KU WICHITA GASTROENTEROLOGY
The University of Kansas

PATIENT INFORMATION FORM

NAME_____ DOB_____ TODAY'S DATE_____

Primary Care Physician_____ Referring Provider_____

Why are you here today? _____

LIST YOUR Medical Problems and Surgical History:

_____

_____

_____

Date of Previous Colonoscopy _____ Polyps removed Yes___ No ___ If yes, how many? _____

Date previous EGD (stomach scope) _____

Medications:_____

_____

Allergies:_____

_____

Family Health Problems:

Grandparents	
Father	
Mother	
Brother/Sister	
Son/Daughter	

Please list all family members and age at diagnosis of colon, endometrial, breast, ovarian, uterine, stomach, esophageal, pancreatic or liver Cancer:

_____

_____

_____

Please list all family members who have been diagnosed with Crohns, Ulcerative Colitis, Celiac disease, Hepatitis B and Hepatitis C:

_____

Circle One: Single Married Separated Divorced Widowed

Sexual Partner Preference: Male Female Both

Have you been sexually active within the last month: ___ No ___ Yes

Have you ever used any of the following: ___ Marijuana ___ Cocaine ___ Speed ___ Other IV Drugs

Alcoholic Beverages: ___ Amount ___ Drinks per Week ___ History? ___ How Much ___How Long

Cigarettes/Cigar/Pipe/Vape (E-Cigarettes): ___ Amount ___ Packs Per Day ___ Don't Smoke __Quit Date

Hepatitis Risk Factors (circle Yes or No):

History of tattoos?	YES	NO
History of Blood Transfusions?	YES	NO
Ever been in Prison?	YES	NO
Ever snorted cocaine?	YES	NO
Born between 1945-1965?	YES	NO
History of Hemodialysis?	YES	NO
Received clotting factors prior to 1987?	YES	NO
History of organ transplant prior to 1992?	YES	NO
Have you ever been screened for Hepatitis A, B or C?	YES	NO
Ever been in Military?	YES	NO
History of needle stick or blood exposure?	YES	NO
If you answered yes to any of the above questions, would you like to be screened for Hepatitis B and C?	YES	NO

Circle any of the following conditions that you have a history of:

Skin
Rash
Itching
Lumps

Endocrine
Excessive Sweating
Excessive thirst
Excessive Urination
Heat intolerance
Cold intolerance

Eyes
Blurred Vision
Diminished or Vision Loss
Painful or irritated eyes

Psychology
Depression
Anxiety
Sleep Disturbance
Eating disorder

Hematology
Easy bruising
Swollen glands
Fatigue
Anemia

General
Weight Loss
Weight gain
Loss of appetite
Fever
Weakness

Cardiology
Shortness of breath
Chest pain
Dizziness
Lower extremity swelling

Gastroenterology
Nausea
Vomiting
Heartburn
Trouble Swallowing
Abdominal pain
Diarrhea
Change in bowel habits
Constipation
Black stools
Blood in stools

Muscoskeletal
Joint pain
Stiffness
Leg cramps
Neck pain
Metal in body

KU SCHOOL OF MEDICINE WICHITA MEDICAL PRACTICE ASSOCIATION
The University of Kansas

ADULT PATIENT DEMOGRAPHIC FORM

PLEASE PRINT CLEARLY

PATIENT INFORMATION

Patient's Full Legal Name

Last:	First:	Middle Initial:

Preferred Name/Nickname:	Social Security Number:	Date of Birth:	Sex:
	- -	/ /	☐ Male ☐ Female

Race:
☐ African American/Black ☐ Asian ☐ White
☐ Middle Eastern or North African ☐ Native Hawaiian or Pacific Islander
☐ American Indian or Alaska Native ☐ Other _____

Ethnicity:
☐ Hispanic or Latino
☐ Not Hispanic or Latino

Marital Status:
☐ Single ☐ Married
☐ Divorced ☐ Widowed

Street Address / PO Box:	Lot / Apt #:	City:	State:	Zip Code:

Primary Phone #:	Cell/Mobile?	Secondary Phone #:	Cell/Mobile?
( )	☐ Yes ☐ No	( )	☐ Yes ☐ No

Email Address:	Preferred Language:

How were you referred to or how did you discover KU Wichita MPA Clinics?

Patient Guardian Full Name (If Applicable)	Relationship:	Phone #:	City & State:
		( )	

CURRENT HEALTHCARE PROVIDER INFORMATION

Primary Care Physician/Provider:	Referring Physician/Provider:

Preferred Hospital:	Preferred Pharmacy:

CURRENT EMPLOYMENT/STUDENT STATUS

Employer:	Employment Status:	Student Status:
	☐ FT ☐ PT ☐ Self ☐ Military ☐ Unemployed ☐ Retired ☐ Disabled	☐ FT ☐ PT ☐ Not a Student

Employer Address:	Employer Phone:	Name of School:
	( )	

BILLING/INSURANCE INFORMATION

Primary Health Insurance Company:	Policy Holder Full Name:	Policy Holder Date of Birth:

Secondary Health Insurance Company:	Policy Holder Full Name:	Policy Holder Date of Birth:

HIPAA CONTACTS - AUTHORIZED REPRESENTATIVES

By listing contacts below, you authorize our office to communicate with them regarding your health, treatment, and billing under HIPAA. ☐ No HIPAA Contacts

Name:	Relationship:	Phone #:
Name:	**Relationship:**	**Phone #:**

EMERGENCY CONTACTS

Someone we may contact in an emergency or if you're unreachable, but are not authorized to receive your medical information. ☐ No Emergency Contacts

Primary Emergency Contact Full Name:	Relationship:	Phone #:	City & State:

Signature of Patient, Responsible Party, or Authorized Legal Representative

Date

Printed Name of Patient, Responsible Party, or Authorized Legal Representative

Relationship to Patient

SCHOOL OF MEDICINE WICHITA
MEDICAL PRACTICE ASSOCIATION
The University of Kansas

NEW PATIENT OUTPATIENT CONSENT FORM
Consent for Treatment, Telehealth & AI Dictation

CONSENT FOR OUTPATIENT TREATMENT

I voluntarily consent to receive outpatient healthcare services at UKSM-W Medical Practice Association, including evaluation, diagnosis, and treatment by licensed healthcare physician and providers. I understand I have the right to be informed about my treatment, including potential risks and alternatives, and may withdraw this consent at any time in writing. This consent remains valid for the duration of my care unless revoked.

INFORMED CONSENT FOR TELEHEATH SERVICES

I authorize the use of telehealth technology for remote evaluations and treatment.

- I may be seen via video or audio-only communication, depending on clinical need and technology availability.
- I understand that technical issues may delay care.
- Privacy laws, including HIPAA, apply to all telehealth services.
- My physician and provider will not record the session without my consent, and my information will not be shared with third parties without authorization.
- I may withdraw this consent at any time without affecting my right to future care.
- I understand my insurance may not fully cover telehealth visits and I may be responsible for uncovered charges.
- Telehealth may involve the transmission of my medical information across state or regional networks using secure platforms with encryption and privacy protections.

USE OF ARTIFICIAL INTELLIGENCE (AI) DICTATION TECHNOLOGY

To support accurate and efficient documentation of your care, our clinic uses HIPAA-compliant, AI-powered dictation technology to transcribe verbal information into text for inclusion in your medical record. By signing this consent to treatment, you acknowledge and understand the following:

- AI may be used to transcribe verbal information into text for efficiency and accuracy in my medical record.
- Audio input used for AI transcription is deleted within 7 days. AI is not used to make clinical decisions.
- My physician and provider will personally review and confirm all AI-dictated content before it becomes part of my official medical record.
- Security protocols including encryption and access control protect the confidentiality of my information.
- I may request access to or corrections of my records at any time.

YOUR RIGHT TO OPT-OUT OF AI DICTATION TECHNOLOGY

You have the right to decline the use of AI dictation during your visit. If you choose to opt out:

- Please notify your physician and provider or clinic staff before your appointment begins.
- Your physician and provider will document your visit using traditional methods.
- You acknowledge that opting out may result in longer documentation times and may affect the efficiency of your visit.

VALUABLES

I understand that UKSM-W Medical Practice Association is not responsible for any personal valuables that are lost, stolen, or damaged while I am on clinic premises. I am advised not to bring valuables to appointments.

PATIENT ACKNOWLEDGMENT

By signing below, I confirm that I have read and understand this consent form. I have had the opportunity to ask questions, and all concerns have been addressed to my satisfaction. I voluntarily agree to the above terms.

Patient Name *(Print)*	**Date of Birth (MM/DD/YYYY)**
Patient Signature	**Date**

If the patient lacks capacity or is a minor, signature of the parent, guardian, or authorized legal representative is required:

Representative Name *(Print)*	**Relationship/Authority to Sign**
Representative Signature	**Date**

KU WICHITA INTERNAL MEDICINE CLINIC POLICIES

EMERGENCIES: In case of emergency, call 9-1-1 or go to your nearest emergency room. For nonemergent calls, you may call the Midtown office at (316) 293-1840 or CHC at (316) 293-2622 and leave a message. Your call will be returned the next business day.

INCLEMENT WEATHER: In the event of severe weather, please call the clinic before you come. A recording will alert you if the clinic is closed and you may also receive a text message or call. We will call you the next open day to reschedule your appointment.

APPOINTMENT CANCELLATION POLICY: Please, call the clinic at least 24 hours before your appointment if you need to cancel or reschedule. Cancelling your appointment in advance gives us the opportunity to offer medical services to another patient. Three (3) missed appointments within 12 months, inclusive of cancelations less than 24 hours in advance, may prompt a discussion with our care team regarding your scheduling needs. If our clinic needs to reschedule your appointment, you will receive an automated call to reschedule.

VOICE REMINDERS AND TEXT MESSAGE: Are used to remind you about upcoming scheduled appointments and helpful clinic notifications. Standard texting rates apply. If you prefer to opt out of receiving important health reminders, please call the scheduling department at the Midtown office at (316) 293-1840 or CHC at (316) 293-2622 to update your account.

PATIENT PORTAL: Our electronic health record offers a secure Patient Portal and mobile phone application called HEALOW which allows you to access your health information and communicate with your physician and provider. Our staff can enable this access and assist you with setting up access.

UPDATED INFORMATION: Keeping the clinic informed of any changes in your personal information, including address, phone, insurance, or emergency contact information or clinical information such as hospitalizations, surgeries, changes in health status or medications is vital to receiving safe and effective health care.

RX HISTORY: I understand and give consent for the clinic to access my prescription medication history from other providers and/or pharmacies.

FORM COMPLETION: All forms requiring medical review and authorized signature will require a scheduled appointment. Forms will be completed during or after the visit and released accordingly. (This does not include new patient forms.)

ACTIVE STATUS: In order to provide you with the best care, it is recommended that most patients be seen in-person, once every 3-6 months. Your clinician will work with you to decide how often you need to be seen based on your health care needs. Patients that fail to maintain contact with the clinic may be placed in Inactive Status and we will not be able to provide care or prescription refills. If we have not seen you in three (3) years or more, your status will be considered inactive. Should you wish to return to the clinic after being placed in Inactive Status, you will need to repeat the intake process.

CONFIDENTIALITY: All communication between you and the clinic is held in strictest confidence and will not be released unless: (1) you authorize release of information with your signature; (2) you present with potential harm to yourself or others; (3) there is suspicion of abuse or neglect of a minor or elder; or (4) the clinic is required to do so by federal, state, or local law.

TRAINEES: You are receiving care at a teaching clinic; therefore, medical students, interns, advanced practice provider (APP) students, and resident or fellow physicians may be involved in your treatment, under the supervision of a faculty provider.

RESEARCH: This clinic works with physicians who are performing a variety of research projects. Your Physician, advanced practice provider (APP), or a member of the research team may discuss these projects as viable alternatives or additions to your regular care. You may be asked to participate in this research, but you are under no obligation to do so.

I have read, understand, and will adhere to the UKSM-W Medical Practice Association Clinic Policy.

_____ _____

Patient Name ***(Print)*** **Date of Birth (MM/DD/YYYY)**

_____ _____

Patient or Responsible Party Signature **Date**

SCHOOL OF MEDICINE WICHITA
MEDICAL PRACTICE ASSOCIATION
The University of Kansas

FINANCIAL POLICY

Thank you for choosing UKSM-Wichita Medical Practice Association (UKSM-W MPA) for your medical care. We appreciate that you have entrusted us with your healthcare, and we are committed to providing you with the best patient care possible. Because healthcare benefits and coverage options have become increasingly complex, we have developed this financial policy to help you better understand your rights and responsibilities as a patient.

INSURANCE COVERAGE
Insurance policies are an agreement between the patient and his or her insurance company. It is the responsibility of the patient/guardian to know his or her insurance benefits which includes copayments, deductibles, and coinsurance. For the convenience of the patient, we will file your claims with the insurance company provided by the patient/guardian. It is the responsibility of the patient/guardian to make accurate and detailed insurance policy information available, within the timely filing limits of the plan, to enable processing of claims. If accurate insurance policy information is not provided within the timely filing limits of the insurance plan, the patient/guardian may become financially responsible for charges. The patient will be considered self-pay if valid insurance policy information is not received. The patient is responsible for notifying our office of any insurance policy updates.

WORKERS COMPENSATION
Appropriate referral and all necessary accident information must be received at the time of appointment scheduling. An injury form is required to be completed in full at the time of visit with all workers compensation information. UKSM-W MPA will file your workers compensation claim if all required information is provided; otherwise, you will be fully responsible for the balance.

PERSONAL INJURY/MOTOR VEHICLE ACCIDENT INSURANCE
UKSM-W MPA does not accept liens for assignment of payment in the case of liability actions. An injury form is required to be completed in full at the time of visit with all motor vehicle accident information. We will bill your personal primary automobile insurance for all auto accidents. Our relationship is with you, not your auto insurance company; therefore, it is often necessary for you to inquire on your claim with your auto insurance carrier to ensure payment. Health insurance companies will not pay until a claim has been processed by the automobile insurance.

SELF-PAY
Self-Pay patients are patients without insurance policy coverage. You will be required to complete the self-pay agreement and pay for the professional service on the date of your appointment unless you have been qualified for a federal assistance program or set up a payment arrangement with the billing department prior to your visit. You may also receive a statement for any additional ancillary services you received. A 35% discount may apply to those charges.

Some patients may qualify for a UKSM-W MPA federally funded assistance program. The patient responsible amount will decrease for individuals that qualify for this program, and in some cases, may be reduced to zero. Eligibility is determined based on specific criteria and documentation. Patients who qualify will be billed according to the adjusted schedule. Patients who do not qualify will be billed according to the standard fee schedule.

The Health Insurance Portability and Accountability Act (HIPAA) allows patients to elect to opt-out of using their insurance benefits and pay for services up front. If the patient/guardian chooses to opt-out, they have the right to request restriction of their health information from their insurance company. The patient/guardian must request to fill out the Health Information Exchange Opt-Out Form. If the patient/guardian chooses the election to opt-out of using insurance benefits for services, they must complete the Insurance Opt-Out and Self-Pay Acknowledgment form at every visit and pay for services up front.

COPAY
A copay is a fixed dollar amount that your health insurance requires the patient/guardian to pay upfront for a covered service. Copays are due at the time of service. If you are unable to pay your copay at the time of service, you will still be seen and billed for the copay. We do not turn patients away due to inability to pay at the time of service. For individuals who qualify for the UKSM-W MPA federally funded assistance program, the patient responsible amount may be reduced, including the possibility of a reduced or waived copay.

DEDUCTIBLES AND COINSURANCE
A deductible is the amount you pay for coverage of services before your health insurance plan kicks in. After you meet your deductible, you pay a percentage of health care expenses known as coinsurance. The amount you pay for your deductible and coinsurance depends on the patient's insurance plan. Some services may require payment of deductibles and/or coinsurance. If requested, payment is due by the deadline we provide, which may be before your appointment or on the day of service. For patients who qualify for the federal grant program, payment responsibility may be based on a nominal fee schedule and subject to a cap on total fees for services rendered. These limits are determined by program guidelines and eligibility criteria. Grant participants will not be billed standard deductibles or coinsurance amounts if they exceed the capped fee structure.

PATIENT STATEMENTS
You will receive a monthly statement from us for any remaining balance after all insurance plans on file have processed your claim. Your payment is expected within 20 days of receipt of this statement. Methods of communication, including but not limited to email and text messages, may be used to contact a patient regarding their remaining balance. Patients are opted-in for voice messages, text

messages, and email reminders regarding their balance. To opt-out, please provide verbal or written notice to a UKSM-W MPA receptionist or the business office.

BALANCES AND PAYMENTS
We accept payments via cash, check credit card, and Care Credit. If you are unable to pay your balance in full, you can contact our Billing Office to set up a payment plan. To avoid delinquency, our office requires that a formal payment arrangement be established, with consistent monthly payments made toward any outstanding balance. Accounts not paid in full within 90 days will be considered past due. Please note that unpaid balances may be referred to an external collection agency for further action. If you are experiencing financial hardship, you may request to complete a financial assistance application. Eligibility for financial assistance is based on specific income and expense criteria. Upon review and approval, your outstanding balance may be reduced in accordance with our financial assistance guidelines. Patients who do not make payment arrangements or qualify for assistance may be subject to dismissal from our practice. In some cases, this may include immediate family members listed under the same account. However, patients who qualify for the UKSM-W MPA federally funded assistance program may be eligible for additional financial support or fee adjustments to avoid dismissal or collections. Please contact our Billing Office to discuss available options before any action is taken. If your account is sent to a collection agency, you will be responsible for all costs of collection, including interest, court costs, and reasonable attorney's fees. If you're unable to pay the full balance due on your statement, please contact our Billing Office at 316-293-3429 to make payment arrangements.

NO SURPRISES ACT/GOOD FAITH ESTIMATE
UKSM-W MPA will produce a *"Good Faith Estimate"* if requested by the self-pay patient/guardian. Good Faith Estimates provide a quote for the cost of treatment prior to services being performed. The patient may authorize the physician and provider to proceed or halt treatment based upon their current financial situation. Additional details of the No Surprises Act can be provided to the patient upon request.

ADVANCE BENEFICIARY NOTICE (ABN)
You may be asked to sign a waiver of liability or Advance Beneficiary Notice (ABN) for certain services that could potentially be denied for payment by your insurance company despite information from them that a service is covered. If you sign the form and your insurance company does not pay for the service, you are financially responsible for the bill. You have the option to decline any service prior to it being performed.

REFERRALS AND AUTHORIZATIONS
It is the responsibility of the patient/guardian to obtain a referral from their primary care physician prior to the scheduled visit. If a referral was not obtained, the patient/guardian accepts full financial responsibility for services rendered.

ADDRESS AND PHONE NUMBERS
It is the responsibility of the patient/guardian to notify our office whenever there is a change to their address, phone number, insurance, or other contact information. Failure to provide timely updates may delay the billing process and could result in referral to an outside collection agency.

I understand that I am responsible for all charges incurred during my treatment at UKSM-Wichita MPA clinics regardless of insurance coverage. I agree to keep my account current and make any financial arrangements needed. However, if I qualify for the UKSM-Wichita MPA federally funded assistance program, my patient responsible amount may be reduced according to program guidelines, which may include nominal fees or a full waiver of charges.

I authorize payment of medical benefits to UKSM-Wichita MPA for services rendered. I also authorize the physician and provider to release any information required to process insurance claims and understand that the physician and provider may bill my insurance directly for services provided. I understand the UKSM-Wichita MPA Financial Policy and will adhere to the policy.

Patient Name ***(Print)***	**Date of Birth (MM/DD/YYYY)**
Patient Signature	**Date**

If the patient lacks capacity or is a minor, signature of the parent, guardian, or authorized legal representative is required:

Representative Name ***(Print)***	**Relationship/Authority to Sign**
Representative Signature	**Date**

CONSENT TO COMMUNICATE ELECTRONICALLY

What types of communication could be sent to me?

University of Kansas School of Medicine – Wichita Medical Practice Association "UKSM-W MPA" may send messages regarding your care, such as:

- Appointment reminders and scheduling updates
- Billing and payment notices
- Health-related information or education
- Feedback requests about your visit or services

How might I receive communications?

You may receive communications through one or more of the following:

- Email Notifications
- Text message (SMS)
- Phone or Voice over Internet Protocol (VoIP).

Some messages may be sent using automated dialing systems or include prerecorded/artificial voice.

Will the communications be secure?

Most emails will be encrypted. However, some emails or text messages containing limited personal information may not be encrypted and could pose a security risk. While the likelihood of interception is low, unencrypted messages may be accessed by unauthorized parties. By consenting to electronic communication, you acknowledge and accept this risk. UKSM-W MPA will take reasonable steps to protect your information but cannot guarantee complete security of unencrypted messages.

Are there any costs to me?

Standard text messaging or data rates may apply depending on your mobile plan. Please contact your wireless carrier for details.

What if I do not want to receive these communications?

You are not required to consent to receive electronic communications. You may opt out at any time by:

- Replying "STOP" to any text message
- Clicking "Unsubscribe" on any email
- Contacting your UKSM-W MPA clinic directly

Your preferences will remain in effect unless you update them or give a different type of consent for a specific clinic service or communication platform (such as a patient portal).

Consent Options (Select One):

☐ **I ACCEPT** – I consent to receive electronic communications from UKSM-W Medical Practice Association.

☐ **I DECLINE** – I do not wish to receive electronic communications at this time.

Patient Name ***(Print)*** _____ **Date of Birth (MM/DD/YYYY)** _____

Patient Signature _____ **Date** _____

If the patient lacks capacity or is a minor, signature of the parent, guardian, or authorized legal representative is required:

Representative Name ***(Print)*** _____ **Relationship/Authority to Sign** _____

Representative Signature _____ **Date** _____

SCHOOL OF MEDICINE WICHITA
MEDICAL PRACTICE ASSOCIATION
The University of Kansas

ACKNOWLEDGEMENT OF PATIENT RIGHTS AND RESPONSIBILITIES

PATIENT RIGHTS

As a patient of UKSM-W Medical Practice Association (MPA), you have the right:

- To be treated with respect, dignity, consideration, and compassion.
- To receive services free of discrimination on the basis of race, color, sex/gender, ethnicity, national origin, religion, age, class, sexual orientation, physical or mental ability.
- To participate in creating a care plan and in making decisions that affects your care.
- To be informed about services and options available to you, including the cost.
- To have your personal information and medical records be treated confidentially.
- To communicate in a language you can understand.
- To consent or refuse to participate in any proposed research study without retribution or difference in the quality of your care.
- To file a grievance about services you are receiving or denial of services.
- To not be subjected to physical, sexual, verbal and/or emotional abuse or threats.

PATIENT RESPONSIBILITIES

As a patient of UKSM-W MPA, you have the responsibility:

- To treat other patients and staff of this clinic with respect and courtesy.
- To protect the confidentiality of other patients you encounter in this clinic.
- To participate as much as you are able in creating a care plan, asking questions until you fully understand your care plan, and participating in decision-making that affects your care.
- To let your physician and provider/care team know any concerns you may have about your care plan or changes in your needs.
- To make and keep appointments to the best of your ability, or if possible, to call to cancel or change an appointment time.
- To keep clinic informed of changes in your personal information, including address, phone number, or insurance to ensure timely processing of bills and to promptly meet your financial obligations.
- To provide accurate information to your physician and provider/care team about your symptoms, past illnesses, hospitalizations, medications, and behaviors that may affect your health.
- To follow your care plan and tell physicians and nurses about any obstacles you may encounter in continuing your care plan.
- To consent to a blood test if any healthcare worker should come in contact with your blood.
- To follow clinic rules, such as our no-smoking policy and clinic expectations for patient and visitor behavior, which includes refraining from the use of profanity; verbally abusive, offensive, and/or sexually suggestive language; threatening statements or any act or threat of inappropriate behavior.

I acknowledge that I have reviewed and understand these rights and responsibilities, and I understand that my signature below means that I am agreeing to do my part to respect the clinic's policies and to help create a safe, healing environment. I understand that failure to comply with the terms of this Agreement may prevent me from continuing to receive care from the clinic.

_____ _____

Patient Name ***(Print)*** **Date of Birth (MM/DD/YYYY)**

_____ _____

Patient Signature **Date**

If the patient lacks capacity or is a minor, signature of the parent, guardian, or authorized legal representative is required:

_____ _____

Representative Name ***(Print)*** **Relationship/Authority to Sign**

_____ _____

Representative Signature **Date**

ACKNOWLEDGEMENT OF POLICIES

University of Kansas School of Medicine – Wichita Medical Practice Association ("MPA") has made updates to the following policies:

- **Notice of Privacy Practices** - *Revised December 2025*
- **Financial Policy** - *Revised December 2025*
- **Notice of Non-Discrimination** - *Revised December 2025*

Printed copies of each policy are available upon request at the front desk. Please sign below to acknowledge that you have been informed of these policy updates and have had the opportunity to review or request a copy.

_____ _____

Patient Name ***(Print)*** **Date of Birth (MM/DD/YYYY)**

_____ _____

Patient Signature **Date**

If the patient lacks capacity or is a minor, signature of the parent, guardian, or authorized legal representative is required:

_____ _____

Representative Name ***(Print)*** **Relationship/Authority to Sign**

_____ _____

Representative Signature **Date**