



Physician Partners
of America

PAIN RELIEF GROUP

Patient Information

First Name:	Middle Name:	Last Name:
DOB:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	SSN:
Ethnicity: <input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Hispanic/Latino		
Race: <input type="checkbox"/> African American <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Other:		
Primary Language:		
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Domestic Partner		
Address:		
City:	State:	Zip:
Primary Phone:	Cell Phone:	Home Phone:
Work Phone:	E-mail:	

Employment Status: <input type="checkbox"/> Employed <input type="checkbox"/> Retired <input type="checkbox"/> Student <input type="checkbox"/> Un-Employed		
Employer:	Occupation:	Employer Phone:
Employer Address:		

Emergency Contact Full Name:	Relationship:
Primary Phone:	Work Phone:

Is the Patient Financially Responsible? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, Please Complete this Section		
Relationship:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	SSN:
First Name:	Middle Name:	Last Name:
Address:		
City:	State:	Zip:
Primary Phone:	Cell Phone:	Home Phone:
Employer:	Occupation:	Employer Phone:
Employer Address:		

Is the Reason for Your Visit the Result of An Accident? <input type="checkbox"/> Yes <input type="checkbox"/> No?		
If Yes, Please Complete this Section		
Which Type of Accident? <input type="checkbox"/> Workman's Comp <input type="checkbox"/> Automobile <input type="checkbox"/> Other:		
Date of Accident:	Claim #:	Claim Adjuster:

Insurance Company:	Insured DOB:
Insured/Card Holder's Name:	Relationship:
ID#:	Group #:
	Phone:
Secondary Insurance Company:	Insured DOB:
Insured/Card Holder's Name:	Relationship:
ID#:	Group #:
	Phone:

Patient Signature: _____

Date: / /

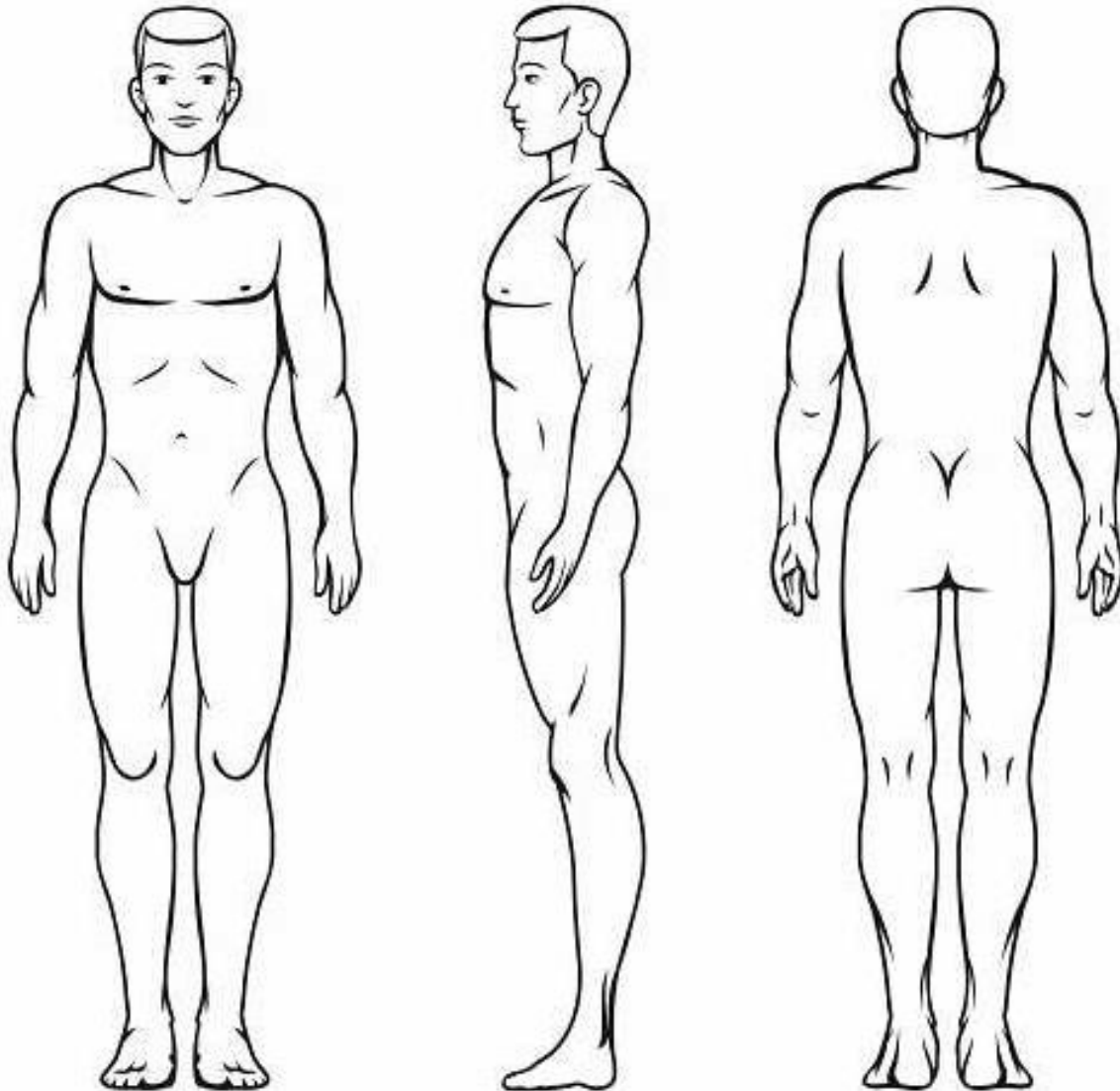


TELL US ABOUT YOUR MOST SIGNIFICANT PROBLEM

How did you hear about us? Friend Internet Insurance Advertisement Other: _____

Where is your pain located? Please list all that apply

Where is your pain located? Please mark on graphic below



Patient Initials: _____

Date: / /



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How long has your pain been occurring?		
Is your pain constant or Intermittent?		
Circle all that apply to the type of pain you are feeling? Circle All That Apply		
Achy	Burning	Dull Sharp Shooting Stabbing Tingling
Circle anything that makes the pain worse? Circle All that Apply		
Activities	Bending	Stretching Sitting Standing Twisting Walking
Circle any of the following that relieve the pain? Circle All that Apply		
Heat/ice packs	Laying Down	Pain Medication Rest Standing Sitting Stretching
What is your pain on a scale of 0-10 on TODAY?	What is your pain on a scale of 1-10 on your BEST day?	What is your pain on a scale of 1-10 on the WORST day?
_____	_____	_____
Have you had any prior treatment for this condition? Circle All that Apply		
Physical Therapy	Spine Injection	Anti-Inflammatory Medications Pain Medications
Bed Rest	TENS unit	Previous Pain Management Doctor
What recent studies/imaging have you had relating to this condition? Please Circle all that Apply		
X Ray	MRI	CT Scan EMG (Needle testing of Muscles) Nerve Conduction Study Discogram

Do you have a Primary Care provider? If yes please list here
Any other Healthcare Providers we should know about? Please list here

PAST MEDICAL, SURGICAL, FAMILY MEDICATION AND SOCIAL HISTORY

Have you had any Sports Injuries? If yes when?
Have you ever had any broken bones? If yes when?
What bone/s?
Have you ever been disabled?
Are you currently disabled? IF yes what type?
SSD SSI

Patient Initials: _____

Date: / /



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COUNTER

Medication	Dosage	Prescribing Physician	For Which Condition

Review of Symptoms: Have you recently experienced any of the following? Circle or mark answers below

<u>General/Constitutional</u> <input type="checkbox"/> Fevers /Chills <input type="checkbox"/> Infection anywhere <input type="checkbox"/> Sleep Problems	<u>Cardiovascular</u> <input type="checkbox"/> Chest Pain (any) <input type="checkbox"/> Rapid Heartbeat <input type="checkbox"/> Heart murmur	<u>Respiratory</u> <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Wheezing <input type="checkbox"/> Sleep Apnea/C-PAP/Oxygen
<u>Gastrointestinal</u> <input type="checkbox"/> Nausea / Vomiting <input type="checkbox"/> Constipation <input type="checkbox"/> Stomach/Abdominal Pain	<u>Genitourinary</u> <input type="checkbox"/> Kidney stone pain <input type="checkbox"/> Painful Urination <input type="checkbox"/> Blood in Urine	<u>Neurological</u> <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling <input type="checkbox"/> Incontinence of bladder
<u>Muscle/Bones/ Joints</u> <input type="checkbox"/> Muscle Spasms <input type="checkbox"/> Muscle weakness <input type="checkbox"/> Joint Pain/ extremity	<u>Endocrine</u> <input type="checkbox"/> Severe Thirst <input type="checkbox"/> Severe Fatigue <input type="checkbox"/> Decreased Sex Drive	<u>Psychiatric</u> <input type="checkbox"/> Anxiety nervousness <input type="checkbox"/> Feeling Sad /Depressed <input type="checkbox"/> Suicidal Ideation <input type="checkbox"/> Addiction to anything
<u>Hematological</u> <input type="checkbox"/> Easy bleeding bruising <input type="checkbox"/> Bleeding disorder/problem <input type="checkbox"/> Lymph node enlargement	<u>Allergy / Immunology</u> <input type="checkbox"/> Shellfish Allergy <input type="checkbox"/> Environmental Allergies <input type="checkbox"/> HIV	<u>Cancer</u> <input type="checkbox"/> Prostate/Colon <input type="checkbox"/> Breast <input type="checkbox"/> Lung <input type="checkbox"/> Other _____

Patient Initials: _____

Date: / /



AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient's Name: _____

DOB: ____/____/____ Phone Number: _____

I authorize the release of my medical records to Physician Partners of America (PPOA) for review and continuation of my medical care. I authorize the following physician offices, clinics, legal offices, diagnostic centers, and medical providers to provide copies of my health records to:

Persons/organizations receiving: (Insert Entity Name)

(List all facilities, clinics, and offices from which information may be requested)

PHYSICIAN OFFICES (please list all physicians you have seen in the past two years)

Physician Name	Address	Phone Number

HOSPITAL/OTHER FACILITIES (surgeries/procedures, radiology reports, laboratory results)

Facility Name	Address	Phone Number

Restrictions: _____ there are NO restrictions to the information that can be released
 _____ the following information CAN NOT be released:

DURATION: This Authorization will remain in effect: (please check selection):

_____ from the date of this Authorization until ____/____/____

_____ until the provider fulfill this Authorization request

_____ until the following event occurs: _____

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

(Entity Name)
(Entity Address)
(Entity City / State Zip)
(Entity Phone)
(Entity Fax)

Patient Initials: _____

Date: / /



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PATIENT PERSONAL HEALTH INFORMATION CONSENT FORM

Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my healthcare, Physician Partners of America originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information is utilized to plan my care and treatment, to bill for services provided to me, to communicate with other healthcare providers and other routine healthcare operations such as assessing quality and reviewing competence of healthcare professionals.

Physician Partners of America’s *Notice of Privacy Practices* provides specific information and complete description of how my personal health information may be used and disclosed. I have been provided a copy of the *Notice of Privacy Practices* and acknowledge that I have reviewed the notice prior to signing this consent. I understand that the Physician Partners of America reserves the right to change the *Notice of Privacy Practice at any time, and I as a patient have the right to review changes at any time.* I understand that I have the right to restrict the use and/or disclosure of my personal health information for treatment, payment or healthcare operations and that the Physician Partners of America is not required to agree to the restrictions requested. I may revoke this consent at any time in writing except to the extent that the Physician Partners of America has already taken action in reliance on my prior consent. This consent is valid until revoked by me in writing.

I request the following restrictions on the use and/or disclosure of my personal health information.

I further understand that any and all records, whether written, oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.

I have reviewed Physician Partners of America’s *Notice of Privacy Practices* dated July 30, 2015.

I acknowledge that I may request a copy of Physician Partners of America’s *Notice of Privacy Practices* dated July 30th, 2015 at any time.

Signature of Patient or Legal Representative, _____ Date _____

Print Name of Patient or Legal Representative _____

Witness’s Signature _____ Date _____

Witness’s Printed Name _____

Patient Initials: _____

Date: / /



Opiate Agreement

I, _____, am requesting treatment with opiate pain medication(s) because other therapies, treatments, and/or medication(s) that I have previously received and had not provided me with adequate relief of pain. I understand:

- That it is unlikely that any medication(s) will completely remove or eliminate my pain.
- Opiate pain medication(s) will be prescribed for me for humane reasons as long as my pain continues at the present level or intensity, provided that I follow all terms of this agreement/ Agreement.

My provider has discussed potential long-term opiate therapy with me in detail and I understand some of the possible complications that may occur are:

- Chemical/Physical dependence and addiction
- Severe constipation which could require medical treatment difficulty with urination
- Drowsiness
- Nausea
- Itching

Slowed breathing or respirations

Reduced or absent sexual desire and/or function

- Coma
- Organ damage, failure; or death

I further understand that if I take all my medication(s) sooner than prescribed or if I suddenly stop taking my medication(s), that I could have opiate withdrawal symptoms that can be very painful and life threatening.

Female patients only: I understand that there are both known and unknown risks/ hazards to an unborn infant if the mother takes opiate medication(s). The risks/hazards include but are not limited to opiate addiction of the infant with opiate withdrawal after birth.

I assume full responsibility for notifying my provider if I suspect or confirm that I am pregnant. I further understand that a different plan of treatment, without the use of opiates, will be tried during pregnancy.

Terms/Agreements

This opiate agreement is contingent on compliance with ALL of the following patient and provider terms:

- Only one pharmacy will be used at any one time for filling my opiate prescriptions. The selected pharmacy is: _____
- I agree to receive opiate medication prescriptions ONLY from the providers at Provider Partners of America (hereinafter "PPOA")
- In order to obtain a refill for opiate medication(s), I understand that an appointment must be scheduled with the provider. I further understand that it is my responsibility to sure that I have enough medication to last through the weekend, holiday and/or after hours (**5pm- 8 am**).
- I understand PPOA does not accept telephone requests for opiate prescriptions and I must be seen at my regularly scheduled appointment with the provider to receive an opiate prescription.

Patient Initials: _____

Date: / /



Opiate Agreement

In the case of another provider(s) on-call after hours, on holidays, and/or on weekends, he/she will **NOT** refill my medication(s). It has been explained to me that they may not have charts available for review to make decisions regarding medications.

- I agree to be under the care of a primary care provider. I will inform PPOA if I change my primary care provider. My primary care provider is _____
- I hereby authorize a release of information that allows the providers(s) and/or staff to communicate and collaborate with any other health care provider in my care.
- I understand that at PPOA there are many different professionals on staff who work together with a team approach to treatment plan and progress, and I give permission for the team to discuss my treatment plan and progress.
- I will notify PPOA immediately if I experience medication side effects.
- I understand that if a serious issue effect occurs after hours, on a holiday or during the weekend, that I should immediately seek Emergency assistance from the nearest hospital.
- Prescription dosage(s) have been thoroughly explained to me by my provider and I understand that I SHALL NOT change dosage amounts and/or alter the time schedule of the prescribed medication(s) without directions to do so by my provider.

I understand that opiate medications(s) should be kept in a safe place at all times and that I am responsible for the security of my medication. It has been thoroughly explained to me that the policy does not allow for replacement of misplaced, spilled, inaccessible, or lost opiate medication(s) or prescription (s). I understand that if my medication(s) or prescriptions(s) are stolen that I must deliver a police report to my provider and they will contact the police for verification of the report. A second event such as above may lead to termination of this Agreement.

- I understand the benefits of opiate medications will be evaluated regularly using the following criteria:
 - Increase in general level of functioning, increase in life activities, decrease in the intensity of pain, absence of unacceptable or intolerable adverse side effects, and improvement in mood.
- I agree to participate in psychotherapy sessions and psychological testing as deemed appropriate by my provider and/or the team of health care provider(s).
- I agree to submit a random urine and or/blood screens for other medications and drugs.
- I have been given information about the use of opiate medication, including possible risks and adverse side effects such as the development of tolerance, dependence, addiction, and withdrawal and after thoroughly reviewing the information; I believe the benefits will be greater than the risks.
- I will not hoard or alter opiate prescription.
- I will not drink alcohol within 24-48 hours of taking opiate medication(s).
- I understand that a nurse may notify me of noted violations to this agreement and such notification will be considered appropriate violations in the agreement may result in Opiate Treatment Monitoring for six (6) months.
- I agree to allow PPOA to contact other pharmacies to discuss my medications.

Patient Initials: _____

Date: / /



Opiate Agreement

Opiate Treatment Monitoring:

During this period, I understand that I might have my opiate medication discontinued at any time for any reason, per a decision by my provider and the health care team. Upon notification of such discontinuance, I will be provided with a 30 day supply of appropriate medication(s). I further understand that during this period, I might be referred to an addiction specialist or to a drug detoxification program. In addition, I also realize that I might be immediately referred to an inpatient drug detoxification program and NO further medication will be provided. I attest to the following (initial below):

- _____ I am not using illegal drugs or prescription drugs prescribed for someone other than myself.
- _____ I (**am/am not**) not undergoing treatment for substance (drugs or alcohol) dependence or abuse.
- _____ I have never been involved in the sale, illegal possession, or transport of drugs.

(Female only) I am not pregnant and I will inform the medical staff at PPOA if I become pregnant or intend to become pregnant. I understand there may be harmful effects on an unborn infant if I take opiate medication(s). **(Initial below).**

- _____ An opiate information form was provided.
- _____ I have read or had it read to me
- _____ I understand the possible side effects and complications of opiate therapy.

Release

I release my provider, the team of health care providers, the team of health care providers, and PPOA from liability for any medical and social conditions or consequences related to opiate medication(s) therapy and/or discontinuance of opiate medication(s).

Acknowledgement/Agreement

I hereby acknowledge that the content of this agreement has been explained to me. In addition, I have either read the agreement or had it read to me. I was offered many opportunities to ask questions and discuss any unclear aspects of this Agreement.

I acknowledge that I fully understand that my failure to comply with any term(S) set forth within this agreement will result in a termination of this agreement and possibly of my care and medications at PPOA.

Patient Signature & Date: _____

Provider Signature & Date: _____

Witness Signature & Date: _____

Patient Initials: _____

Date: / /



Opioid Risk Tool (ORT)

Questionnaire developed by Lynn R. Webster, MD to assess risk of opioid addiction.

MARK EACH BOX THAT APPLIES	FEMALE	MALE
FAMILY HISTORY OF SUBSTANCE ABUSE		
Alcohol	<input type="checkbox"/> 1	<input type="checkbox"/> 3
Illegal drugs	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Rx drugs	<input type="checkbox"/> 4	<input type="checkbox"/> 4
PERSONAL HISTORY OF SUBSTANCE ABUSE		
Alcohol	<input type="checkbox"/> 3	<input type="checkbox"/> 3
Illegal drugs	<input type="checkbox"/> 4	<input type="checkbox"/> 4
Rx drugs	<input type="checkbox"/> 5	<input type="checkbox"/> 5
AGE BETWEEN 16–45 YEARS	<input type="checkbox"/> 1	<input type="checkbox"/> 1
HISTORY OF PREADOLESCENT SEXUAL ABUSE	<input type="checkbox"/> 3	<input type="checkbox"/> 0
PSYCHOLOGIC DISEASE		
ADD, OCD, bipolar, schizophrenia	<input type="checkbox"/> 2	<input type="checkbox"/> 2
Depression	<input type="checkbox"/> 1	<input type="checkbox"/> 1
SCORING TOTALS		

ADMINISTRATION

- On initial visit
- Prior to opioid therapy

SCORING (RISK)

- 0–3: low
- 4–7: moderate
- ≥8: high

Patient Initials: _____

Date: / /



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Patient Name: _____ Date: _____

Ordering Provider: _____

The following are some questions given to patients who are on or being considered for medication for their pain. Please answer each question as honestly as possible. There are no right or wrong answers.

SOAPP®-R <small>Source: http://www.opioidrisk.com/node/1209</small>	Patient Score: _____ Tech Initials: _____	Never	Seldom	Sometimes	Often	Very Often
		0	1	2	3	4
1. How often do you have mood swings?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. How often have you felt a need for higher doses of medication to treat your pain?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. How often have you felt impatient with your doctors?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. How often have you felt that things are just too overwhelming that you can't handle them?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. How often is there tension in the home?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. How often have you counted pain pills to see how many are remaining?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. How often have you been concerned that people will judge you for taking pain medication?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. How often do you feel bored?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. How often have you taken more pain medication than you were supposed to?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. How often have you worried about being left alone?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. How often have you felt a craving for medication?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. How often have others expressed concern over your use of medication?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. How often have any of your close friends had a problem with alcohol or drugs?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. How often have others told you that you had a bad temper?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. How often have you felt consumed by the need to get pain medication?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. How often have you run out of pain medication early?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. How often have others kept you from getting what you deserve?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. How often, in your lifetime, have you had legal problems or been arrested?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. How often have you attended an AA or NA meeting?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. How often have you been in an argument that was so out of control that someone got hurt?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. How often have you been sexually abused?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. How often have others suggested that you have a drug or alcohol problem?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. How often have you had to borrow pain medications from your family or friends?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. How often have you been treated for an alcohol or drug problem?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Has any relative had a problem with the following? Circle Y/N for each.

- Alcohol? Y / N
- Addiction? Y / N
- Mental Illness? Y / N

Patient Initials: _____

Date: / /



Consent to Receive Text Message Appointment Reminders

I _____ authorize Physician Partners of America (PPOA) and its affiliates to contact me by automated SMS text message for appointment reminders.

I understand that message/data rates may apply to messages sent by PPOA or its affiliates under my cell phone plan.

My text/mobile number is: (_____) _____ Patient Initials _____

I know that I am under no obligation to authorize PPOA or its affiliates to send me text messages. I may opt out of receiving these communications at any time by calling the Services desk at _____

I understand that text messaging is not a secure form of communication. There is some risk that individually identifiable health information or other sensitive or confidential information contained in such text may be misdirected, disclosed to or intercepted by unauthorized third parties. Information included in text messages may include your first name, date and time of your appointment, name of physician, and physician phone number, or other pertinent information.

Signature: _____

By signing below, I authorize my doctor and staff team members to access my prescribed medication list through the pharmacy database, which will help my to provider deliver comprehensive care to me.

Signature: _____

Date: _____ **Date of Birth:** _____

Patient Initials: _____

Date: / /



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Financial Responsibility

I understand that insurance billing is a service provided as a courtesy and that I am at all times financially responsible to Physician Partners of America (hereinafter “PPOA”) and/or its affiliated entities, for any charges not covered by my healthcare benefits. It is my responsibility to notify PPOA of any changes in my healthcare coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill and/or balance of the bill as determined by PPOA and/or my healthcare insurer, if the submitted claims or any part of the claim are denied for payment. I understand that by signing this form, I am accepting financial responsibility as explained above, for all payment for medical services and/or supplies received.

Assignment of Benefits

I authorize direct remittance of payment of all insurance benefits, including Medicare if I am a Medicare beneficiary, to PPOA for all covered medical services and supplies provided to me during all courses of treatment. This includes care provided by PPOA and/or its affiliated entities or otherwise at its discretion. I understand and agree this Assignment of Benefits will constitute a continuing authorization, maintained on file with PPOA, which will authorize and allow for direct payment to PPOA, of all applicable and eligible insurance benefits for all subsequent and continuing treatment, services, supplies and/or care provided to me by PPOA.

Ownership Disclosure

I understand that PPOA is a physician-owned medical practice comprised of the offices of primary care providers, specialty care providers, and associated ancillary services. These ancillaries include, but may not be limited to, laboratory, pathology, radiology/diagnostic, physical therapy, pharmacy, and ambulatory surgery center services. During the course of my care, I may be referred to one or more of these ancillary departments. I have the right to choose where to receive these services, and I understand that I am not obligated to receive these services at a PPOA ancillary department.

Printed Name of Patient

Name of Guardian/Personal Representative

Signature of Patient

Signature of Guardian or Personal Representative

Patient Initials: _____

Date: / /