THE MURPHY CLINIC

PATIENT INFORMATION

LAST NAME: _____

FIRST NAME: _____ MI: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE: _____

DOB: _____/_____/_____ AGE: _____ SEX: ❑ M ❑ F

SOCIAL SECURITY NUMBER: _____ - _____ - _____

EMAIL ADDRESS: _____

EMPLOYMENT STATUS: ❑ STUDENT ❑ FULL-TIME ❑ PART-TIME ❑ DISABLED ❑ UNEMPLOYED ❑ RETIRED

EMPLOYER: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

WORK PHONE: _____

RACE: _____ ETHNICITY: _____

LANGUAGE: _____

MARITAL STATUS: ❑ MARRIED ❑ SINGLE ❑ DIVORCED ❑ WIDOWED

DO YOU HAVE AN ADVANCE DIRECTIVE? ❑ YES ❑ NO

WOULD YOU LIKE TO ENROLL IN THE ONLINE PATIENT PORTAL? ❑ YES ❑ N

IF NEEDED, MAY WE:

LEAVE A MESSAGE AT HOME? ❑ YES ❑ NO
LEAVE A MESSAGE ON CELL? ❑ YES ❑ NO
LEAVE A MESSAGE AT WORK? ❑ YES ❑ NO
TEXT MESSAGE TO YOUR CELL? ❑ YES ❑ NO

EMERGENCY CONTACT

NAME: _____

RELATIONSHIP: _____

HOME PHONE: _____ CELL PHONE: _____

INSURANCE INFORMATION

RESPONSIBLE PARTY: _____

RELATIONSHIP: _____ DOB: ____/____/_____

• PRIMARY INSURANCE: _____

POLICY #: _____ GROUP #: _____

• SECONDARY INSURANCE: _____

POLICY #: _____ GROUP #: _____

How did you hear about us? _____

For medical & diagnostic treatment rendered to myself or dependents, I hereby authorize the following:

1. Consent to medical & diagnostic treatment by the providers of The Murphy Clinic, LLC.
2. Payment of authorized Medicare/Healthcare insurance benefits be made on my behalf to The Murphy Clinic, LLC for any services furnished to me.
3. Release of any information to obtain examination, treatment and/or payment.
4. My photograph will be taken.
5. Photocopies of this form are valid as the original.

Signature: _____ **Date:** _____

If not the patient, relationship to patient: _____

THE MURPHY CLINIC

INTERNAL MEDICINE, ADDICTION MEDICINE, ACUPUNCTURE & CONCIERGE PRACTICE

GENERAL CONSENT FOR CARE AND TREATMENT

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of Patient or Personal Representative	Date
Printed Name of Patient or Personal Representative	Relationship to Patient
Printed Name of Witness	Employee Job Title
Signature of Witness	Date

THE MURPHY CLINIC

INTERNAL MEDICINE, ADDICTION MEDICINE, ACUPUNCTURE & CONCIERGE PRACTICE

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information (protected health information) used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information. Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be billing your medical plan for your medical services.
- Health Care Operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer service. An example would include a periodic assessment of our documentation protocols, etc. In addition, your confidential information may be used to remind you of an appointment (by phone, text or email) or provide you with information about treatment options or other health related services including release of information to friends and family members that are directly involved in your care or who assist in taking care of you. We will use and disclose your protected information when we are required to do so by federal, state or local law. We may disclose your PROTECTED HEALTH INFORMATION to public health authorities that are authorized by law to collect information, to a health oversight agency for activities authorized by law included but not limited to: response to a court or administrative order, if you are involved in a lawsuit or similar proceeding, response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested. We will release your PROTECTED HEALTH INFORMATION if requested by a law enforcement official for any circumstance required by law. We may release your PROTECTED HEALTH INFORMATION to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

We may release PROTECTED HEALTH INFORMATION to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor. We may use and disclose your PROTECTED HEALTH INFORMATION when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat. We may disclose your PROTECTED HEALTH INFORMATION if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities. We may disclose your PROTECTED HEALTH INFORMATION to federal officials for intelligence and national security activities authorized by law. We may disclose PROTECTED HEALTH INFORMATION to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations. We may disclose your PROTECTED HEALTH INFORMATION to correctional institutions or law enforcement HIPAA/@Notice of Privacy Practices.doc officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals or the public. We may release your PROTECTED HEALTH INFORMATION for workers' compensation and similar programs. Any other uses and disclosures will be made only with your written

authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization. You have certain rights in regards to your PROTECTED HEALTH INFORMATION, which you can exercise by presenting a written request to our Privacy Officer at the practice address listed below.

- The right to request restrictions on certain uses and disclosures of PROTECTED HEALTH INFORMATION, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to request to receive confidential communications of PROTECTED HEALTH INFORMATION from us by alternative means or at alternative locations. The right to access, inspect and copy your PROTECTED HEALTH INFORMATION.
- The right to request an amendment to your PROTECTED HEALTH INFORMATION.
- The right to receive an accounting of disclosures of PROTECTED HEALTH INFORMATION outside of treatment, payment and health care operations.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your PROTECTED HEALTH INFORMATION and to provide you with notice of our legal duties and privacy practices with respect to PROTECTED HEALTH INFORMATION.

We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all PROTECTED HEALTH INFORMATION that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated.

For more information about HIPAA contact: The U.S. Department of Health & Human Services Office of Civil Rights 200 Independence Avenue, S.W. Washington, D.C. 20201.

To communicate with the Privacy Officer of The Murphy Clinic, LLC, address correspondence to:

Privacy Officer
The Murphy Clinic, LLC
350 Lakeview Court, Suite B
Covington, LA 70433

THE MURPHY CLINIC
INTERNAL MEDICINE, ADDICTION MEDICINE, ACUPUNCTURE & CONCIERGE PRACTICE

PATIENT HIPAA ACKNOWLEDGEMENT AND CONSENT FORM

Last Name	First Name	MI	Date of Birth

NOTICE OF PRIVACY PRACTICES

- _____ **(Patient/Representative initials)** I acknowledge that I have received the practice/clinic's Notice of Privacy Practice/ clinics, which describes the ways in which the practice/clinic may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice/clinic's Notice of Privacy Practice/clinics.

DISCLOSURE TO FRIENDS AND/OR FAMILY MEMBERS

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM? I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

Name	Relationship	Contact Number

Patient/Representative may revoke or modify this specific authorization and that revocation or modification must be in writing.

COMMUNICATION ABOUT MY HEALTHCARE

I agree the Provider or an agent of the Provider or an independent physician's office may contact me for the purposes of scheduling necessary follow-up visits recommended by the treating physician.

CONSENT FOR PHOTOGRAPHING OR OTHER RECORDING FOR SECURITY AND/OR HEALTH CARE OPERATIONS

I consent to photographs, digital or audio recordings, and/or images of me being recorded for patient care, security purposes and/or the practice's/clinic's health care operations purposes (e.g., quality improvement activities). I understand that the practice/clinic retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used outside the facility without a specific written authorization from me or my legal representative unless otherwise permitted or required by law.

CONSENT TO EMAIL, CELLULAR TELEPHONE, OR TEXT USAGE FOR APPOINTMENT REMINDERS AND OTHER HEALTHCARE COMMUNICATIONS:

If at any time I provide an email address or cellphone number at which I may be contacted, I consent to receiving non-secure instructions and other healthcare communications at the email or text address I have provided or you or you EBO Servicer have obtained, at any text number forwarded, or transferred from that number. These instructions may include, but not be limited to: post-procedure instructions, follow-up instructions, educational information, and prescription information. Other healthcare communications may include, but are not limited to, communications to family or designated representatives regarding my treatment or condition, or reminder messages to me regarding appointments for medical care. Note: You may opt out of these communications at any time. The practice/clinic does not charge for this service, but standard text messaging rates or cellular telephone minutes may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

RELEASE OF INFORMATION:

I hereby permit practice/clinic and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

- Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.
- If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.
- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

I certify that I have read and fully understand the above statements from all pages and consent fully and voluntarily to its contents.

Patient/Representative Signature	Relationship to Patient	Date

THE MURPHY CLINIC

INTERNAL MEDICINE, ADDICTION MEDICINE, ACUPUNCTURE & CONCIERGE PRACTICE

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT DEMOGRAPHICS

Printed Name: _____ Date of Birth: _____

Address: _____

_____

Social Security #_____ Telephone: _____

INFORMATION TO BE RELEASED: COVERING THE PERIODS OF HEALTH CARE:

From (date) _____ to_____

From (date) _____ to_____

PLEASE CHECK TYPE OF INFORMATION TO BE RELEASED:

____ Pertinent documentation	____ Operative Report	____ Lab Results	____ Complete Health Record
____ History and Physical	____ Consulting Reports	____ Progress Notes	____ EKG
____ Discharge Summary	____ X-Ray Reports	____ X-Ray Films / Images	____ EEG
____ Photographs, videotapes	____ Complete Billing File	____ Itemized Bill	____ All Records

____ Other, (specify)_____

PURPOSE OF REQUEST:

____ Treatment or Consultation	____ At the request of the patient	____ Billing or Claims payment
____ All	____ Other, (specify) _____	

I, THE UNDERSIGNED AUTHORIZE AND REQUEST THE MURPHY CLINIC, LLC:

____ **Release information to:** ____ **Obtain information from:**

Name: _____

Address: _____

DRUG AND/OR ALCOHOL ABUSE, AND/OR PSYCHIATRIC, AND/OR HIV/AIDS RECORDS RELEASE

I understand that my medical or billing record may contain information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease. Hepatitis B or C testing, HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment, and/or other sensitive information, I agree to its release.

TIME LIMIT & RIGHT TO REVOKE AUTHORIZATION:

Except to the extent that action has already been taken in reliance on the authorization, at any time I can revoke this authorization by submitting a notice in writing to the facility Privacy Officer at [350 Lakeview Court, Suite B Covington, LA 70433]. Unless revoked, this authorization will expire on the following date or event _____, or one year from the date of signature, unless otherwise specified.

RE-DISCLOSURE

I understand that once information is released to the above named person or persons, my information may be subject to re-disclose. I understand that I do not have to sign the authorization or payment for services will be denied if I do not sign this form unless it is for research-related treatments or provided solely to give information to a third party as specified under Purpose of Request. I can inspect or copy the protected health information to be used or disclosed. **I authorize The Murphy Clinic, LLC to use and disclose the protected health information specified above.**

I understand that if I authorize the release of Drug & Alcohol Abuse treatment records (such as from Center for Addictions) that those records are protected by Federal Law. The Authorization for Release of Information form does not authorize re-disclosure of medical information beyond the limits of this consent. Federal Law (42 CFR Part 2) for Alcohol/Drug abuse, prohibit information disclosed from records protected by this law from being re- disclosed, even to the patient, without the specific written consent of the patient or as otherwise permitted by such law and/or regulations. A general authorization for the release of medical or other information is NOT sufficient for these purposes. Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

_____ _____

Signature of Patient or Representative **Date**

_____ _____

Representative's Relation to Patient Expiration Date of Authorization

_____ _____

Signature of Witness Date

Updated August 26, 2019. A photocopy of this consent shall be considered as valid as the original.

THE MURPHY CLINIC

INTERNAL MEDICINE, ADDICTION MEDICINE, ACUPUNCTURE & CONCIERGE PRACTICE

MEDICAL HISTORY INFORMATION

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

Preferred Pharmacy: _____ **Location:** _____ **Phone:** _____

Drug Allergies: _____

MEDICATIONS

MEDICATION	DOSAGE

*If you need to list more medications, please write them on the back of this paper.

PERSONAL MEDICAL HISTORY

DISEASE / CONDITION	CURRENT	PAST	COMMENTS
Alcoholism or Abuse			
Drug Abuse or Addiction			
Asthma			
Cancer (Type:)			
Depression			
Anxiety			
Diabetes (Type:)			
COPD			
Heart Disease			
High Blood Pressure			
High Cholesterol			
Thyroid Disorder			
Kidney Disease			
Headaches			
Stroke			

SURGERIES

TYPE	DATE

FAMILY MEDICAL HISTORY

DX	Alcoholism/ Abuse	Asthma	Cancer	COPD	Depression	Drug Abuse/ Addiction	Early Death	Mental Illness	Heart Disease	High Cholesterol	High Blood Pressure	Stroke	Thyroid Disorder
Mom													
Dad													
Bro													
Sis													
Child													
MGM													
MGF													
PGM													
PGF													

SOCIAL HISTORY:

Occupation: _____

Marital Status: Married Single Divorced Widowed Other

Tobacco Use:

Never Smoker YES NO

Current Smoker YES NO If current smoker, how many packs do you smoke per day? _____

Former Smoker YES NO If yes, how long ago did you quit smoking? _____

Alcohol Use:

Do you drink? YES NO If yes, what is your preferred alcohol type? Beer Wine Liquor

Number of drinks per week? _____

REASON FOR TODAY'S VISIT:

_____

_____

_____

Are you having any symptoms TODAY? (Ex. fever, cough, headache, fatigue, dizziness, etc.)

_____

_____

_____

THE MURPHY CLINIC

INTERNAL MEDICINE, ADDICTION MEDICINE, ACUPUNCTURE & CONCIERGE PRACTICE

Narcotic Medication Agreement

Name:_____ **Date:** _____

You have agreed to receive narcotics as part of your treatment from The Murphy Clinic. It is important that you have an understanding of the risks and responsibilities that go along with this treatment. Please read each statement and sign this agreement/contract below. If you have any questions regarding this information or the office policy regarding the prescribing of narcotics, please request clarification.

I, _____understand that:

Any medical treatment is initially a trial, and that continued prescription is based on evidence of benefit. I understand that the goal of using narcotics is th decrease my symptoms and increase my functional level. If my symptoms do not significantly decrease and/or my function increase, the medication will be stopped.

I am aware that the use of such medicine has risks associated with it, including, but not limited to: sleepiness or drowsiness, constipation, nausea, itching, vomiting, lightheadedness, dizziness, confusion, allergic reaction, slowing of breathing rate, slowing of reflexes or reaction time, kidney or liver disease, sexual dysfunction, physical dependence, tolerance to analgesia, addiction, withdrawal and the possibility that the medicine will not provide complete relief.

The overuse of narcotic medication can result in serious health risks including respiratory depression or even death.

Medications will be strictly monitored and all of my medications should be filled at the same pharmacy. (Should the need arise to change pharmacies our office must be informed).

The pharmacy I have selected is:

_____

_____I will not call the office to have a prescription called in after office hours, on Fridays, weekends or holidays.

_____I am responsible for making and keeping scheduled appointments. Early refill requests will not be honored.

_____ I will take the narcotic medication only as prescribed. Any changes must first be discussed and agreed upon with The Murphy Clinic's providers.

(985) 200-1003 | 350 Lakeview Court, Ste B, Covington, LA 70433

Name_____ Date_____

_____ Medications will not be replaced for any reasons including if they are lost, get wet, are destroyed, stolen, etc. It is expected that you will take the highest possible degree of care with your medication and prescription. They should not be left where others might see or otherwise have access to them.

_____ I agree that only my physician at The Murphy Clinic will prescribed my narcotic medication unless it is authorized by us under limited circumstances. I will not obtain or use narcotics or other controlled substances from a source other than The Murphy Clinic for any changes or need for additional narcotic medications. If it is brought to the attention of The Murphy Clinic that other providers are prescribing medications for me, The Murphy Clinic reserves the right to discontinue prescribing medication and/or discharge me from the clinic.

_____ I will inform The Murphy Clinic's provider of any changes in my medical condition including pregnancy, any changes in any prescription and/or over the counter medication that I take and of any side effects that I may experience from any of the medications that I take.

_____ I agree to tell The Murphy Clinic provider my complete and honest personal drug/medication usage and history.

_____ I will not use any illegal "street drugs" while receiving medications from The Murphy Clinic.

_____ I will communicate fully and honestly with my physician about the character and intensity of my symptoms, the effect of the symptoms on my daily life, and how well the medicine is helping to relieve my symptoms.

_____ Routine blood work and drug screens or random pill counts may be a part of my treatment plan. I agree to have them done on the day the physician requests it.

_____ The prescribing physician has permission to discuss all diagnostic and treatment details with dispensing pharmacists or other professionals who provide my health care for purposes of maintaining accountability.

_____ If the responsible legal authorities have questions concerning my treatment , as might occur, for example, if I were obtaining medications at several pharmacies, all confidentiality is waived and these authorities may be given full access to my records.

____ It is a felony to obtain narcotic medications under false pretenses, forged or altered prescriptions. This could include getting medication from more than one doctor, misrepresenting myself to obtain medications, using them in a manner other than prescribed or diverting the medications in any other way (selling). These acts will be reported to law enforcement authority.

(985) 200-1003 | 350 Lakeview Court, Ste B, Covington, LA 70433

Name:_____ Date: _____

_____ I know that narcotic medications will be stopped if any of the following occurs:

- I trade, sell, or misuse the medication
- I have broken any part of this agreement
- I do not do a blood or urine test when asked
- My blood or urine test shows the presence of medications that our physician is not aware of, the presence of illegal drugs, or does not show medications that I am receiving a prescription for
- I get narcotics from sources other than The Murphy Clinic
- The Murphy Clinic provider feels that it is my best interest that narcotic treatment be stopped
- Any aggressive behavior or verbal abuse toward physician or staff
- I consistently miss scheduled appointments.

It is understood that failure to adhere to this agreement may result in cessation of therapy with controlled substance prescribing (no narcotic prescriptions will be written) by The Murphy Clinic.

I have read the Narcotic Medication Agreement and without question understand all of this agreement. By signing this agreement I affirm that I have read, understand and accept all of the terms of this agreement.

Patient signature: _____ Date: _____

Clinic Witness: _____ Date: _____

(985) 200-1003 | 350 Lakeview Court, Ste B, Covington, LA 70433