

If your physician has given you the script for your therapy, it is necessary for you to bring this with you as well, as some insurance companies will not allow us to treat you without it.

You should wear something comfortable so the therapist can access the individual body part(s) necessary for your treatment. We have included a map with directions on the back of this page. If you have any questions, please call us at (843) 651-6565 or (843) 314-3980.

We look forward to treating you and helping you reach the goals set forth by you, your physician, and your therapist.

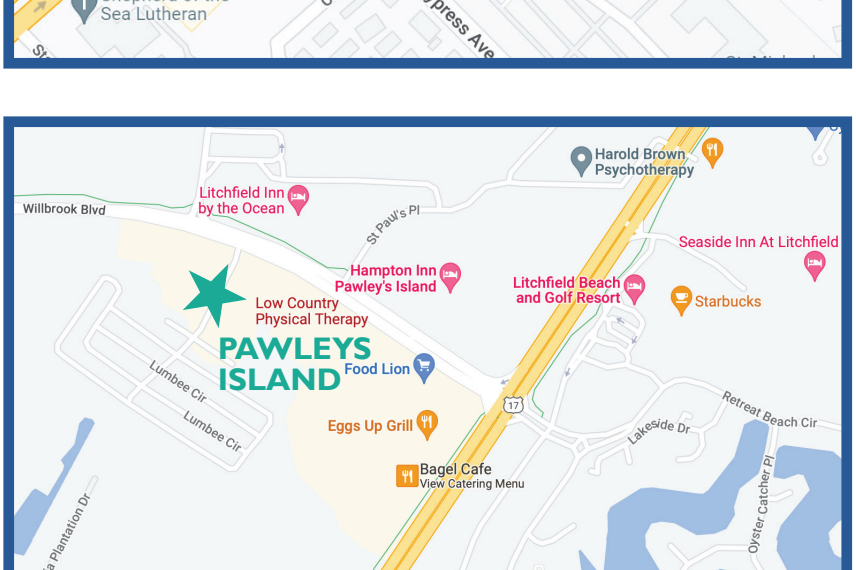
Thank you,
Low Country Physical Therapy

# TWO CONVENIENT LOCATIONS!


## Murrells Inlet

2586 S Highway 17 Unit C
Murrells Inlet, SC 29576
p: 843.651.6565
f: 843.651.6575

Directions:
Located on west side of Business 17 between Glenns Bay Rd. in Surfside Beach and the Garden City Connector, opposite St. Michael's Catholic Church.




## Pawleys Island

267 Willowbrook Blvd. Suite D
Pawleys Island, SC 29585
p: 843.314.3980
f: 843.314.3979

Directions:
Continue south on Business 17 or Ocean Blvd. Turn right onto Willbrook Blvd. Office is on the left, the 3rd entrance into Mingo Plaza next to Quigley's Pint & Plate.

**"WE TREAT YOU LIKE FAMILY"**

2586 S Highway 17 Unit C / Murrells Inlet, SC 29576 / Tel: (843) 651-6565/ Fax: (843) 651-6575
267 Willbrook Blvd, Suite D / Pawleys Island, SC 29585 / Tel: (843) 314-3980 / Fax: (843) 314-3979
www.lowcountrypt.com

# NEW PATIENT INFORMATION FORM

(Please print your name as it is shown on your insurance card.)

## PATIENT INFORMATION

Patient's First Name:_____ MI: _____ Last Name: _____ Date of Birth: _____/_____/_____

Social Security #: (not required but helpful for ins) [ ]Male [ ]Female Patient Nickname: _____

_____

Mailing Address: _____ Street Address (if different): _____

City: _____ State: _____ Zip Code: _____ Primary Contact no: _____

Email Address: Occupation: Emergency Contact Name: Emergency Contact Phone No.:

_____ _____ _____ _____

Referred to clinic by (please check one box):

[ ]Medical Provider [ ] Drive By [ ]Google/Internet Search [ ] Google Review [ ] Printed Advertisement [ ] Previous Patient
[ ]Referred by a PT [ ] Insurance Company Referral [ ] Social Media [ ] Direct Mail [ ]Radio [ ]Friend/Family
[ ]Referral from Another Patient [ ]Attended Workshop/Injury Screening [ ] Clinic Website [ ]Other_____

Referring Physician Name and Phone Number:

_____

Primary Care Physician Name and Phone Number:

_____

## INSURANCE INFORMATION
## (ALSO COMPLETE NEXT PAGE IF WORKERS COMP OR NO FAULT/AUTO)

### Primary Insurance Plan: (i.e. BCBS)

Insured's ID Number: _____

Insured's Policy Group #: _____

Insured's Name: _____

Insured's Address: _____
(if different)

Insured's City: _____

Insured's State: _____

Insured's Zip Code: _____

Insured's Phone #: _____

Insured's Birth Date: _____

Insured's Gender: _____

Insured's Employer: _____

Relation to Insured: _____

### Secondary Insurance Plan: (i.e. BCBS)

Insured's ID Number: _____

Insured's Policy Group #: _____

Insured's Name: _____

Insured's Address: _____
(if different)

Insured's City: _____

Insured's State: _____

Insured's Zip Code: _____

Insured's Phone #: _____

Insured's Birth Date: _____

Insured's Gender: _____

Insured's Employer: _____

Relation to Insured: _____

## ACCIDENT DETAILS: PLEASE COMPLETE IF THIS VISIT IS DUE TO INJURY

Employment related: [ ] YES [ ] NO

Accident related:
[ ] Auto [ ] YES [ ] NO

Date of first symptom or accident:
_____/_____/_____

If auto accident related, please indicate in which state the accident occurred: _____

_____

Give details of accident and complete next page if accident related:

_____

_____

_____

I authorize the release of any medical or other information necessary to process insurance claims.
I authorize payment of medical benefits directly to this practice for the services rendered.

Patient/Guardian Signature: _____ Date _____/_____/_____

## ONLY COMPLETE IF THIS IS A WORKER'S COMPENSATION OR NO FAULT/AUTO CASE

### Workers Comp Carrier Name:

Insurance Co. Address: _____
Insurance Co. City: _____
Insurance Co. State: _____
Insurance Co. Zip: _____
Carrier Case/Claim #: _____
WCB #: _____
Case Mgr./Adjuster Name: _____
Case Mgr./Adjuster Phone #: _____
Employer's Name: _____

### No Fault/Auto Case Insurance Name:

Insurance Co. Address: _____
Insurance Co. City: _____
Insurance Co. State: _____
Insurance Co. Zip: _____
Carrier Case/Claim #: _____
WCB #: _____
Case Mgr./Adjuster Name: _____
Case Mgr./AdjusterPhone #: _____
Employer's Name: _____

*I refuse to provide this practice with my personal health insurance information. I am aware that if WC/No Fault denies payment, I am solely responsible for the remainder of the bills._____Initials*

Please provide a summary of the accident and resultant claim.

# PATIENT HISTORY FORM

Name: _____ Age: _____ DOB: _____ Occupation: _____

Leisure activities, including exercise routines: _____

Primary Care Physician/Family Physician: _____

Are you on a work restriction from your doctor? **YES** **NO** Do you smoke? **YES** **NO**

Are you latex sensitive? **YES** **NO** Please list any known allergies _____

Do you have a pacemaker or defibrillator? **YES** **NO** Do yo have cancer? **YES** **NO** If "yes", how active is your cancer _____

Do you have a stimulator of any kind (brain stimulator, pelvic stimulator, etc.)? **YES** **NO**

FOR WOMEN: Are you currently pregnant or think you might be pregnant? **YES** **NO**

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Allergies | ☐ YES ☐ NO | Diabetes | ☐ YES ☐ NO | Metal Implants | ☐ YES ☐ NO |
| Anemia | ☐ YES ☐ NO | Dizzy Spells | ☐ YES ☐ NO | MRSA | ☐ YES ☐ NO |
| Anxiety | ☐ YES ☐ NO | Emphysema/Bronchitis | ☐ YES ☐ NO | Multiple Sclerosis | ☐ YES ☐ NO |
| Arthritis | ☐ YES ☐ NO | Fibromyalgia | ☐ YES ☐ NO | Muscular Disease | ☐ YES ☐ NO |
| Asthma | ☐ YES ☐ NO | Fractures | ☐ YES ☐ NO | Osteoporosis | ☐ YES ☐ NO |
| Autoimmune Disorder | ☐ YES ☐ NO | Gallbladder Problems | ☐ YES ☐ NO | Parkinsons | ☐ YES ☐ NO |
| Cancer | ☐ YES ☐ NO | Headaches | ☐ YES ☐ NO | Rheumatoid Arthritis | ☐ YES ☐ NO |
| Cardiac Conditions | ☐ YES ☐ NO | Hearing Impairment | ☐ YES ☐ NO | Seizures | ☐ YES ☐ NO |
| Cardiac Pacemaker | ☐ YES ☐ NO | Hepatitis | ☐ YES ☐ NO | Smoking | ☐ YES ☐ NO |
| Chemical Dependency | ☐ YES ☐ NO | High Cholesterol | ☐ YES ☐ NO | Speech Problems | ☐ YES ☐ NO |
| Circulation Problems | ☐ YES ☐ NO | High/Low Blood | ☐ YES ☐ NO | Strokes | ☐ YES ☐ NO |
| COVID-19 | ☐ YES ☐ NO | HIV/AIDS | ☐ YES ☐ NO | Thyroid Disease | ☐ YES ☐ NO |
| Currently Pregnant | ☐ YES ☐ NO | Incontinence | ☐ YES ☐ NO | Tuberculosis | ☐ YES ☐ NO |
| Depression | ☐ YES ☐ NO | Kidney Problems | ☐ YES ☐ NO | Vision Problems | ☐ YES ☐ NO |

Please list prior surgeries and date(s) _____

Date of injury/onset of current symptoms: _____ Date of surgery: _____

What do you think caused your symptoms? _____

Please circle any of the following services that you are currently receiving or have received in the last 12-months:

Physical Therapy  Occupational Therapy  Chiropractic Care  Massage Therapy  Speech Therapy  Home Health

Have you had any of the following for your current problem:  X-Ray  Injection  MRI  CT Scan  Other: _____

Have you ever had this problem before?  **YES**  **NO**  If yes, when? _____

In your current living environment:  Do you have stairs?  **YES**  **NO**  Do you live alone?  **YES**  **NO**

How would you rate your overall quality of life?  Excellent  Good  Fair  Poor

Please list 3 activities that you are unable to do or having difficulty with as a result of your problem.

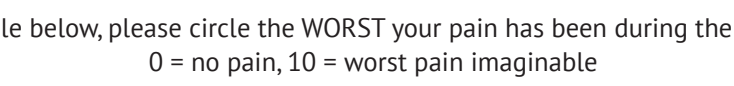
1. _____

2. _____

3. _____

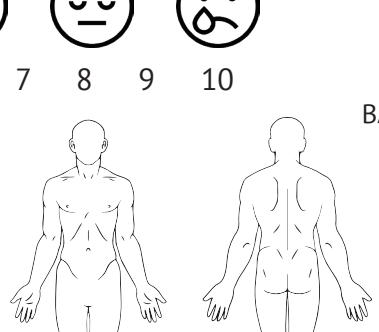
Name: _____ DOB:_____

Using the scale below, please circle the WORST your pain has been during the past 24 hours.
0 = no pain, 10 = worst pain imaginable



0  1  2  3  4  5  6  7  8  9  10

On the chart to the right, please mark the areas where you feel PAIN with an "O" and NUMBNESS/TINGLING with an "X".




## MEDICATION ASSESSMENT:

Please list any medications you are currently taking (including pills, injections, skin patches, vitamins, herbs, etc):

| Medication Name | Dosage | Frequency | Route of Administration (circle how you take this med) |
|---|---|---|---|
| | | | mouth, injection, patch |
| | | | mouth, injection, patch |
| | | | mouth, injection, patch |
| | | | mouth, injection, patch |
| | | | mouth, injection, patch |
| | | | mouth, injection, patch |
| | | | mouth, injection, patch |
| | | | mouth, injection, patch |

Next referring MD appointment: _____/_____/_____

## CONSENT TO TREAT AND CONDITIONS OF ADMISSION

**1 CONSENT TO REHABILITATION PROCEDURES:** The undersigned consents to the procedures which may be performed during this and future out-patient physical therapy visits that are performed at Low Country Physical Therapy, hereinafter referred to as "The Clinic". I/We consent to examination, therapy procedures and therapy care given the patient by or under the supervision of the physical therapist.

**2 LEGAL RELATIONSHIP BETWEEN The Clinic PHYSICAL THERAPISTS:** All Physical Therapists (PT), and Physical Therapist Assistants (PTA) are employed by The Clinic. The Clinic serves as a medical teaching facility; therefore, physical therapist students, physical therapist assistant students and physical therapy residents may be involved in your care under the supervision of an attending PT or PTA.

**3 FINANCIAL AGREEMENT:** The undersigned agrees whether he/she signs as agent or as patient, that in consideration of the services to be rendered to the patient, he/she hereby individually obligates himself/herself to pay the account of The Clinic in accordance with the regular rates and terms of The Clinic.

**4 ASSIGNMENT OF INSURANCE BENEFITS:** The undersigned authorizes, whether he/she signs as agent or as patient, direct payment to The Clinic of any insurance or other applicable (e.g., Medicare, Commercial Insurance) benefits otherwise payable to or on behalf of the undersigned or patient for these outpatient services, at rate not to exceed The Clinic's regular charges. It is agreed that payment to The Clinic, pursuant to the authorization, by an insurance company shall discharge said insurance company of any and all obligations under a policy to the extent of such payment. The Clinic will make every effort to get pre-certification information in advance of the first visit, however this is dependent on whether accurate and complete insurance information has been disclosed to The Clinic prior to the initial visit. The undersigned authorizes payment of Medicare/Insurance benefits to be made on behalf of the patient for all services furnished by The Clinic. It is further understood by the undersigned that he/she is financially responsible for charges not collected by this agreement, unless otherwise stated by applicable written contract or law.

**5 PHOTOGRAPHING AND VIDEOTAPING:** The Clinic may photograph, film, videotape or otherwise make video and/or audio recordings of the patient only for purposes of diagnosing and treating the patient's condition. No photograph or videotape will be used for any other purpose other than treatment without the patient's written consent.

**6 COMMUNICATION:** The Clinic may contact you via telephone, email, text message, and/or social media to convey information related to your current treatment plan and appointments, as well as provide you with information regarding alternative treatment options and events that may be of interest to you.

**7 DISCLOSURE OF HEALTH INFORMATION:** I understand that The Clinic is a health provider who must comply with the Health Insurance Portability and Accountability Act of 1996. HIPAA protects the privacy of individually identifiable health information. The Clinic Notice of Privacy Practice outlines your rights and our responsibilities regarding your medical information and who to contact if you have any concerns regarding your medical information. Your initials below acknowledge that you have been given a copy of The Clinic Notice of Privacy Practices.

**Patient's Initials:** _____ **Date:** _____

**8 CANCELLATION AND NO-SHOW POLICY:** With the exception of serious emergencies, it is expected that you keep all your appointments. If you need to re-schedule an appointment, we require 24 hours' notice. In such a case, please call our office and arrange for a make-up appointment with our receptionist. The make-up appointment needs to be in the same week, preferably the very next day.

**In instances of repeated cancellations without 24 hours' notice or no-show to a scheduled appointment, we reserve the right to charge you a fee as allowed by insurance contracts.**

The undersigned certifies that he/she has read the foregoing and is the patient, the patient's legal representative, or is duly authorized by the patient as the patient's general agent to execute this document and accept and agree to its terms.

_____

**Patient/Guardian Signature** **Date** **Print Patient Full Name**

## FINANCIAL POLICY FOR PROFESSIONAL PHYSICAL THERAPY & SPORTS MEDICINE

The information below explains the financial policies of our clinic:

- We check your insurance coverage and benefits for therapy for each episode of care. The payers do not guarantee coverage when we check benefits and authorize therapy visits; therefore, it is the patient's responsibility to verify coverage and understand their insurance policy.

- Therapy services are billed on time-based procedure codes. Your therapist will provide care specific to your needs and will choose the appropriate charge code based on the procedures performed. Charges can vary per visit based on the activities performed. Your therapist will be happy to explain the procedures billed if you have any questions.

- At the time of your first visit, provided accurate and complete insurance information has been disclosed in advance, we will provide you with an **ESTIMATE** of the amount of money that you will need to pay per visit based on the information we have received from your insurance. This estimate **does not** guarantee payment by your insurance.

- The amount not covered by insurance will be **ESTIMATED** and explained to you on your first visit. This amount is payable on the date that services are rendered when you check in.

- When you have not met your deductible, we will request an **ESTIMATED PAYMENT** from you that is applied towards your deductible. **You will receive a bill** for the remainder of the insurance allowable once the claim has been filed.

- Insurance companies have their own schedule of what they consider to be "usual and customary." These fees often vary between plans. Our charges are based on the time and the type of procedures used by your therapist for each session. If we are in network with your insurance, you will be responsible for the amount "allowed" by your insurance for each procedure based on your insurance contract. It is impossible for us to know the details of each individual policy.

- Your insurance is an agreement between you, your employer, and the insurance carrier. **We encourage you to contact your insurance company to better understand your benefit for therapy services.**

- If you have had a recent procedure that should apply to your deductible, it may not have been billed by the hospital or physician's office yet and therefore may not be listed when we checked your benefits. **Please contact your insurance if you feel that your deductible information is incorrect.**

- If you have a co-insurance percentage that you are expected to pay, we will collect an **estimated** amount on that coinsurance, and **you will receive a bill** for the difference between what you paid and what the insurance company allows after we file your claim. Co-payments (flat amounts per visit) will be collected at each date of service.

- In instances of repeated cancellations without 24 hours-notice or no-show to a scheduled appointment, we reserve the right to charge you a fee as allowed by insurance contracts in the amount posted in our clinic.

- In instances of repeated non-compliance with your scheduled visits, we also reserve the right to discontinue care and will inform your physician of the fact that your service has been discontinued due to non-compliance with the prescribed rehabilitation program.

**Patient/Guardian Signature** **Date** **Print Patient Full Name**

## Your Information. Your Rights. Our Responsibilities.

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.

### Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

### Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Market our services and sell your information

### Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

### Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

### Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

**Ask us to correct your medical record**

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

**Request confidential communications**

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

**Ask us to limit what we use or share**

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

**Get a list of those with whom we've shared information**

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

**Get a copy of this privacy notice**

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

**Choose someone to act for you**

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

**File a complaint if you feel your rights are violated**

- You can complain if you feel we have violated your rights by contacting us using the information on the last page of this notice.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

**Your Choices**

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation

*If you are not able to tell us your preference, for example if you are aphasic, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*

In these cases, we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

**Our Uses and Disclosures**

**How do we typically use or share your health information?**

We typically use or share your health information in the following ways.

**Treat you**

We can use your health information and share it with other professionals who are treating you.

*Example: A doctor treating you for an injury asks the therapist about your range of motion progress following surgery.*

**Run our organization**

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

*Example: We use health information about you to manage your treatment and services.*

**Bill for your services**

We can use and share your health information to bill and get payment from health plans or other entities.

*Example: We give information about you to your health insurance plan so it will pay for your services.*

**How else can we use or share your health information?**

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

**Help with public health and safety issues**

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

**Do research**

We can use or share your information for health research.

**Comply with the law**

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

**Respond to organ and tissue donation requests**

We can share health information about you with organ procurement organizations.

**Work with a medical examiner or funeral director**

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

**Address workers' compensation, law enforcement, and other government requests**

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

**Respond to lawsuits and legal actions**

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.

Other Instructions for Notice

- This notice is effective September 1, 2022
- For questions or concerns regarding your privacy, please contact our Privacy Officer:
  Name: Sam Echols, PT, OCS
  Address: 6 N. 2nd Street, Suite 202, Fernandina Beach, FL 32034
  Email: sechols@therapypartnersolutions.com

# PROTECTED HEALTH INFORMATION RELEASE

Full name:_____ Date of Birth: _____ SS#:_____

This will authorize:_____ Fax#:( _____ ) _____

To disclose my protected health information, as described below to:

Low Country Physical Therapy (Murrells Inlet)
2586 S Highway 17 Unit C
Murrells Inlet, SC 29576
Tel: (843) 651-6565 Fax: (843) 651-6575

Low Country Physical Therapy (Pawleys Island)
267 Willbrook Blvd. Suite D
Pawleys Island, SC 29585
Tel: (843) 314-3980 Fax: (843) 314-3979

☐ Specific Information Only (list) _____

_____

_____

Dates of care included: From _____ to _____

I understand that I may inspect or copy the protected health information described by this authorization. I understand that this authorization may be revoked in writing by me and delivered to the Privacy Contact of your organization at any time, although revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may be subject to federal or state law protecting its confidentiality.

Date: _____

Patient Signature or Authorized Representative:_____

Relationship to Patient:_____

**EXPIRATION DATE:** This authorization will expire on (date or event)_____/_____/_____ (If no date or event is stated, expiration is six (6) months from the date signed).