* = Required

Request Date *	
Service Requested	☐ *CAP Children* ☐ *CAP Adults* ☐ *Private Duty Nurse* ☐ *PACE*

Beneficiary Demographics	
Beneficiary's First Name	
Last Name	
Beneficiary has Medicaid? *	☐ *Yes* ☐ *Pending* ☐ *Not Applied* ☐ *No*
Medicaid MID	
Social Security Number *	
Medicare ID	
Date of Birth *	
Age	
Gender *	☐ *Male* ☐ *Female*
Marital Status *	☐ *Married* ☐ *Never Married* ☐ *Partner or Significant Other* ☐ *Separated* ☐ *Divorced* ☐ *Widowed*
County *	
Primary language	☐ *English* ☐ *Spanish* ☐ *Other*

Beneficiary Address	
Address 1	
Address 2	
City	
State	
Zip	
Phone	
Receiving Protective Services? *	☐ *Yes* ☐ *No*

Legal Guardian Details	
Legal guardian in place? *	☐ *Yes* ☐ *No*
Guardian Last Name	
First Name	
Phone	
Address 1	
Address 2	
City	
State	
Zip	

Private Insurance Details	
Private Insurance? *	☐ *Yes* ☐ *No*
If private insurance in place, does private insurance cover in-home aide or nursing services?	☐ *Yes* ☐ *No*
If in-home aide or nursing coverage, enter coverage amount	
Insurer's Name	
Policy ID #	
Phone	

Other Services Beneficiary Is Receiving	
Home Health	☐
PCS	☐
Hospice	☐
CAP/C or CAP/DA	☐
Independent Living Services	☐
Block grant services	☐
Is beneficiary receiving another Medicaid program about to end? *	☐ *Yes* ☐ *No*
Specify	☐
Beneficiary has been informed regarding their choice of providers.	☐ *Yes* ☐ *No*
Specify Agency *	
Is beneficiary interested in the CAP Choice Option?	☐ *Yes* ☐ *No*
Beneficiary (legal guardian) has agreed to this request? *	☐ *Yes* ☐ *No*
Is beneficiary currently in an institution (hospital or nursing facility)?	☐ *Yes* ☐ *No*

Beneficiary Conditions and Related Support Needs

Diagnosis Information			
Diagnosis	ICD Code	ICD Version (9 or 10)	Primary Dx?
		☐ *9* ☐ *10*	☐ *Yes* ☐ *No*
		☐ *9* ☐ *10*	☐ *Yes* ☐ *No*
		☐ *9* ☐ *10*	☐ *Yes* ☐ *No*
		☐ *9* ☐ *10*	☐ *Yes* ☐ *No*
		☐ *9* ☐ *10*	☐ *Yes* ☐ *No*
		☐ *9* ☐ *10*	☐ *Yes* ☐ *No*
		☐ *9* ☐ *10*	☐ *Yes* ☐ *No*
		☐ *9* ☐ *10*	☐ *Yes* ☐ *No*
		☐ *9* ☐ *10*	☐ *Yes* ☐ *No*
		☐ *9* ☐ *10*	☐ *Yes* ☐ *No*

Is there an active AIDS diagnosis? *	☐ *Yes* ☐ *No*
If AIDS dx present, current CD4 (T) count?	☐ *200 or less* ☐ *201-349* ☐ *350-499* ☐ *500 or greater*
Is there a MH diagnosis?	☐ *Yes* ☐ *No*
Is there a IDD diagnosis?	☐ *Yes* ☐ *No*
Medically Stable? *	☐ *Yes* ☐ *No*
Prognosis	

Hospitalizations (Include current stay if applicable)	
Total number of hospital stays in the last year? *	
# of hospital readmissions in the last year (for the same admitting diagnosis)? *	
# of unplanned hospitalizations in the last year (regardless of diagnosis)? *	
If hospitalized, did any hospitalization result in a length of stay greater than 10 days?	☐ *Yes* ☐ *No*

Medications			
Medication Name	Strength	PRN	If PRN, freq > every 4 hrs?
		☐ *Yes* ☐ *No*	☐ *Yes* ☐ *No*
		☐ *Yes* ☐ *No*	☐ *Yes* ☐ *No*
		☐ *Yes* ☐ *No*	☐ *Yes* ☐ *No*
		☐ *Yes* ☐ *No*	☐ *Yes* ☐ *No*
		☐ *Yes* ☐ *No*	☐ *Yes* ☐ *No*
		☐ *Yes* ☐ *No*	☐ *Yes* ☐ *No*
		☐ *Yes* ☐ *No*	☐ *Yes* ☐ *No*
		☐ *Yes* ☐ *No*	☐ *Yes* ☐ *No*
		☐ *Yes* ☐ *No*	☐ *Yes* ☐ *No*

# of Prescription Meds	
# of Meds Requiring Nurse to Administer	
# of Psychiatric/Psychotropic Meds Used for MH Dx	
Requires RN Monitored injections and/or IVs	☐ *Yes* ☐ *No*
Considering all current medications, does beneficiary require medications assistance?	☐ *Yes* ☐ *No*

Sensory/Communication Limitations	
Speech ability/making self-understood (Rarely/never)	☐ *Yes* ☐ *No*
Hearing (Severe difficulty or none)	☐ *Yes* ☐ *No*
Vision (Severe difficulty or blind)	☐ *Yes* ☐ *No*

Orientation and Cognitive Status	
Is Beneficiary Oriented	
- To Time *	☐ *No* ☐ *Yes-Intermittently* ☐ *Yes-Continuously*
- To Person *	☐ *No* ☐ *Yes-Intermittently* ☐ *Yes-Continuously*
- To Place *	☐ *No* ☐ *Yes-Intermittently* ☐ *Yes-Continuously*
Beneficiary has Cognitive Skills for Daily Decision-making *	☐ *No* ☐ *Yes - Intermittently* ☐ *Yes - Continuously*

Mood			
Unrealistic fears	☐	Crying/tearfulness	☐
Sad, pained, worried facial expressions	☐	Negative statements	☐
Persistent anger	☐	Anxious non-health concerns	☐
Elevated mood, euphoric	☐	Expansive	☐
Unpleasant mood in morning	☐	Hallucinations	☐
Excessive irritability	☐		

Behavior			
Wandering	☐	Verbal expressions of distress	☐
Repetitive verbalizations	☐	Angry outbursts	☐
Repetitive physical movements	☐	Dangerous to self	☐
Self-deprecation	☐	Withdrawal from activities of interest	☐
Insomnia/disturbed sleep patterns	☐	Paranoid ideation	☐
Suicide attempt/ideation	☐		

Interpersonal Functioning			
Homicidal	☐	Combative/Hx of Altercations	☐
Dangerous to others	☐	Physically abusive	☐
Verbally abusive	☐	Socially inappropriate behavior	☐
Evictions due to inapprop. behavior	☐	Resists care	☐
Fear of strangers	☐	Illogical comments	☐
Reduced social interaction/isolation	☐		

Cardio-Respiratory Support Needs					
Suctioning - tracheal	☐	*Frequency*	☐ *Every hour* ☐ *Every two hours* ☐ *Every four hours* ☐ *Every six hours*	☐ *Every eight hours* ☐ *Every 12 hours* ☐ *Every 24 hours* ☐ *Less than once a day*	☐ *3-6 times per week* ☐ *1-2 times per week* ☐ *Less than weekly* ☐ *PRN* ☐ *Other*

Suctioning - other	☐	*Frequency*	☐ *Every hour* ☐ *Every two hours* ☐ *Every four hours* ☐ *Every six hours*	☐ *Every eight hours* ☐ *Every 12 hours* ☐ *Every 24 hours* ☐ *Less than once a day*	☐ *3-6 times per week* ☐ *1-2 times per week* ☐ *Less than weekly* ☐ *PRN* ☐ *Other*
Ventilator dependent	☐	*Frequency*	☐ *Continuous* ☐ *Continuous during sleep* ☐ *Every hour* ☐ *Every two hours* ☐ *Every four hours*	☐ *Every six hours* ☐ *Every eight hours* ☐ *Every 12 hours* ☐ *Every 24 hours* ☐ *Less than once a day*	☐ *During Sleep* ☐ *Being weaned* ☐ *PRN* ☐ *Other*
		Stable?	☐ *Yes* ☐ *No*		
Vent Type	☐ *Negative pressure* ☐ *Pressure-cycled* ☐ *Volume-cycled*		☐ *Combination pressure and volume cycled* ☐ *Flow-cycled* ☐ *Time-cycled*		
Infection free?	☐ *Yes* ☐ *No*				
Pulse oximetry	☐	*Frequency*	☐ *Continuous* ☐ *Continuous during sleep* ☐ *Every hour* ☐ *Every two hours* ☐ *Every four hours*	☐ *Every six hours* ☐ *Every eight hours* ☐ *Every 12 hours* ☐ *Every 24 hours* ☐ *Less than once a day*	☐ *During Sleep* ☐ *Being weaned* ☐ *PRN* ☐ *Other*
Non-vent tracheostomy	☐	*Problems with weaning?*		☐ *Yes* ☐ *No*	
Nebulizer care	☐	*At least 2 schedule/day & 1 PRN/day?*		☐ *Yes* ☐ *No*	

Cardiac monitoring	☐		
Chest physiotherapy/use of chest PT vest	☐		
Use of cough assist device	☐		
Apnea monitoring	☐		
CPAP/BiPAP	☐	*Help getting device on?*	☐ *Yes* ☐ *No*
Oxygen therapy	☐	*Requires rate adjustments?*	☐ *Yes* ☐ *No*
Respiratory assessment	☐	*Multiple times/day?*	☐ *Yes* ☐ *No*

Nutrition-Related Support Needs

Enteral Feeding/Tube Feeding	☐	*Frequency*	☐ *Every hour* ☐ *Every two hours* ☐ *Every four hours* ☐ *Every six hours*	☐ *Every eight hours* ☐ *Every 12 hours* ☐ *Every 24 hours* ☐ *Less than once a day*	☐ *3-6 times per week* ☐ *1-2 times per week* ☐ *Less than weekly* ☐ *PRN* ☐ *Other*
% of daily nutrition/fluids	*%*	*Feeding Tube Type*	☐ *DT (duodenal)* ☐ *GJ tube (gastrostomy-jejunostomy)* ☐ *GT (gastrotomy)* ☐ *JT (jejunostomy)*	☐ *Low profile GT* ☐ *NG (nasogastric)* ☐ *0G (orogastric)* ☐ *Other*	

Parenteral Nutrition (TPN)	☐				
Soft/Mechanical Soft	☐				
Thickened Diet	☐				
Pureed Diet	☐				
Supplemental formula diet physician prescribed	☐				
Diabetes management (daily)	☐	*Insulin use*	☐ *Yes* ☐ *No*	*Sliding Scale*	☐ *Yes* ☐ *No*
Weight management	☐				
Fluid mgmt/force fluids	☐				
Input/output monitoring	☐				
Other nutrition treatment/Diet?	☐				

Other, Desc	

Ancillary Therapies Being Received				
Physical Therapy	☐	*Frequency*	☐ *More than once a week* ☐ *Weekly* ☐ *Every two weeks*	☐ *Monthly* ☐ *Less than monthly*
Physical Therapy Details				
Occupational Therapy	☐	*Frequency*	☐ *More than once a week* ☐ *Weekly* ☐ *Every two weeks*	☐ *Monthly* ☐ *Less than monthly*
Occupational Therapy Details				
Speech Therapy	☐	*Frequency*	☐ *More than once a week* ☐ *Weekly* ☐ *Every two weeks*	☐ *Monthly* ☐ *Less than monthly*
Speech Therapy Details				
Other	☐	*Other, Desc*		
Other Therapy Details				

Other Support Needs					
Continence Management	☐	*If checked, is Continence Management for:*		☐ *Bowel* ☐ *Bladder*	
Indwelling Catheter	☐ *Yes* ☐ *No*				
Colostomy Bag	☐				
Seizure management	☐				
	☐				
Dialysis	☐	*Dialysis Type*	☐ *Hemodialysis* ☐ *Peritoneal* ☐ *Hemofiltration* ☐ *Hemodiafiltration* ☐ *Intestinal dialysis*	*Dialysis Frequency*	☐ *Once a week* ☐ *Twice per week* ☐ *Three times per week* ☐ *Four times per week* ☐ *Five times per week* ☐ *More than five times per week*
Wound Care	☐	*Open Wound?*	☐ *Yes* ☐ *No*	*Sterile Dressing*	☐ *Yes* ☐ *No*
Ulcer Care	☐	*Ulcer Staging*	☐ *Normal* ☐ *Category/Stage One* ☐ *Category/Stage Two* ☐ *Category/Stage Three* ☐ *Category/Stage Four* ☐ *Unstageable* ☐ *Suspected Deep Tissue Injury*		
Isolation - infection/disease	☐				

Functional Limitations		
ADL Limitations		
Bathing - Does beneficiary need hands-on assistance?	☐ *Yes*	☐ *No*
Personal Hygiene - Does beneficiary need hands-on assistance?	☐ *Yes*	☐ *No*
Dressing - Does beneficiary need hands-on assistance?	☐ *Yes*	☐ *No*
Bed Mobility - Does beneficiary need hands-on assistance?	☐ *Yes*	☐ *No*
Mobility - Does beneficiary need hands-on assistance?	☐ *Yes*	☐ *No*
Transfer - Does beneficiary need hands-on assistance?	☐ *Yes*	☐ *No*
Toileting/Elimination - Does beneficiary need hands-on assistance?	☐ *Yes*	☐ *No*
Eating - Does beneficiary need hands-on assistance?	☐ *Yes*	☐ *No*
Other Functional Limitations		
Can the beneficiary ambulate without person assistance?	☐ *Yes*	☐ *No*
Is the beneficiary confined to a wheelchair or bedbound?	☐ *Yes*	☐ *No*
Contractures	☐	
Paralyzed	☐	
Fall risk	☐	
Additional Comments about Treatment Needs		
Additional Comments		

Informal Caregiver Availability

Caregiver Entry	
Last Name *	
First Name *	
Lives with Beneficiary?	☐ *Yes* ☐ *No*
Has Power of Attorney?	☐ *Yes* ☐ *No*
Relationship to Beneficiary	☐ *Mother* ☐ *Father* ☐ *Sister* ☐ *Brother* ☐ *Grandmother* ☐ *Grandfather* ☐ *Spouse* ☐ *Other relative* ☐ *Friend* ☐ *Professional* ☐ *Other*
Other, Desc	
Hrs/Day Available?	
Trained as Caregiver?	☐ *Yes* ☐ *No*
Contact Phone	☐

Caregiver Entry	
Last Name *	
First Name *	
Lives with Beneficiary?	☐ *Yes* ☐ *No*
Has Power of Attorney?	☐ *Yes* ☐ *No*
Relationship to Beneficiary	☐ *Mother* ☐ *Father* ☐ *Sister* ☐ *Brother* ☐ *Grandmother* ☐ *Grandfather* ☐ *Spouse* ☐ *Other relative* ☐ *Friend* ☐ *Professional* ☐ *Other*
Other, Desc	
Hrs/Day Available?	
Trained as Caregiver?	☐ *Yes* ☐ *No*
Contact Phone	☐

Will 24-hour caregiver availability be required to ensure beneficiary safety? *	☐ *Yes* ☐ *No*

Beneficiary Consent	
The beneficiary has consented to sharing the information documented in this Service Request Form with any agency or organization responsible for enrolling or assisting the beneficiary once enrolled in the requested service or program(s). *	☐ *Yes* ☐ *No*

Submitting Agency Identification and Beneficiary Primary Care Physician	
Submitter Name	
CAP Case Management Agency	
Submitting Agency Name (If not a CAP Agency)	
Address	
City	
State	
Zip	
Phone	
Fax	

Referring Physician Details	
Beneficiary's Referring Physician *	
Physician NPI *	
Physician Location Code	
Physician Telephone	
Comments	

NC DMA Long-Term Services and Supports authorization of Level of Care
Service Request for Home and Community-Based Services Physician Attestation

This form is to verify that the assessment of medical, functional, psychosocial and behavioral health needs identified in the Service Request Form (SRF) for the listed individual are consistent with nursing facility level of care criteria. Based on this verification, this individual is considered medically stable to participate in a home and community based program.

Beneficiary Information:

Name: _____
MID #: _____
Primary Diagnoses (list attached): __ Yes __No
Medication list attached: __ Yes __No
Physician's Name: _____
Physician's Address:_____

_____ _____
Physician Signature Date Attestation

Return this form to: _____
Contact Information**:** _____

For CSC/NCTracks Use Only:

Prior Approval Level of Care (LOC) Determination for A31 Community Alternatives Program (CAP) Children (CAP/C) or Disabled Adults (CAP/DA or CAP/Choice)

The Community Alternatives Program is a Medicaid Home and Community–Based Services (HCBS) Waiver authorized under § 1915(c) of the Social Security Act, found in 42 CFR440.180. Federal regulations for HCBS waivers may be found in 42 CFR Part 441 Subpart G. The CAP program waives certain NC Medicaid requirements to furnish an array of home and community based services to **children and adults with medical and physical disabilities** who are at risk of institutionalization. The services are designed to provide an alternative to institutionalization for beneficiaries in this target population who prefer to remain in their primary private residences, and would be at risk of institutionalization without these services.

New Hanover Regional Medical Center

Name: _____ _____ _____
(Last Name) (First Name) (Middle Initial)

DOB: _____ MRN#: _____

HAR#: _____ CSN#: _____

PATIENT ACKNOWLEDGMENT & INFORMATION LISTING INSTRUCTIONS (INPATIENT)

(Inpatients, Surgical/Pre-Admission Testing, OPSU, ED/ER)

PATIENT ACKNOWLEDGMENT OF RECEIPT OF NOTICE

1. I acknowledge that I have received or have been offered a copy of NHRMC's Joint Notice of Privacy Practices. _____ (Initial)

2. I acknowledge my right and have been offered the option to request to receive communications of my personal health information by alternative means or at alternative locations. I understand that NHRMC may refuse to accommodate my request if it is not reasonable. _____ (Initial)

PATIENT INFORMATION LISTING INSTRUCTIONS

I do ☐ / do not ☐ want my name, location, general condition, and religious affiliation released as part of NHRMC's patient information listing. I understand that if I do not consent to the disclosure, information on my behalf will not be released to visitors such as family and friends, outside phone callers, florists, and members of the clergy, etc. Visitors and phone calls are allowed, but I will be responsible for providing the information.

OPTIONAL FAMILY/FRIEND LIST FOR TELEPHONE DISCLOSURES OF DETAILED CONDITION INFORMATION DURING THIS HOSPITALIZATION

	Name	Relationship
1.		
2.		
3.		

I understand that the individuals identified above must provide the following code word to NHRMC before information will be provided, and that I am responsible for notifying them of this code word: _____ .
(code word)

Patient Name (printed) _____ Representative Name (printed) _____

Relationship to Representative/ Authority to act on behalf of the Patient _____ Reason patient could not sign for him/herself _____

Signature of Patient or Representative _____ Date _____ Time _____

Witness Name (printed) _____ Date _____ Time _____

FOR NHRMC Staff USE ONLY

If acknowledgment of receipt of the Notice of Privacy Practices is not obtained from the patient or the patient's representative, please explain your efforts to obtain their acknowledgment and the reason you could not obtain it:

_____

_____

THIS FORM PART OF PERMANENT MEDICAL RECORD

New Hanover Regional Medical Center

Name: _____ _____ _____
(Last Name) (First Name) (Middle Initial)

DOB: _____ MRN#: _____

HAR#: _____ CSN#: _____

TERMS OF ADMISSION TO OR REGISTRATION AT NEW HANOVER REGIONAL MEDICAL CENTER

CONSENT FOR TREATMENT: The patient is under the control of the attending physician. The undersigned consents to any medical treatments or procedures (except for invasive procedures which require special consent), X-ray, examination, diagnostic and laboratory procedures, medications, injections, taking of photographs or video for clinical, educational, telemedicine, virtual monitoring/surveillance for patient safety or identification purposes, and hospital services rendered to the patient under the general and special instructions of the attending physician(s) or other providers assisting in the care of the patient. The undersigned also consents to the admission of the patient to New Hanover Regional Medical Center ("Medical Center") if this is deemed necessary for the care of the patient. All of the terms and conditions of this agreement shall also apply to such admission. The undersigned is aware that the practice of medicine and surgery is not an exact science and acknowledges that no guarantee or assurance has been made or implied to the patient as to the result that may be obtained from examination or treatment. The undersigned has been informed of his/her patient rights and responsibilities.

RELEASE OF INFORMATION: The undersigned hereby authorizes the Medical Center to disclose the patient's medical record or other medical information to any person or corporation which is or may be liable for all or part of the Medical Center's charges or to any person or corporation who has the responsibility for reviewing such charges, including but not limited to medical service organizations, health maintenance organizations, insurance companies, employers, welfare funds, or peer review organizations. The undersigned agrees the Medical Center may copy medical record(s) which is/are to be sent to a receiving facility in the event the undersigned must be transferred or to determine eligibility for transfer to another care provider/facility. The undersigned acknowledges and consents that the medical records, laboratory results, radiology reports and billing information may be sent or disclosed to another medical facility, physician office, or provider involved in the care of the patient or responsible for any part of the patient's charges.

I consent to the Medical Center and any of the above providers, including their business associates, contacting me on my cellular device and to them using automatic telephone dialing and artificial/pre-recorded message. I understand I can opt out of this cellular consent provision and still receive services. Such opt out should be made in writing and effective from the time of receipt forward.

REQUEST FOR PAYMENT, ASSIGNMENT OF BENEFITS, AND RELEASE OF INFORMATION FOR MEDICARE/MEDICAID PATIENTS: The undersigned requests payment of authorized Medicaid/Medicare benefits, if any, for any services furnished to the patient by or in Medical Center and hereby assigns such benefits otherwise payable directly to the patient, to Medical Center. The undersigned authorizes Medical Center to submit a claim for such services to Medicare/Medicaid. The undersigned authorizes any holder of medical or other information about the patient to release to Medicare/Medicaid, or its agents, claims processors or utilization reviewers, any information needed to determine these benefits or benefits for related services.

ASSIGNMENT OF INDIVIDUAL BENEFITS: If the undersigned is entitled to medical benefits of any type whatsoever arising out of any policy of insurance insuring patient or any other party liable to patient, the undersigned authorizes Medical Center to submit a claim for such services, and benefits are hereby assigned to the Medical Center for application on the patient(s) bill. It is agreed that Medical Center may receive any such payment and such payment shall discharge the paying insurance company of any and all obligations under the policy to the extent of such payment. The undersigned and/or patient are responsible for charges not covered by the insurance. The undersigned certifies that the patient information contained on this form that is given by or on behalf of the patient in applying for payment from all third party payors is correct.

FINANCIAL AGREEMENT: The undersigned understands and agrees that the patient and guarantor are financially responsible to New Hanover Regional Medical Center for charges for medically necessary services or services requested by or on behalf of the patient if such services are not covered by the patient's hospitalization plan, insurance, or Medicaid/Medicare. A Financial Assistance application is available to any patient or responsible party anticipating difficulty financing all or part of the patient's Medical Center bill. The undersigned certifies that he/she has read the foregoing and is the patient or guarantor of this bill, or is duly authorized by the patient as patient's general agent to execute this document and accept its terms. I hereby acknowledge NHRMC may check my credit history in accordance with the Fair Credit Reporting Act, 15 USC 1681b(a)(3)(A). A review of my credit history is required to be considered for any Financial Assistance Programs. In the event my account(s) is not satisfied in full, my account may be reported to the credit bureaus. The undersigned hereby agrees that upon discharge of the patient by Medical Center, the undersigned will be responsible for the patient and will make necessary arrangements to have the patient transferred from the Medical Center.

PERSONAL VALUABLES: The Medical Center has a safe for money, valuables and other personal property. **The undersigned has been offered an opportunity to place patient valuables in the safe for safekeeping. The Medical Center, its employees, agents, contractors, students and staff are not liable for the loss or damage to any money, valuables, and other personal property not deposited in the safe.**

SELF-ADMINISTERED DRUGS: If you are in an outpatient status, Medicare will not cover drugs that are considered to be self-administered. The undersigned agrees to pay for such drugs supplied by the Medical Center.

PHYSICIANS AS INDEPENDENT CONTRACTORS:

I understand, acknowledge and agree that, the physicians who provide care or other services at New Hanover Regional Medical Center are independent practitioners and are not agents, servants or employees of the hospital; (2) the physicians exercise their own medical judgment in treating me or otherwise providing professional services to me and (3) in addition to receiving the hospital bill, in most cases these independent practitioners (such as my primary care physician, anesthesiologist, pathologist, radiologist, emergency medicine physician) will send me a separate bill for their services rendered.

I HAVE READ, OR I HAVE HAD EACH OF THE SECTIONS READ TO ME, AND ALL OF MY QUESTIONS HAVE BEEN ANSWERED. I understand I may request a copy of these terms, and I acknowledge that I am the patient or I am authorized to act on behalf of the patient to sign this sealed document verifying consent to the above stated terms.

Patient Name (printed) _____ Representative Name (printed) _____

Relationship to Representative/ Authority to act on behalf of the Patient _____ Reason patient could not sign for him/herself _____

Signature of Patient or Representative _____ Date _____ Time _____

Witness Name (printed) _____ Date _____ Time _____

THIS FORM IS PART OF THE PERMANENT MEDICAL RECORD