Basic Biographic Information:

Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Apt. # City State Zip Code

Phone Numbers: Home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status (Circle One): Single, Married, Separated, Divorced, Widowed, Living Together

Employer/ School:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Physician:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When was your last physical exam?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about us? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider you are here to see:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of pharmacy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family Medical Problems:

Children [Name(s) and Age(s)]: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Father [Name, Age, Problem Areas]: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mother [Name, Age, Problem Areas]: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Siblings [Name, Age, Problem Areas]: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

History of Mental Illness in the family of origin: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What kind of medications have you tried in the past: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Circle any of the following that is a problem for you now:

Alcohol Drugs Hallucinations

Anger Finances Marital/ Romantic Relationships

Anxiety/ Nervousness Friends Relatives

Children Sex Work

Confused Stress Weight

Depressed Suicidal Thoughts

Reason(s) for seeking treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had any kind of treatment before? (Circle One) Yes or No

If “yes,” when and with whom? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

And for what problem(s)?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you taking any psychiatric medications now? (Circle One) Yes or No

List all medications you take regularly now:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever attempted to kill or injure yourself? (Circle One) Yes or No

What else do you think your provider should know about? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Informed Consent for Treatment

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ have chosen to seek mental health services with Refresh Psychiatry, understand these services may include but are not limited to counseling, medication management and related services. I understand, that these services may offer the opportunity to resolve issues and improve functioning. However, I also understand that there can be no guarantee of specific outcome of treatment. My provider has discussed my treatment options with me. I have been apprised of the potential benefits and risks inherent in such treatment. I understand that as treatment progresses my therapist will discuss with me any change in my treatment plan that would necessitate an additional informed consent to treatment.

Treatment involves a cooperative relationship between provider and client. As such, I understand that a time will be reserved in advance for my sessions. I will keep these appointments or give at least 24-hour notice. Otherwise I may be charged for the missed time. I further understand that I remain responsible for any fees incurred for my treatment. I understand that I agree to relinquish medical information about me to my insurance company for purposes of processing claims. This may include diagnosis, dates and times of treatment and treatment summaries (when requested). Ultimately, I remain responsible for any deductibles, co-pays or remaining balances.

I understand that my sessions are confidential. However that confidentiality has exceptions which may include but are not limited to the following: a) I choose to release information by a signed waiver (in couples counseling both parties must sign the waiver for disclosure of information) b) where a judge makes a court order c) I raise my mental status or competency in a court proceeding d) if there is a reason to believe there is a clear and immediate probability I may injure myself or others – therapist maintains a right to inform intended victim of the threat e) if there is evidence or strong suspicion of child, disabled or elder abuse or neglect.

I understand that I may terminate treatment at any time. It is advised that I discuss these considerations with my therapist so that any unresolved issues could be addressed. I understand that this is a recommendation only and that I am free to decide how to end my sessions. I understand that I am free to discuss with my therapist any relevant referral options for additional or adjunct treatment.

I have read and discussed the above information with my therapist and I freely consent to treatment.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_

Patient Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_

Guardian Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_

Witness Signature Date

Signature on File and Assignment of Benefits Agreement

Kindly accept a photocopy of this authorization as if it were an original executed authorization. I understand that Refresh Psychiatry may utilize computerizing billing; therefore, my signature below acts as a signature on file. I authorize the release of any payment and medical information necessary to process me or my family member’s claim and related claims.

SIGN \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby authorize payment directly to Refresh Psychiatry of the insurance benefits otherwise payable to me for their professional services. I understand that I am financially responsible to Refresh Psychiatry for all chances covered by this agreement.

SIGN \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**24 Hour Cancellation Policy/ No Show Fee**

To Our Valued Patients:

A broken appointment is a loss for everyone. The patient deprives himself/ herself of necessary clinical services. The Doctor / Therapist loses valuable time that should be spent treating patients. Accordingly, the following policy has been put in place to protect the patients and providers at Refresh Psychiatry.

For any appointment scheduled at Refresh Psychiatry, there is a cancellation/No Show policy. 24 hours before your appointment, a confirmation call or text will be made. Any appointment canceled or rescheduled after the confirmation is made, will result in the patient being charged the full rate. As such, your credit card information will be kept in our confidential files and in case of a late cancellation or no show.

By signing this form, I acknowledge and agree to all fees associated with any cancellation of less than 24 hours in advance no show fee. I also understand and agree that the cancellation/ no show fee must be paid in full prior to any subsequent appointments at Refresh Psychiatry.

Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Credit Card on File**

Name on the card: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Credit Card #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Expiration Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Security Code on Back: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

A Word About Insurance

We are pleased to participate in your medical plan. In addition to providing you with quality medical care, it will be our responsibility to file insurance claims on your behalf.

Your assistance will also be needed. While your insurance will cover most of the cost of your medical care there are some expenses which will become your responsibility. These expenses may include any of the following combination of the following:

1. Co-Payment (this charge mist be paid at the time of visit).
2. Your deductible (If your plan provides that you meet a deductible), you will see this applied as a charge marked, “patient responsibility.” This amount will not appear until we have been notified by your insurance carrier either by phone or in writing. You will be required to make the payment due at time of notification (which can be the same day as your appointment or afterwards).
3. Uncovered benefits are also our responsibility. Some plans do not include well child care, immunizations, medications, therapy sessions and some other procedures. These uncovered expenses will also be patient responsibility.
4. Co-Insurance coverage is also a potential expense not covered by your health insurance plan. Any plan that has a co-insurance associated with it will be the responsibility of the patient.

My signature below indicates that I have read the information above and agree to accept any financial responsibility as outlined above:

Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Consent To Release Confidential Information**

Authorization to Obtain and Release Information

**Patient Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This will authorize **Refresh Psychiatry** to disclose and/or to obtain form:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Doctor or Organization, address and phone number

The following information:

**Description of Information to be Disclosed:**

(Patient should initial each item to be disclosed)

Presence in Treatment: \_\_\_\_\_\_\_ Psychiatric Evaluation: \_\_\_\_\_\_\_

Entire Contents of Chart: \_\_\_\_\_\_\_ Labs Reports / Drug Screen: \_\_\_\_\_\_\_

Discharge / Transfer Summary: \_\_\_\_\_\_\_ Treatment Plan: \_\_\_\_\_\_\_

Medical Information: \_\_\_\_\_\_\_ Diagnosis: \_\_\_\_\_\_\_

Medication History Log: \_\_\_\_\_\_\_ Other: \_\_\_\_\_\_\_

Progress Notes: \_\_\_\_\_\_\_

**Purpose:**

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services.

If other purposes, please specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Right to Revocation:**

I understand that I have a right to revoke this authorization, in writing, at any time by sending a written notification.

**Expiration:**

This information release is for a specific instance, valid for 90 days and will expire on the following date:\_\_\_\_\_\_\_\_. Unless sooner revoked, this consent is valid for one year due to the need for ongoing communication for the coordination of treatment and will expire on the following date:\_\_\_\_\_\_\_\_\_\_\_.

**Conditions:**

I understand that **Refresh Psychiatry** will not condition my treatment on whether I give authorization for the requested disclosure. The consequence of refusing to sign this authorization have been explained to me.

**Form of Disclosure:**

Unless you have requested in writing that disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner we dem to be appropriate and consistent with applicable law, included by not limited to verbally, in paper format or electronically.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Parent / Guardian Date

**Telepsychiatry Consent Form**

Telepsychiatry provides psychiatric services using interactive video conferencing tools, such as Skype, Zoom, Whatsapp, FaceTime, Doxy, in which the psychiatrist and the patient are not at the same location. Telepsychiatry will allow the patient to receive medical care without the need to visit the office. Potential risks include, but may not be limited to: information transmitted may not be sufficient (poor resolution of video); delays in medical evaluation and treatment due to deficiencies or failures of the equipment; security protocols can fail, causing a breach of privacy; and a lack of access to all the information available in a face to face visit may result in errors in medical judgment. Alternative to telepsychiatry include traditional face to face sessions.

**Your Rights:** 1) I understand that the laws that protect the privacy and confidentiality of medical information also apply to telepsychiatry; 2) I understand that the aforementioned video-conferencing programs are known to incorporate network and software security protocols to protect the confidentiality of information and audio/visual data. These protocols include measures to safeguard the data and to aid in protecting against intentional or unintentional corruption. 3) I have the right to withdraw my consent to the use of telepsychiatry during the course of my care at any time. 4) I understand that Refresh Psychiatry has the right to withhold or withdraw consent for the use of telepsychiatry during the course of my care at any time; 5) I understand that all rules and regulations which apply to the practice of medicine in the State of Florida also apply to telepsychiatry.

**Your Responsibilities:** 1) I will not record any telepsychiatry sessions without the prior written consent of the psychiatrists Refresh psychiatry from here in referred to as psychiatrist, and I understand that the psychiatrist will not record telepsychiatry sessions without my consent; 2) I will inform the psychiatrist if any other person can hear or see any part of our session before the session begins. Likewise, the psychiatrist will inform me if any other person can hear or see any part of the session before the session begins. 3) I understand that I MUST be a resident of Florida to be eligible for telepsychiatry services from the psychiatrists at Refresh Psychiatry. 4) I understand that my Initial Consultation will not be done by telepsychiatry except in special circumstances under which I will be required to verify my identity to the psychiatrist’s satisfaction before the evaluation.

Your signature below indicates that you have read and understand the information provided above regarding telepsychiatry, and that you authorize the psychiatrist to use telepsychiatry in the course of diagnosis and treatment.

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient or Parent/Legal Guardian Signature Date

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient’s name Relationship to patient