



Account Number \_\_\_\_\_

<b>PATIENT INFORMATION</b>	<p><b>Patient Name:</b> _____  <div style="display: flex; justify-content: space-between; font-size: small;"> <span>Last</span> <span>First</span> <span>MI</span> <span>Salutation</span> </div> </p> <p>SSN: _____ DOB: ____/____/____ Sex: <input type="checkbox"/> M <input type="checkbox"/> F</p> <p>Address: _____ Marital Status: <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W</p> <p>City: _____ State: _____ ZIP: _____</p> <p>Home Phone: (____) ____-____ Cellular: (____) ____-____</p> <p>Email (optional): _____</p> <p><input type="checkbox"/> Yes, I wish to receive PRHS's exclusive monthly newsletter and future news announcements via email. I understand I can unsubscribe at any time.</p> <p><b>Employer:</b> _____ Work Phone (____) ____-____</p> <p>Address: _____ Occupation/Position: _____</p> <p>City: _____ State: _____ ZIP: _____</p> <p><b>Responsible Party:</b> Relation to Patient (Check one): <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Parent <input type="checkbox"/> Other</p> <p>Name: _____ Phone: (____) ____-____</p> <p>SSN: _____ DOB: ____/____/____ Sex: <input type="checkbox"/> M <input type="checkbox"/> F</p> <p>Employer: _____ Work Phone: (____) ____-____</p>
<b>INSURANCE INFORMATION</b>	<p><b>Primary Insurance:</b> _____ <b>Secondary Insurance:</b> _____  <small>(Personal Insurance if Primary is Worker's Comp or Auto)</small></p> <p>Policy #: _____ Policy #: _____</p> <p>Group #: _____ Group #: _____</p> <p>Is the patient the subscriber to this policy?  <input type="checkbox"/> YES <input type="checkbox"/> NO (If NO, please complete below)      <input type="checkbox"/> YES <input type="checkbox"/> NO (If NO, please complete below)</p> <p>Subscriber's Name: _____ Subscriber's Name: _____</p> <p>Subscriber's DOB: _____ Subscriber's DOB: _____</p> <p>Relation to patient: _____ Relation to patient: _____</p>
<b>INJURY INFORMATION</b>	<p>My condition is related to (Check one): <input type="checkbox"/> Work <input type="checkbox"/> Auto <input type="checkbox"/> Sports <input type="checkbox"/> Other <input type="checkbox"/> None</p> <p>Date of Injury/Accident/Onset: ____/____/____ Injury Area: _____</p> <p>Referring Doctor: _____ Primary Doctor: _____</p> <p>Diagnosis: _____</p>
	<p><b>EMERGENCY CONTACT:</b></p> <p>Name: _____ Phone: (____) ____-____ Relation: _____</p>



Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_

Occupation: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

**What is the condition for which you are seeking treatment and how did it occur? If you had recent surgery please list date and type of surgery?** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**What are the chief complaints that you are experiencing due to your injury and the severity?**

**Check all that are appropriate**

	None	Minimal	Moderate	Severe
Awakened by pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Current pain level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty Falling Asleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty finding a comfortable position	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Function	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of motion (stiffness)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain with work activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weakness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Are you experiencing pain?** Yes  No

**Please rate your pain today on a scale of 0 to 10? 0 = no pain, 10 = worst possible pain? \_\_\_\_\_**

**Where is your pain located and how would you describe it?** \_\_\_\_\_  
 \_\_\_\_\_

**Please list any contraindications to treatment or precautions that we should know:** \_\_\_\_\_  
 \_\_\_\_\_

**Prior to the onset of your current symptoms and since your symptoms began, what percentage of the following activities were you able to complete?**

Activities of Daily Living      \_\_\_\_\_% prior to onset      \_\_\_\_\_% since symptoms began  
 Recreation/Sports activities      \_\_\_\_\_% prior to onset      \_\_\_\_\_% since symptoms began  
 Work Activities      \_\_\_\_\_% prior to onset      \_\_\_\_\_% since symptoms began

## PAST MEDICAL HISTORY

Patient Name: \_\_\_\_\_

### Previous Surgeries

When (if not sure, list approximate date)	Type of Surgery

### History of Fractures

When (if not sure, list approximate date)	Area of Fracture

### Diagnostic Testing

Type	Date	Details/Findings
Blood Work		
Bone Density		
CT scan		
EEG		
EMG		
MRI		
Nerve Conduction Test		
X ray		
Other		

Have you seen any specialist for your current condition:  Yes  No If so please list below:

Type	Date	Name

**Medical Conditions – Please check all that you have or have had in the past**

<input type="checkbox"/> Allergies	<input type="checkbox"/> Dizziness	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Current Nausea/Vomiting	<input type="checkbox"/> Rheumatoid Arthritis
<input type="checkbox"/> Asthma	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Joint Replacement	<input type="checkbox"/> Osteoarthritis	<input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> Bowel Dysfunction	<input type="checkbox"/> Headaches	<input type="checkbox"/> Malaise/Fatigue	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Substance Abuse
<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart Condition	<input type="checkbox"/> Mental/Cognitive Disorder	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Syncope/Fainting
<input type="checkbox"/> Diabetes	<input type="checkbox"/> History of Smoking	<input type="checkbox"/> Metal Implants	<input type="checkbox"/> Pregnancy	<input type="checkbox"/> Weight Change

Other: \_\_\_\_\_

**Medications – Please select all medications that you are currently taking**

<input type="checkbox"/> Acetaminophen (Tylenol)	<input type="checkbox"/> Allergy Medications	<input type="checkbox"/> Antibiotics	<input type="checkbox"/> Antidepressants
<input type="checkbox"/> Aspirin/Anti-Coagulants	<input type="checkbox"/> Cardiac(Heart) Medication	<input type="checkbox"/> Cholesterol Medication	<input type="checkbox"/> Diabetic Medication
<input type="checkbox"/> GI Medications	<input type="checkbox"/> Blood Pressure Medication	<input type="checkbox"/> Ibuprofen (Advil, Motrin)	<input type="checkbox"/> Muscle Relaxer
<input type="checkbox"/> Anti-inflammatories	<input type="checkbox"/> Osteoporosis Medication	<input type="checkbox"/> Pain Medication	<input type="checkbox"/> Steroids

Other: \_\_\_\_\_

Hospitalization and Prior Care		
Type	Name of Facility	Discharge Date
Recent Hospitalization		
Recent Skilled Nursing Care		
Recent Home Health Care		
Recent Outpatient Physical Therapy		

**\*If you have received outpatient physical therapy or Chiropractic care this year, how many visits did you attend? \_\_\_\_\_**

**Social History**

Current Smoker     Yes     No    Packs/day \_\_\_\_\_    Years Smoking \_\_\_\_\_

Previous Smoker     Yes     No    Years Smoke Free \_\_\_\_\_    Years Smoked \_\_\_\_\_

Alcohol                     Often     Occasionally     Never

Recreational Drugs     Often     Occasionally     Never

Living Situation     House  Apartment  Stairs in Home  Alone     Family/Roommate

Are you currently working?     Yes     No

If so is it?                     Full Time  Part Time  Full Duty  Restricted Duty

**What are your goals and what do you expect to achieve from treatment?** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Patient Name: \_\_\_\_\_ Account #: \_\_\_\_\_

**PHOENIX REHABILITATION AND HEALTH SERVICES, INC. FINANCIAL POLICY**

We would like to **THANK YOU** for choosing PHOENIX Rehabilitation and Health Services, Inc. PHOENIX Rehabilitation and Health Services, Inc. accepts third party payments and will submit your bills for treatment to the address provided as a courtesy to you. In order for us to bill your insurance company on a regular basis, we request that you sign this release of information and assignment of benefits (if applicable). Typically, insurances pay a predetermined amount of our treatment charges; however it is your responsibility to call your insurance company to check on the coverage provided by your individual policy. As a courtesy to you, we will perform an insurance verification with your insurance company; however we will not take responsibility for any misinformation that we are given during this process. Therefore, it is within your best interest to verify your outpatient benefits with your individual insurance plan and to confirm them with our office prior to initiating treatment

**CONSENT FOR CARE AND TREATMENT**

I hereby give written consent for the provision of treatment. I authorize PHOENIX Rehabilitation and Health Services, Inc. to furnish treatment which is considered necessary and proper in diagnosing or treating my physical condition

**INITIALS** \_\_\_\_\_

**FINANCIAL RESPONSIBILITY**

I understand that in some instances the applicable insurance may not cover all treatment charges incurred. I agree to be financially responsible to PHOENIX Rehabilitation and Health Services, Inc. for any medically necessary therapeutic services that are deemed uncovered by my insurance policy.

**INITIALS** \_\_\_\_\_

**ASSIGNMENT OF BENEFITS**

I hereby authorize payment directly to PHOENIX Rehabilitation and Health Services, Inc. any benefits payable to me and/or my qualified dependents under the insurance coverage or Major Medical provisions of insurance coverage identified on bills submitted by PHOENIX Rehabilitation and Health Services, Inc. for treatment.

**INITIALS** \_\_\_\_\_

**CO-PAYMENTS**

I understand that if my insurance plan requires a co-payment for treatment, my co-payment will be collected at the time of my visit. A surcharge may be applied in order to collect late co-payments. This surcharge will cover expenses incurred by PHOENIX Rehabilitation and Health Services, Inc. to generate additional bills and/or utilize collection services.

**INITIALS** \_\_\_\_\_

**LITIGATION ACCOUNTS**

I understand that PHOENIX Rehabilitation and Health Services, Inc. will directly bill my appropriate insurance; however I am responsible for the payment of my treatment, not the entity being sued. Liability action against someone else will not enable me to refuse payment to PHOENIX Rehabilitation and Health Services, Inc.

**INITIALS** \_\_\_\_\_

**ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES & AUTHORIZATION**

I hereby acknowledge that I have received a copy of PHOENIX Rehabilitation and Health Services, Inc.'s Notice of Privacy Practices. I also understand that additional copies of this Notice are available for my review upon request. By way of my signature below, I provide PHOENIX Rehabilitation and Health Services, Inc. with my authorization and consent to use and disclose my protected health information for the purposes of treatment, payment and health care operations as described in the Notice of Privacy Practices

**INITIALS** \_\_\_\_\_

**CERTIFICATION OF IDENTITY**

I certify that I am in fact the individual I claim to be. I understand that the knowing and willful use of another individual's personal identifying information under false pretenses is a criminal offense.

**INITIALS** \_\_\_\_\_

**I ACKNOWLEDGE THAT I READ AND UNDERSTAND ALL COMPONENTS OF THE PHOENIX REHABILITATION AND HEALTH SERVICES INC. FINANCIAL POLICY AS STATED ABOVE.**

\_\_\_\_\_  
**Signature of Patient or Guardian (if patient is a minor)**

\_\_\_\_\_  
**Date**

**FOR PHOENIX REHABILITATION AND HEALTH SERVICES INC. OFFICE USE ONLY  
PHOENIX REHABILITATION AND HEALTH SERVICES INC. VERIFICATION OF IDENTITY**

I certify that I have verified the identity of the above named party; verification of identity was made by:

- Health Insurance Card that is current  Driver's License or other Photo ID that is current
- Utility bill or other correspondence showing current residence if the Photo ID does not display the patient's current address

\_\_\_\_\_  
**Signature of PHOENIX Rehabilitation and Health Services Inc. Representative**

\_\_\_\_\_  
**Date**



# Welcome Patient Survey

*Thank you for choosing PHOENIX for your rehabilitation. We're glad you're here!  
To help us reach others in our communities, please tell us...*

Email Address (optional): \_\_\_\_\_

- Yes, I wish to receive PHOENIX's exclusive monthly e-newsletter and future news announcements via email.  
I understand I can unsubscribe at any time.

**Do you have a medical prescription (or referral) for therapy? YES or NO**

**Which of these applies or may have influenced your decision to choose PHOENIX?**

**Please check all that apply.**

**PHOENIX was recommended by my medical provider.**

- ◆ My doctor said specifically I should go to PHOENIX.
- ◆ My doctor's staff (physician assistant, nurse, front office) recommended I go to PHOENIX.
- ◆ I chose from list of therapy providers given to me by my doctor or staff personnel.

**PHOENIX was recommended by my employer.**

- ◆ PHOENIX is listed on our Medical Panel of Providers.
- ◆ I was referred by an Occupational Health doctor.
- ◆ I was directed by a rehab nurse or case manager assigned to my work injury claim.

Please list employer or person overseeing your care: \_\_\_\_\_

**I found PHOENIX on-line on via the web.**

- A. I did an internet search for physical or occupational therapy providers in my area. (i.e. Google, Yahoo, Bing, etc.)
- B. I visited the PHOENIX website (www.phoenixrehab.com)
- C. I searched for a therapist on the APTA or AOTA website.
- D. I found PHOENIX via a social networking site or online community (i.e. Facebook, Twitter, LinkedIn, etc.)

Please list the web/internet method(s) you used (mark A, B, C or D): \_\_\_\_\_

**I came to PHOENIX because of a public relations opportunity.**

- ◆ I attended a social or business-related function at PHOENIX (i.e. open house, chamber mixer, etc.)
- ◆ I visited a PHOENIX exhibit/booth during a trade show (i.e. health fair, business expo)

**I came to PHOENIX on recommendation made by another person.**

- ◆ PHOENIX was recommended to me by a friend or family member.

**I am a former patient.**

- ◆ I came back because I am a former patient of PHOENIX (this location or other.)

**I came to PHOENIX because of convenience.**

- ◆ This PHOENIX office is conveniently located to my home or place of work.
- ◆ This PHOENIX office offers convenient appointment hours.

**I came to PHOENIX because of an advertisement.**

- A. I saw an advertisement or listing in the yellow pages or telephone directory.
- B. I saw an advertisement in the newspaper or other print publication.
- C. I received a promotional piece in the mail or by email.
- D. I read about PHOENIX on a brochure or flyer displayed in my community.

Please list the advertisement(s) you saw (mark A, B, C or D): \_\_\_\_\_

**I came to PHOENIX simply because—**

- A. I noticed the PHOENIX sign(s) outside the office.
- B. PHOENIX offered a specialty service (i.e. aquatic therapy, vestibular rehab, certified hand therapy, etc.)
- C. I was directed by my insurance carrier.
- D. I was directed by my attorney.
- E. I am an acquaintance of a PHOENIX staff member.

Please list the specific reason(s) (mark A, B, C, D or E): \_\_\_\_\_



## Acknowledgement of Receipt of Privacy Notice

### Purpose of this Acknowledgement

This Acknowledgement, which allows the Practice to use and/or disclosure personally identifiable health information for treatment, payment or healthcare operations, is made pursuant to the requirements of 45 CFR §164.520(c)(2)(ii), part of the federal privacy regulations for the Health Insurance Privacy and Accountability Act of 1996 (the "Privacy Regulations").

*Please read the following information carefully:*

1. I understand and acknowledge that I am consenting to the use and/or disclosure of personally identifiable health information about me by PHOENIX Rehabilitation and Health Services, Inc. (the "Practice") for the purposes of treating me, obtaining payment for treatment of me, and as necessary in order to carry out any healthcare operations that are permitted in the Privacy Regulations.
2. I am aware that the Practice maintains a Privacy Notice which sets forth the types of uses and disclosures that the Practice is permitted to make under the Privacy Regulations and sets forth in detail the way in which the Practice will make such use or disclosure. By signing this Acknowledgement, I understand and acknowledge that I have received a copy of the Privacy Notice.
3. I understand and acknowledge that in its Privacy Notice, the Practice has reserved the right to change its Privacy Notice as it sees fit from time to time. If I wish to obtain a revised Privacy Notice, I need to send a written request for a revised Privacy Notice to the office of the Practice at the following address: 520 Philadelphia St., Indiana PA 15701, Attention: Compliance Officer
4. I understand and acknowledge that I have the right to request that the Practice restrict how my information is used or disclosed to carry out treatment, payment or healthcare operations. I understand and acknowledge that the Practice is not required to agree to restrictions requested by me except in very limited circumstances as described in the Privacy Notice, but if the Practice agrees to such a requested restriction it will be bound by that restriction until I notify it otherwise in writing.

I request the following restrictions be placed on the Practice's use and/or disclosure of my health information (leave blank if no restrictions):

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I understand the foregoing provisions, and I wish to sign this Acknowledgement authorizing the use of my personally identifiable health information for the purposes of treatment, payment for treatment and healthcare operations.

**BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE REVIEWED AN EXECUTED COPY OF THIS ACKNOWLEDGEMENT AND A COPY OF THE PRACTICE'S POLICY NOTICE AND AGREE TO THE PRACTICE'S USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS.**

\_\_\_\_\_  
Signature of Patient or Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Name of Personal Representative (if applicable)

\_\_\_\_\_  
Relationship to Patient

### To Be Completed by the Practice

The requested restrictions on the use and/or disclosure of the patient's health information set forth above are:

\_\_\_\_\_ Accepted      \_\_\_\_\_ Denied      \_\_\_\_\_ Not Applicable

\_\_\_\_\_ Other (explain) \_\_\_\_\_

\_\_\_\_\_  
Signature of Authorized Practice Representative

\_\_\_\_\_  
Date

**AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION  
PHOENIX REHABILITATION AND HEALTH SERVICES, INC.**

**Patient Name:** \_\_\_\_\_

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

**Date of Birth:** \_\_\_\_\_ **Date of Request:** \_\_\_\_\_

As required by the Privacy Regulations, **PHOENIX Rehabilitation and Health Services, Inc.** may not use or disclose your protected health information except as provided in our Notice of Privacy Practices without your authorization.

I hereby authorize this office and any of its employees to use or disclose my protected health information to the following person(s), entity(s), or business associates of this office:

**Employer/HR, Adjustor, Nurse case manager, Referring physician, Specialist(s), Attorney (if appropriate).**

Protected health information authorized to be disclosed:

**Initial evaluations, Clinical daily documentation, Home exercise program, Re-evaluations, Progress reports, Discharge summary, Scripts and Appointment status.**

For the specific purpose of (describe in detail):

**To receive a written job description (for WC) from the employer and review required job capabilities for full duty work.**

**Effective dates** for this authorization: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ through \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

This authorization will expire at the end of the above period.

I understand that the information disclosed above may be again disclosed to additional parties and is no longer protected.

**I understand I have the right to:**

1. Revoke this authorization by sending written notice to PHOENIX Rehabilitation and Health Services, Inc. and that revocation will not affect PHOENIX Rehabilitation and Health Services, Inc.'s previous reliance on the uses or disclosures pursuant to this authorization.
2. Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization and as a result of this authorization.
3. Inspect a copy of my protected health information being used or disclosed under federal law.
4. Refuse to sign this authorization.
5. Receive a copy of this authorization.
6. Restrict what is disclosed with this authorization.

I also understand that if I do not sign this document, it will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits whether or not I provide authorization to use or disclose protected health information.

\_\_\_\_\_  
**Signature of Patient or Patient's Authorized Representative**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Authorized Facility Signature**

\_\_\_\_\_  
**Date**





Patient Name: \_\_\_\_\_  
 Account #: \_\_\_\_\_

**PATIENT INFORMATION BROCHURE**

Welcome to PHOENIX Rehabilitation and Health Services, Inc. We are anxious to rise to your physical, occupational, and/or speech therapy needs. Please review this informational brochure thoroughly and keep it on hand for the duration of your care with us. Please allow the information below to help make your PHOENIX rehabilitation experience a smooth and successful journey!

**CLINIC LOCATION & OFFICE HOURS**

ADDRESS	
CITY, STATE, ZIP	
OFFICE PHONE	
FAX	
THERAPIST	
OFFICE HOURS	

**TIMELINESS**

All patients are expected to arrive to their scheduled therapy appointments on time.

**CANCELLATION NOTICE**

Please contact our office at least 24 hours in advance if you need to cancel a scheduled appointment.

**NO-SHOWS**

If you fail to show up for 3 scheduled appointments or cancel an excessive number of times, your treatment may be discontinued and your referring physician will be notified.

**PROPER ATTIRE FOR PHYSICAL THERAPY**

Please wear appropriate and comfortable clothing to your physical therapy sessions. Proper attire should enable your therapist to view and access the involved area as well as allow you to maneuver in the gym without restriction. For your safety, athletic shoes are recommended, unless your medical condition interferes with your ability to wear this type of footwear.

**HOME EXERCISE PROGRAM COMPLIANCE**

Your therapist will design & educate you on an appropriate home exercise program for your physical condition. In order to obtain maximal benefits from your therapy experience, you are expected to comply with your therapist's recommendations for your home program. You should inform your therapist immediately of any activities which seem helpful or detrimental to your condition or any changes in your symptoms.

**DOCTOR'S APPOINTMENTS**

Please remind us of the date of your next doctor's appointment so that we can prepare the necessary communication for your physician.

**BILLING QUESTIONS/CONCERNS**

At any point during or after your care with PHOENIX, if you have Billing questions or concerns you can contact the clinic in which you were seen at or our PHOENIX Business Office directly @ (888)644-PRHS.

**YOUR INSURANCE BENEFITS**

As a courtesy to you, we have verified your individual insurance benefits for outpatient physical, occupational, and/or speech therapy to be:

INSURANCE COMPANY	
CONTACT PERSON	
INSURANCE COVERAGE	
CO-INSURANCE	
DEDUCTIBLE	
CO-PAYMENT	
MAX or LIMITS TO COVERAGE	
OTHER DETAILS	

It is within your best interest to confirm the above benefits with your insurance company prior to beginning therapy; the insurance verification listed above does not guarantee the accuracy of the information.

PHOENIX Rehabilitation and Health Services, Inc. ensures quality care for all of its patients. We want you to have an optimal healthcare experience at our clinic. Should you have any questions or concerns, please call our office immediately. My signature below acknowledges receipt of the above listed information.

\_\_\_\_\_

Patient Signature
Date
PRHS Representative Signature

**RISE TO OUR PATIENTS' NEEDS...**