Sage Recovery & Wellness Center

ADULT REGISTRATION FORM

CLIENT INFORMATION

Legal First & Last Name:	**Preferred name:**	Middle:

Birth Date:	Age:	Marital Status:	Are you a veteren?

Sex: ☐ Male ☐ Female ☐ Transgender, Gender Pronoun _____ ☐ Other, Gender Pronoun _____

Address:	City:	State:	Zip Code:

Social Security no.:	Home phone no.:	Cell phone no.:	Ethnicity:

Occupation:	Employer:	Employer phone no.:

Who can we thank for your referral? Name/Organization:

Reason for seeking treatment?

INSURANCE INFORMATION

(Please fill in this information and then give your insurance card to the receptionist.)

If the client is NOT the person responsible for payments, a Release of Information for Financials and Attendance is required.

Person responsible for payments:	Birth date:	Address (if different):	Phone no.:
Is this person a patient here?	○ Yes ○ No	Is this person covered by insurance?	○ Yes ○ No
Occupation:	Employer:	Employer address:	Employer phone no.:

Primary Insurance Carrier: | Other:

Subscriber's name:	Birth date:	Group no.:	Policy/Member ID no.:

Client's relationship to subscriber: | Other:

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Client's relationship to subscriber: | Other:

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to client:	Cell phone #:	Work phone #:

I certify that the above information is true to the best of my knowledge.

_____ _____

Client Signature Date

CLIENT NAME: _____X

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Medication Sheet

Medication: Include over the counter and herbal	Reason for taking?	Dosage/ Frequency:	Taken as prescribed?	Prescribing Physician:	Length of time on this medication:	Date last taken:

Name: _____ DOB: _____ Date: _____

_____ _____

Signature of Medical Director, Cole Weatherby, DO Date

CLIENT NAME: _____X

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Physical Health Screen

Please check any symptoms you have experienced in the **past 24 hours**:

- ☐ Anxiety/Racing Heart
- ☐ Restlessness
- ☐ Irritability
- ☐ Insomnia
- ☐ Headaches/Migraines
- ☐ Sensitivity to Light/Sound
- ☐ Difficulty Concentrating
- ☐ Sweating
- ☐ Fever or Chills
- ☐ Nausea/Vomiting
- ☐ Diarrhea
- ☐ Dizziness
- ☐ Fainting
- ☐ Non-healing wounds or abscess
- ☐ Wet and/or bloody cough
- ☐ **Heart Palpitations**
- ☐ **Pain/Tightness in the chest**
- ☐ **Difficulty breathing**
- ☐ **Confusion**
- ☐ **Delirium tremens (DTs)**
- ☐ **Seizures**
- ☐ **Strokes**
- ☐ **Hallucinations-visual/auditory**
- ☐ Other: _____
- ☐ None

Please check the box indicating any of the following of which you have been diagnosed:

- ☐ Tuberculosis
- ☐ HIV/AIDS
- ☐ STD
- ☐ Diabetes
- ☐ Heart disease/attack/condition
- ☐ Liver problems
- ☐ Seizures
- ☐ Hepatitis B or C
- ☐ Impaired immune system
- ☐ Stroke
- ☐ Cancer/Malignancy
- ☐ Fainting
- ☐ Menstrual Disorders
- ☐ High/Low BP
- ☐ Osteopenia/Osteoporosis
- ☐ Dental problems, specify: _____
- ☐ Hypo/Hyperthyroidism
- ☐ Polycystic Ovarian Syndrome
- ☐ Irritable Bowel Syndrome
- ☐ Fibromyalgia
- ☐ Chronic Pain
- ☐ Gastritis
- ☐ Migraines
- ☐ Other: _____
- ☐ None

Any known allergies? _____

Have you ever overdosed? ☐ YES ☐ NO

If yes, how many times? _____

Have you received a physical health exam in the last 12 months? ☐ YES ☐ NO

If applicable: Most recent OBGYN visit: _____

Date of most recent bloodwork? _____ Were the results normal? ☐ YES ☐ NO

If results were not normal, please explain: _____

Do you have a Psychiatric Advance Directive? ☐ YES ☐ NO (If yes, please provide a copy.)

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☐Referred to medical provider ☐No referral ☐Needs medical clearance

Therapist Signature: _____ Date: _____

Printed Name & Credentials: _____

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Client Intake

Emotional/Behavioral

Do you have feelings of:
Hopelessness: ☐ YES ☐ NO If yes, rate intensity (1=mild – 10=severe): ____ / 10
Helplessness: ☐ YES ☐ NO If yes, rate intensity (1=mild – 10=severe): ____ / 10
Worthlessness: ☐ YES ☐ NO If yes, rate intensity (1=mild – 10=severe): ____ / 10
Feelings of isolation:☐ YES ☐ NO If yes, rate intensity (1=mild – 10=severe): ____ / 10
Loss of pleasure in previously fun activities: ☐ YES ☐ NO If yes, rate intensity (1=mild – 10=severe): ____ / 10

Explain any yes responses: _____

Do you currently have suicidal thoughts, or thoughts of hurting yourself? ☐ YES ☐ NO

If yes, explain:_____

_____

Do you have a history of self-injurious behavior (cutting, burning, scratching, banging head, hitting, etc.)? ☐ YES ☐ NO

If yes, Describe: _____

How often? _____ When was the first time? _____ When was the last time? _____

Have you ever had thoughts of suicide in the past? ☐ YES ☐ NO

If yes, explain:_____

_____

Do you have any past suicide attempts? ☐ YES ☐ NO

If yes, explain:_____

_____

Have you ever rehearsed a suicide plan? ☐ YES ☐ NO

If yes, explain:_____

How would you rate the following statement? **I am satisfied with my life (1=not satisfied – 10=very satisfied): ____ / 10**

SPIRITUALITY

Do you have any cultural, religious, or spiritual beliefs and/or preferences that we should take into consideration for your treatment? ☐ YES ☐ NO

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What role does spirituality play in your healing process? _____

PAST TREATMENT

Have you been diagnosed with any mental health or substance use disorder(s)? ☐ YES ☐ NO

Diagnosis(es): _____ Date(s): _____

Have your symptoms changed over time? _____ If so, how? _____

Have you received previous treatment for mental health and/or substance use? ☐ YES ☐ NO

List any inpatient, outpatient, or detox facilities where services were received:

_____

_____

MILITARY HISTORY

Have you served in the military? ☐ YES ☐ NO

Military branch: _____ Date(s) of service: _____

LEGAL SYSTEM

Any present or past involvement with the legal system? ☐ YES ☐ NO

Please list any current or past criminal charges, arrests, or other relevant involvement with the legal system:

	Dates	Please explain
Criminal Charges/Arrests		
Probation/Parole		
Family Courts (custody/ divorce)		
Child/Adult Protective Services		
Other:		

Have legal situations influenced your decision to seek treatment? ☐ YES ☐ NO

If yes, what is the urgency of the situation and what are the requirements? _____

_____

_____

EDUCATION/VOCATIONAL QUESTIONS

What is your highest level of education?

Any vocational training or education? ☐ YES ☐ NO

Any learning disabilities? ☐ YES ☐ NO

Any current issues pertaining to employment? ☐ YES ☐ NO

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If so, please explain:

EATING AND EXERCISE HABITS

Have you experienced any changes in appetite recently? ☐ YES ☐ NO
If so, explain:

Do you ever restrict or avoid particular foods so much that it negatively affects your health or weight? ☐ YES ☐ NO

Have you ever made yourself vomit to control your weight or shape? ☐ YES ☐ NO

Have you ever used laxatives, diet pills or diuretics to control your weight or shape? ☐ YES ☐ NO

Have you gained or lost more than 10 pounds in the past 3 months? ☐ YES ☐ NO

Do you exercise? ☐ YES ☐ NO

If so, how often and for how long?

FINANCIAL ISSUES AND MONEY MANAGEMENT HABITS

Have you ever felt the need to bet more and more money? ☐ YES ☐ NO

Have you ever had to lie to people important to you about how much you have gambled or spent ☐ YES ☐ NO

Are there any financial issues you are currently experiencing? ☐ YES ☐ NO

Explain:

FAMILY HISTORY OF SUBSTANCE ABUSE/MENTAL HEALTH

Family Member	Paternal/Maternal	Substance/Mental Health Issue	Are they sober?

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Substance Use Assessment

******Feel free to skip any questions in this section that do not apply to you.***

Have you ever used alcohol, illegal drugs, or prescription drugs that were not prescribed to you or in higher doses than were prescribed?

☐ YES ☐ NO

Have you ever experienced...

Divorces or loss of relationship due to substance use? ☐ YES ☐ NO
Job related issues due to substance use? ☐ YES ☐ NO
Financial issues due to substance use? ☐ YES ☐ NO
Blackouts or memory impairments because of substance use? ☐ YES ☐ NO
Physical/medical issues because of substance use? ☐ YES ☐ NO
Explain:

Have you experienced or are currently experiencing other addictive behaviors like food, pornography, shopping, sex, and/or
internet addiction? ☐ YES ☐ NO
If so, please explain:

SUBSTANCE USE HISTORY (*if applicable*)

Last day of alcohol or drug use:

Longest period of sobriety from all drugs/alcohol?

What have you tried in the past when attempting to quit?

Were you given an ultimatum to accept treatment: ☐ YES ☐ NO

If yes, what was the ultimatum? _____
_____

How are you currently supporting yourself? _____

How are you supporting your habit? _____

How are you obtaining your drugs? _____

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Please explain relapse history and triggers that you believe might have led to relapse:

CLIENT NAME: _____X

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*The chart below pertains to specific substances you have used in the past and/or present. Please **check ONE** number under the category that best describes your use pattern. Consider only drugs taken without a prescription from your doctor, unless the prescriptions were/are taken at a higher dosage than prescribed.*

	Age of first use	Date of most recent use	Never used	Tried but quit	Several times a year	Several times a month	Week-ends only	Several times a week	Daily	Several times a day
Alcohol (beer, wine, liquor)			0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐
Tobacco (chewing tobacco, dip, snuff, cigarettes, cigars, e-cig)			0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐
Cannabis (marijuana, dabs, hash)			0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐
Stimulants (Cocaine or crack cocaine)			0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐
Stimulants (MDMA or Ecstasy)			0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐
Amphetamines (Speed, methamphetamine, methylphenidate-Concerta & Ritalin, Adderall, Vyvanse)			0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐
Benzodiazepines/ Anxiolytics (Valium, Xanax, Klonopin, Ativan, Librium)			0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐
Opioids (heroin, opium, morphine, codeine, fentanyl, hydrocodone, buprenorphine, oxycodone, hydromorphone, "lean")			0 ☒	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐
Hallucinogens (LSD, PCP, psilocybin, mescaline, DMT, research chemicals such as 2C-E and 2C-P)			0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐
Sedatives and hypnotics (Phenobarbital, Ambien, Lunesta, Phenergan, Benadryl)			0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐
Inhalants (glue, gasoline, spray cans, whiteout, poppers, whippets)			0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐
Other (Kratom, Kava, Bath Salts, K2)			0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐

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Recovery Environment and Support Systems

Is your motivation for treatment being forced upon you by another? (External reasons to get help) ☐ YES ☐ NO

If so, who/relation?_____

Is your motivation for treatment coming from you? (Internal reasons to get help) ☐ YES ☐ NO

Do you have support? ☐ YES ☐ NO If yes, who?_____ Are they sober? ☐ YES ☐ NO

Are you willing to allow your family or support system to be involved in treatment? ☐ YES ☐ NO

What are your short-term treatment goals?

What are your long-term treatment goals?

Do you have any needs or special requirements for treatment?

Client Printed Name: _____

Client Signature: _____ Date: _____

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☐Referred for nutrition assessment ☐No referral

Therapist Signature: _____Date:_____

Printed Name & Credentials: _____

CLIENT NAME: _____X

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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.

Expiration: Unless sooner revoked, this authorization expires on the 60 days after my last appointment.

Revocation: I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to the therapist I am working with at **Sage Recovery & Wellness Center**. I understand that I may revoke this authorization, by requesting in writing, a discontinuation of this document to **7004 Bee Caves Rd, 2-200, Austin, Texas 78746**. I also understand that the written revocation must be signed and dated with a date that is later than the date of this authorization. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

I, _____, consent to the release of privileged information and waive the privilege of confidentiality afforded for medical and mental health care, alcohol and drug rehabilitation, and authorize Sage Recovery & Wellness Center's staff to communicate with the individuals listed below to exchange any information for the purpose of clarifying and enhancing my care and treatment.

Please check one or both of the following:
To obtain from ☐ To disclose to ☐

Name:_____ Relationship to Client:_____

Phone: _____ Fax: _____

**Ask the front desk staff for another copy of this form if you would like to or are required to release privileged information to more than one individual.*

Please check at least one of the following to indicate what information you would like released to the above individual.

☐ Assessment ☐ Treatment Plans ☐ Letter of Admission	☐ Discharge Summary ☐ Letter of Completion	☐ Urine Analysis ☐ Group Notes ☐ Individual Therapy Notes	☐ Attendance ☐ Financials ☐ Other: _____

Sage Recovery & Wellness Center, and others listed above, are hereby released from all liability arising out of, or in any way incidental to, producing records or providing information according to this authorization.

A duplicate, photocopy or facsimile reproduction of this document may be used in lieu of the original.

This authorization is subject to revocation in writing by the undersigned.

Client Signature_____Date_____

Witness Signature _____

Assessment Authorization Form

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I, _____, certify that I understand, agree, and received a copy of the information provided below.

- Confidentiality Statement
- Notice of Privacy Practices
- Authorization for Use and Disclosure of Protected Health Information for Payment
- Payment and Insurance

Client Signature: _____ Date: _____

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☐ Client received a copy of the Confidentiality Statement and information regarding Appointments, Payment, and Insurance.

Staff Signature: _____Date: _____

Confidentiality Statement

Sage Recovery & Wellness Center is required to provide you with confidentiality and consent information and to obtain your signature to acknowledge that you have read and understood this form.

Those laws require us to treat all contact with you as confidential; this includes phone calls, appointments, and written communication.

Treatment at Sage Recovery & Wellness Center is a voluntary and joint effort. Sage Recovery & Wellness Center staff members are employees of Sage Recovery & Wellness Center and are not directly affiliated with your insurance carrier.

Please note as part of the center's way of protecting your privacy we do not return calls from caller ID. If you would like a return call please leave a message on our confidential voicemail. Even if the request is initiated by you, we also cannot accept requests to be "connected" or "friends" with clients on social media sites as it could breach legally-protected confidentiality. If you see a Sage Recovery & Wellness Center staff member outside of the center, acknowledgment will be left to you in order to respect your privacy. Please note that email correspondence is not a secure method for communication and choosing to do so could result in an unintentional breach of confidentiality.

- I authorize Sage Recovery & Wellness Center to call or send text messages to the **phone number** provided on the **registration form** and to leave a message referencing any items that assist the center in carrying out treatment provided, such as **appointment reminders, insurance items and any calls pertaining to my clinical care**. I understand it is my choice which phone number I authorize consent for.
- I authorize Sage Recovery & Wellness Center to mail any items that assist the practice in carrying out treatment, payment, and healthcare operations (TPO), such as discharge follow up letters and patient statements, to the **address** provided on the **registration form.**

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Appointments, Payment, and Insurance

Appointments: All office visits are by appointment and may be scheduled through the front desk staff or your therapist. Consistency is an important part of the counseling process; therefore, the appointment time you schedule is reserved for you and is not available to anyone else. Please arrive on time, as you use up your session time when you arrive late for an appointment. The usual length of an appointment is 50 minutes. **If you are unable to keep a scheduled appointment, you must notify Sage Recovery & Wellness Center at least 2 business days' notice in advance to avoid having to pay for the canceled or missed appointment. Please leave a message on our confidential voicemail during non-business hours.**

Cancellation Policies: Since scheduling of an appointment involves the reservation of time specifically for you**, a minimum of 2 business days' notice is required for rescheduling or canceling an appointment**. Without 2 business days' notice, you will be financially responsible for the full amount of the scheduled session. Most insurance companies do not reimburse for missed sessions. Your compliance in keeping appointments and actively participating in treatment is vital.

Payment: Self pay clients, including those not billing any insurance company or third-party payer, are expected to pay in full at time of service unless other arrangements have been made. Except in the case of minors or when other arrangements are made, the individual receiving services is financially liable. I understand additional fees are charged for lengthy telephone communications, court attendance and report/letter writing. Insurance does not cover this.

Insurance: I understand I may be responsible for the remaining balance if the insurance or third party does not cover the full allotted amount. Sage Recovery & Wellness Center will send me an invoice with the remaining amount, which I am required to pay in full within 30 days after the rendering of services. I understand co-pays are expected at the time of service and that co-pays are non-negotiable. Failure to pay your part may jeopardize your insurance benefits. I understand should I become ineligible for insurance coverage, I agree to notify the center and I will be responsible for 100% of the remaining balance. I understand that a re-billing fee/financial charge complying with Texas State Law may be applied to any overdue balance. In the event of non-payment, I will bear the cost of collection, court costs, and/or legal fees should this be required. If services are conjoint (couples or family therapy), all clients 18 and older need to sign this contract due to confidentiality and your individual rights, regardless of who is the identified financially responsible client.

Notice of Privacy Practices

Information about your visits to Sage Recovery & Wellness Center are considered **protected health information (PHI)**. Sage Recovery & Wellness Center is required by law to maintain the privacy of your information and to provide you with this notice that details our privacy practices. Sage Recovery & Wellness Center keeps your health information in confidential records that are maintained and protected, as required by law. With the exception of disclosures permitted in this notice, no one except Sage Recovery & Wellness Center staff will have access to your information.

Information you provide to Sage Recovery & Wellness Center will be used to provide services to you and to ensure quality of care. **Except as described in this notice or when required/permitted by state/federal law, Sage Recovery & Wellness Center will not disclose your information unless you provide a written authorization for us to disclose your information.** If you authorize Sage Recovery & Wellness Center to disclose your information, you make revoke this authorization in writing at any time, except to the extent that the information has already been disclosed.

Uses and Disclosures:

- Sage Recovery & Wellness Center may use or disclose your information for the following purposes:
  - To notify you when an appointment is cancelled or rescheduled
  - To disclose relevant information in cases of a serious, imminent threat to health or safety
    - *In accordance with Texas law, if any individual arrives at Sage Recovery & Wellness Center under the influence of any substance that causes impairment and has driven themselves to the center, the individual will be assisted in finding a safe, alternative ride home. If the individual should choose to drive themselves home after being informed of this regulation, staff members will be required to inform the legal authorities of this.*

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- For public health purposes, such as mandated reporting of suspected abuse, neglect, or exploitation of a child, an elderly person, or a person with a disability or mandated reporting of a provider of counseling services behaving in a sexually inappropriate manner.
- As ordered by a court - Sage Recovery & Wellness Center will attempt to contact you before disclosing information from your record in response to a subpoena or court order. In certain situation where you bring legal action against the organization, Sage Recovery & Wellness Center may be required to release your information to officers of a court.
- For limited national security purposes, such as to military command authorities if you are a member of the armed forces or for national security and intelligence activities
- For mental health oversight activities, such as a State Board investigation or a record-keeping audit

- Sage Recovery & Wellness Center Duties:
  - Sage Recovery & Wellness Center is required to abide by the terms of the privacy notice that is currently in effect. This notice of privacy practices is effective 1/1/14.
  - Sage Recovery & Wellness Center may change the terms of our privacy practices. Any future changes to the terms will apply to all previous and future health information that Sage Recovery & Wellness Center maintains.
  - Approximately 10 years after you contact Sage Recovery & Wellness Center, the center will destroy your record in a way that protects your privacy.
  - You have the right to request restrictions on certain uses and disclosure of your information. Sage Recovery & Wellness Center is not required to agree to a requested restriction.
- Your individual rights:
  - You have the right to receive confidential communications.
  - You have the right to inspect and copy your record, however, you will not receive the original copy. Under limited circumstances, your request may be denied. You may request review of this denial and the Sage Recovery & Wellness Center will discuss with you the details of the review process. If you believe the information we have about you is incorrect or incomplete, you may request an amendment to the record. Sage Recovery & Wellness Center is not required to accept the amendment.
  - You may request a list of the disclosures of your information.
  - If you believe your privacy rights have been violated, you may file a written complaint with the Sage Recovery & Wellness Center CEO, Joint Commission, or HIPAA. You will not be retaliated against if you make a complaint.
  - You have a right to a paper copy of this notice (or any future privacy notices). Please let the office manager know if you would like a copy of this notice.

If you have any questions about this notice, have a complaint, or wish to exercise your individual rights, please contact the Sage Recovery & Wellness Center CEO, Tiffany Anschutz, at (512) 306-1394.

Authorization for Use and Disclosure of Protected Health Information for Payment

By signing, I authorize Sage Recovery & Wellness Center to use and/or disclose certain protected health information (PHI) about me to my **insurance carrier or third-party payer**. Our office will bill your insurance company for services provided. This office cannot accept responsibility for collecting your insurance claims or for negotiating a settlement on a disputed claim. You are responsible for payment, deductible, and insurance claims on your account. When possible, Sage will provide you with an estimate of what your insurance will cover. However, that is only an estimate and **the client is responsible for any fees that insurance does not cover. Note: Insurance companies typically have up to 365 days to completely process claims.**

This authorization permits Sage Recovery & Wellness Center to use and/or disclose the following identifiable health information about me collected during the assessment completed at Sage Recovery & Wellness Center.

The information will be used or disclosed for the following purpose:

- To verify insurance benefit coverage
- To bill insurance or a third-party payer for services rendered

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The purpose of this release is so that I can make an informed decision whether to allow the release of the information or other financial compensation from insurance or a third party in exchange for using or disclosing protected health information.

I do not have to sign this authorization in order to receive treatment from Sage Recovery & Wellness Center. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed in pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to Sage Recovery & Wellness Center.

Private Pay/Non-Medicaid and Medicare Agreement

Please be advised that Sage Recovery & Wellness Center is **not a Medicare or Medicaid listed provider**. We do not file claims to Medicare or Medicaid. I understand that Sage Wellness & Recovery is accepting me as a private pay patient and I will be

responsible for paying for any services that I receive. The provider will not file a claim to Medicaid for the services that are provided to me.

The purpose of this release is so that I can make an informed decision whether to allow the release of the information or other financial compensation from insurance or a third party in exchange for using or disclosing protected health information.

I do not have to sign this authorization in order to receive treatment from Sage Recovery & Wellness Center. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed in pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to Sage Recovery & Wellness Center.

For Office Staff Use Only

☐ Client received a copy of the Confidentiality Statement and information regarding Appointments, Payment, and Insurance.

Staff Signature: _____Date: _____