

Toole Family Dentistry, LLC

Patient Registration Form

Patient

First Name: _____

Last Name: _____

Middle Initial: _____

Date of Birth: _____ Age: _____

Social Security Number: _____

Driver's License Number: _____

Address: _____

Address 2: _____

City, State, Zip: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

(Please Check Preferred Number)

I would like to be contacted by **text message** regarding appointment notifications. *(Please Check)*

Email Address: _____

I would like to be contacted by **email** regarding appointment notifications. *(Please Check)*

Patient and Responsible Party are the same *(please check)*

If not the same please complete below

Responsible Party

Relationship to Insured:

Spouse

Child

Other

First Name: _____

Last Name: _____

Middle Initial: _____

Date of Birth: _____ Age: _____

Social Security Number: _____

Driver's License Number: _____

Address: _____

Address 2: _____

City, State, Zip: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

(Please Check Preferred Number)

Insurance Company: _____

Group #: _____

ID#: _____

Address: _____

Address 2: _____

City, State, Zip: _____

Phone #: _____

Employer: _____

Address: _____

Address 2: _____

City, State, Zip: _____

Phone #: _____

How did you hear about us? (check all that apply)

Neighborhood Source

Money Mailer

Seen from Street

Insurance Website

Personal Referral: Name: _____

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

- Are you under a physician's care now? Yes No If yes, please explain: _____
- Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: _____
- Have you ever had a serious head or neck injury? Yes No If yes, please explain: _____
- Are you taking any medications, pills, or drugs? Yes No If yes, please explain: _____
- Do you take, or have you taken, Phen-Fen or Redux? Yes No _____
- Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No _____
- Are you on a special diet? Yes No
- Do you use tobacco? Yes No
- Do you use controlled substances? Yes No

Women: Are you _____

- Pregnant/Trying to get pregnant? Yes No
- Taking oral contraceptives? Yes No
- Nursing? Yes No

Are you allergic to any of the following?

- Aspirin
- Penicillin
- Codeine
- Local Anesthetics
- Acrylic
- Metal
- Latex
- Sulfa drugs
- Other If yes, please explain: _____

Do you have, or have you had, any of the following?

- | | | | |
|--|--|--|---|
| AIDS/HIV Positive <input type="radio"/> Yes <input type="radio"/> No | Cortisone Medicine <input type="radio"/> Yes <input type="radio"/> No | Hemophilia <input type="radio"/> Yes <input type="radio"/> No | Radiation Treatments <input type="radio"/> Yes <input type="radio"/> No |
| Alzheimer's Disease <input type="radio"/> Yes <input type="radio"/> No | Diabetes <input type="radio"/> Yes <input type="radio"/> No | Hepatitis A <input type="radio"/> Yes <input type="radio"/> No | Recent Weight Loss <input type="radio"/> Yes <input type="radio"/> No |
| Anaphylaxis <input type="radio"/> Yes <input type="radio"/> No | Drug Addiction <input type="radio"/> Yes <input type="radio"/> No | Hepatitis B or C <input type="radio"/> Yes <input type="radio"/> No | Renal Dialysis <input type="radio"/> Yes <input type="radio"/> No |
| Anemia <input type="radio"/> Yes <input type="radio"/> No | Easily Winded <input type="radio"/> Yes <input type="radio"/> No | Herpes <input type="radio"/> Yes <input type="radio"/> No | Rheumatic Fever <input type="radio"/> Yes <input type="radio"/> No |
| Angina <input type="radio"/> Yes <input type="radio"/> No | Emphysema <input type="radio"/> Yes <input type="radio"/> No | High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No | Rheumatism <input type="radio"/> Yes <input type="radio"/> No |
| Arthritis/Gout <input type="radio"/> Yes <input type="radio"/> No | Epilepsy or Seizures <input type="radio"/> Yes <input type="radio"/> No | High Cholesterol <input type="radio"/> Yes <input type="radio"/> No | Scarlet Fever <input type="radio"/> Yes <input type="radio"/> No |
| Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No | Excessive Bleeding <input type="radio"/> Yes <input type="radio"/> No | Hives or Rash <input type="radio"/> Yes <input type="radio"/> No | Shingles <input type="radio"/> Yes <input type="radio"/> No |
| Artificial Joint <input type="radio"/> Yes <input type="radio"/> No | Excessive Thirst <input type="radio"/> Yes <input type="radio"/> No | Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No | Sickle Cell Disease <input type="radio"/> Yes <input type="radio"/> No |
| Asthma <input type="radio"/> Yes <input type="radio"/> No | Fainting Spells/Dizziness <input type="radio"/> Yes <input type="radio"/> No | Irregular Heartbeat <input type="radio"/> Yes <input type="radio"/> No | Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No |
| Blood Disease <input type="radio"/> Yes <input type="radio"/> No | Frequent Cough <input type="radio"/> Yes <input type="radio"/> No | Kidney Problems <input type="radio"/> Yes <input type="radio"/> No | Spina Bifida <input type="radio"/> Yes <input type="radio"/> No |
| Blood Transfusion <input type="radio"/> Yes <input type="radio"/> No | Frequent Diarrhea <input type="radio"/> Yes <input type="radio"/> No | Leukemia <input type="radio"/> Yes <input type="radio"/> No | Stomach/Intestinal Disease <input type="radio"/> Yes <input type="radio"/> No |
| Breathing Problem <input type="radio"/> Yes <input type="radio"/> No | Frequent Headaches <input type="radio"/> Yes <input type="radio"/> No | Liver Disease <input type="radio"/> Yes <input type="radio"/> No | Stroke <input type="radio"/> Yes <input type="radio"/> No |
| Bruise Easily <input type="radio"/> Yes <input type="radio"/> No | Genital Herpes <input type="radio"/> Yes <input type="radio"/> No | Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No | Swelling of Limbs <input type="radio"/> Yes <input type="radio"/> No |
| Cancer <input type="radio"/> Yes <input type="radio"/> No | Glaucoma <input type="radio"/> Yes <input type="radio"/> No | Lung Disease <input type="radio"/> Yes <input type="radio"/> No | Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No |
| Chemotherapy <input type="radio"/> Yes <input type="radio"/> No | Hay Fever <input type="radio"/> Yes <input type="radio"/> No | Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No | Tonsillitis <input type="radio"/> Yes <input type="radio"/> No |
| Chest Pains <input type="radio"/> Yes <input type="radio"/> No | Heart Attack/Failure <input type="radio"/> Yes <input type="radio"/> No | Osteoporosis <input type="radio"/> Yes <input type="radio"/> No | Tuberculosis <input type="radio"/> Yes <input type="radio"/> No |
| Cold Sores/Fever Blisters <input type="radio"/> Yes <input type="radio"/> No | Heart Murmur <input type="radio"/> Yes <input type="radio"/> No | Pain in Jaw Joints <input type="radio"/> Yes <input type="radio"/> No | Tumors or Growths <input type="radio"/> Yes <input type="radio"/> No |
| Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No | Heart Pacemaker <input type="radio"/> Yes <input type="radio"/> No | Parathyroid Disease <input type="radio"/> Yes <input type="radio"/> No | Ulcers <input type="radio"/> Yes <input type="radio"/> No |
| Convulsions <input type="radio"/> Yes <input type="radio"/> No | Heart Trouble/Disease <input type="radio"/> Yes <input type="radio"/> No | Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No | Venereal Disease <input type="radio"/> Yes <input type="radio"/> No |
| | | | Yellow Jaundice <input type="radio"/> Yes <input type="radio"/> No |

Have you ever had any serious illness not listed above? Yes No _____

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

Toole Family Dentistry

Kevin C. Toole DDS

480 Northfield Drive Suite 400

Brownsburg Indiana 46112

Telephone: 317-286-3502

Fax: 317-286-3745

Email: toolefamilydentistsry@gmail.com

- This agreement is to inform you of your financial obligation to our practice. We are committed to providing you with the highest quality dental care using only the best material and technology available in the market today. We are also committed to providing you with up- to-date information and educational tools so that you may fully participate in maintaining optimum oral health. This financial agreement is intended to facilitate our ability to provide excellent service to you while minimizing our administrative costs.
- All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and the insurance company. Our office is not a party to that contract. If payment from your insurance company is not received within 60 days from date of service, you will be expected to pay the balance in full.
- Your estimated co-payment for treatment, which is the amount not covered by your insurance, is due at the time service is provided. Your estimated co-payment may be adjusted after the time of service depending upon the final reconciliation of the insurance benefit payment. Our office accepts cash, personal checks, MasterCard, and Visa. In addition, we offer outside financing available through Care Credit .
- As a courtesy to you we will help you process all your insurance claims. You may direct your insurance company to pay your benefits directly to our office by signing the authorization on the Assignment of Benefits Agreement at the end of this document. In order for our office to file your insurance claim, you must bring a completed dental insurance form or proof of insurance at each appointment.
- Our office will accept an assignment of benefits from your insurance company with the provisions listed below. It is important to understand, though, that the agreement regarding your dental benefits is between you, your employer, and your insurance company. The obligation you have with our practice is to pay for treatment, regardless of the amount that may or may not be reimbursed by your insurance company. The following provisions identify our policies governing insurance claims.
- Although we are willing to complete insurance information forms and submit a claim on your behalf, we do not accept responsibility for the outcome of the transaction. Completing insurance forms is a courtesy we extend to you in an effort save you time and to facilitate payment to our office from your insurance company. By having our office process your insurance forms, it is important that you understand that this does not eliminate your financial obligation for your treatment.

- We require you to sign this agreement and/or any other necessary assignment documents that may be required by your insurance company. This instructs your insurance company to make payment directly to our office.
- We require you to pay the estimated copayment, which is the amount not covered by your insurance company, at the time we provide service to you. The copayment is only an estimate of charges and may be found to be insufficient after review by your insurance company.
- Insurance payments ordinarily are received within 30-60 days from the time of billing. If your insurance company has not made payment to our office within 60 days, we will ask you to pay the entire balance at that time. You will be responsible for seeking reimbursement from your insurance company at that time. Returned checks and balances older than 60 days will be subject to collection fees and finance charges at the rate of 1.5% per month (18% annually).
- Our office does not guarantee that your insurance company will pay for treatment you receive from our practice. We perform routine insurance billing procedures upon verification of coverage. However, if your claim is denied, you will be responsible for paying the full amount at that time.
- Our office will not enter into a dispute with your insurance company over any claim, although we will provide necessary documentation your insurance company requests to sort out any confusion or questions that may arise. We will cooperate fully with the regulations and requests of your insurance company. It is ultimately your responsibility to resolve any type of dispute over payments made or not made by your insurance company.
- A non-refundable deposit is required for any appointment over 1 hour and 30 minutes. The deposit amount shall be the estimated patient co-payment for that particular visit. Any cancellation less than 2 business days will deem the deposit non- refundable.
- Please do not hesitate to ask if you have any questions regarding this financial agreement. We are committed to providing you with the most positive experience in dental care. I HAVE READ AND ACCEPT TERMS AND CONDITIONS OF THIS FINANCIAL AND ASSIGNMENT OF BENEFITS AGREEMENT. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO THE DOCTOR.

Patient or Guardian Printed Name: _____

Patient or Guardian Signature: _____

Date: _____

Toole Family Dentistry
HIPAA NOTICE OF PRIVACY PRACTICES

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

The Dental Practice Covered By This Notice

This Notice describes the privacy practices of **Toole Family Dentistry**. "We" and "our" means the Dental Practice. "You" and "your" means our patient.

How to Contact Us/ Our Privacy Official

If you have any questions or would like further information about this Notice, you can either write to or call the Privacy Official for our Dental Practice:

Dental Practice Name:	Toole Family Dentistry
Privacy Official for Dental Practice:	Toole Family Dentistry
Dental Practice mailing address:	Toole Family Dentistry
Dental Practice email address:	Toolefamilydentistry@gmail.com
Dental Practice phone number:	317-286-3502

Information Covered By This Notice

This Notice applies to health information about you that we create or receive and that identifies you. This Notice tells you about the ways we may use and disclose your health information. It also describes your rights and certain obligations we have with respect to your health information. We are required by law to:

- ⌚ maintain the privacy of your health information;
- ⌚ give you this Notice of our legal duties and privacy practices with respect to that information; and
- ⌚ abide by the terms of our Notice that is currently in effect.

Our Use and Disclose of Your Health Information Without Your Written Authorization

Common Reasons for Our Use and Disclosure of Patient Health Information

Treatment. We will use your health information to provide you with dental treatment or services, such as cleaning or examining your teeth or performing dental procedures. We may disclose health information about you to dental specialists, physicians, or other health care professionals involved in your care.

Payment. We may use and disclose your health information to obtain payment from health plans and insurers for the care that we provide to you.

Health Care Operations. We may use and disclose health information about you in connection with health care operations necessary to run our practice, including review of our treatment and services, training, evaluating the performance of our staff and health care professionals, quality assurance, financial or billing audits, legal matters, and business planning and development.

Appointment Reminders. We may use or disclose your health information when contacting you to remind you of a dental appointment. We may contact you by using a postcard, letter, voicemail, or email.

Treatment Alternatives and Health-Related Benefits and Services. We may use and disclose your health information to tell you about treatment options or alternatives or health-related benefits and services that may be of interest to you.

Disclosure to Family Members and Friends. We may disclose your health information to a family member or friend who is involved with your care or payment for your care if you do not object or, if you are not present, we believe it is in your best interest to do so.

Less Common Reasons for Use and Disclosure of Patient Health Information

The following uses and disclosures occur infrequently and may never apply to you.
--

Disclosures Required by Law. We may use or disclose patient health information to the extent we are required by law to do so. For example, we are required to disclose patient health information to the U.S. Department of Health and Human Services so that it can investigate complaints or determine our compliance with HIPAA.

Public Health Activities. We may disclose patient health information for public health activities and purposes, which include: preventing or controlling disease, injury or disability; reporting births or deaths; reporting child abuse or neglect; reporting adverse reactions to medications or foods; reporting product defects; enabling product recalls; and notifying a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

Victims of Abuse, Neglect or Domestic Violence. We may disclose health information to the appropriate government authority about a patient whom we believe is a victim of abuse, neglect or domestic violence.

Health Oversight Activities. We may disclose patient health information to a health oversight agency for activities necessary for the government to provide appropriate oversight of the health care system, certain government benefit programs, and compliance with certain civil rights laws.

Lawsuits and Legal Actions. We may disclose patient health information in response to (i) a court or administrative order or (ii) a subpoena, discovery request, or other lawful process that is not ordered by a court if efforts have been made to notify the patient or to obtain an order protecting the information requested.

Law Enforcement Purposes. We may disclose patient health information to a law enforcement official for a law enforcement purposes, such as to identify or locate a suspect, material witness or missing person or to alert law enforcement of a crime.

Coroners, Medical Examiners and Funeral Directors. We may disclose patient health information to a coroner, medical examiner or funeral director to allow them to carry out their duties.

Organ, Eye and Tissue Donation. We may use or disclose patient health information to organ procurement organizations or others that obtain, bank or transplant cadaveric organs, eyes or tissue for donation and transplant.

Research Purposes. We may use or disclose patient health information for research purposes pursuant to patient authorization waiver approval by an Institutional Review Board or Privacy Board.

Serious Threat to Health or Safety. We may use or disclose patient health information if we believe it is necessary to do so to prevent or lessen a serious threat to anyone's health or safety.

Specialized Government Functions. We may disclose patient health information to the military (domestic or foreign) about its members or veterans, for national security and protective services for the President or other heads of state, to the government for security clearance reviews, and to a jail or prison about its inmates.

Workers' Compensation. We may disclose patient health information to comply with workers' compensation laws or similar programs that provide benefits for work-related injuries or illness.

Your Written Authorization for Any Other Use or Disclosure of Your Health Information

We will make other uses and disclosures of health information not discussed in this Notice only with your written authorization. You may revoke that authorization at any time in writing. Upon receipt of the written revocation, we will stop using or disclosing your health information for the reasons covered by the authorization going forward.

Your Rights with Respect to Your Health Information

You have the following rights with respect to certain health information that we have about you (information in a Designated Record Set as defined by HIPAA). To exercise any of these rights, you must submit a written request to our Privacy Official listed on the first page of this Notice.

Access. You may request to review or request a copy of your health information. We may deny your request under certain circumstances. You will receive written notice of a denial and can appeal it. We will provide a copy of your health information in a format you request if it is readily producible. If not readily producible, we will provide it in a hard copy format or other format that is mutually agreeable. If your health information is included in an Electronic Health Record, you have the right to obtain a copy of it in an electronic format and to direct us to send it to the person or entity you designate in an electronic format. We may charge a reasonable fee to cover our cost to provide you with copies of your health information.

Amend. If you believe that your health information is incorrect or incomplete, you may request that we amend it. We may deny your request under certain circumstances. You will receive written notice of a denial and can file a statement of disagreement that will be included with your health information that you believe is incorrect or incomplete.

Restrict Use and Disclosure. You may request that we restrict uses of your health information to carry out treatment, payment, or health care operations or to your family member or friend involved in your care or the payment for your care. We may not (and are not required to) agree to your requested restrictions, with one exception. If you pay out of your pocket in full for a service you receive from us and you request that we not submit the claim for this service to your health insurer or health plan for reimbursement, we must honor that request.

Confidential Communications: Alternative Means, Alternative Locations. You may request to receive communications of health information by alternative means or at an alternative location. We will accommodate a request if it is reasonable and you indicate that communication by regular means could endanger you. When you submit a written request to the Privacy Official listed on the first page of this Notice, you need to provide an alternative method of contact or alternative address and indicate how payment for services will be handled.

Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information for the six years prior to the date that the accounting is requested except for disclosures to carry out treatment, payment, health care operations (and certain other exceptions as provided by HIPAA). The first accounting we provide in any 12-month period will be without charge to you. We will charge a reasonable fee to cover the cost for each subsequent request for an accounting within the same 12-month period. We will notify you in advance of this fee and you may choose to modify or withdraw your request at that time.

Receive a Paper Copy of this Notice. You have the right to a paper copy of this Notice. You may ask us to give you a paper copy of the Notice at any time (even if you have agreed to receive the Notice electronically). To obtain a paper copy, ask the Privacy Official.

We Have the Right to Change Our Privacy Practices and This Notice

We reserve the right to change the terms of this Notice at any time. Any change will apply to the health information we have about you or create or receive in the future. We will promptly revise the Notice when there is a material change to the uses or disclosures, individual's rights, our legal duties, or other privacy practices discussed in this Notice. We will post the revised Notice on our website (if applicable) and in our office and will provide a copy of it to you on request. The effective date of this Notice (including any updates) is in the top right-hand corner of the Notice.

To Make Privacy Complaints

If you have any complaints about your privacy rights or how your health information has been used or disclosed, you may file a complaint with us by contacting our Privacy Official listed on the first page of this Notice.

You may also file a written complaint with the U.S. Department of Health and Human Services Office for Civil Rights.

The privacy of your health information is important to us. We will not retaliate against you in any way if you choose to file a complaint.

**Toole Family Dentistry
ACKNOWLEDGEMENT OF RECEIPT OF
HIPAA NOTICE OF PRIVACY PRACTICES**

I acknowledge that I have received a copy of this Dental Practice's **HIPAA Notice of Privacy Practices**.

Patient Name (Please Print)

Patient Signature

Date

OR

Signature of Personal Representative

Authority of Personal Representative to Sign for Patient (check one):

Parent Guardian Power of Attorney Other: _____

Please Note: It is your right to refuse to sign this Acknowledgement.

Dental Office Use Only

I tried to obtain written Acknowledgement by the individual noted above of receipt of our **Notice of Privacy Practices**, but it could not be obtained because:

- ___ An emergency prevented us from obtaining acknowledgement.
- ___ A communication barrier prevented us from obtaining acknowledgement.
- ___ The individual was unwilling to sign.
- ___ Other: _____

Staff Member Signature

Date

**Toole Family Dentistry
HIPAA AUTHORIZATION FOR RELEASE OF
PROTECTED HEALTH INFORMATION
("Authorization")**

By signing this Authorization, you agree to the release of your Protected Health Information as described in this Authorization. This Authorization is intended to comply with the requirements of the HIPAA Privacy Rule. If you have questions about this Authorization, please contact the Privacy Official for the Dental Practice, noted below. If you agree with this Authorization, please complete it, sign and date it at the end and provide to us.

Our Dental Practice contact information:

Dental Practice Name:	Toole Family Dentistry
Privacy Official for Dental Practice:	Dr. Kevin Toole
Dental Practice mailing address:	480 E. Northfield Dr Suite 400 Brownsburg, IN 46112
Dental Practice email address:	Toolefamilydentistry@gmail.com
Dental Practice phone number:	317-286-3502

Your contact information (please complete):

Patient name:	
Patient mailing address:	
Patient email address: (Optional)	
Patient phone number:	

Protected Health Information that I am authorizing the Dental Practice to release (please check the records to which this Authorization applies):

I authorize the Dental Practice named above to release the following Protected Health Information:

___ Dental report(s)

___ Dental image(s)

___ All dental records relating to (specify injury or illness): _____

___ All dental records received or created by the Dental Practice between the following dates:

___ Other (specify) _____

The reason for the release of the Protected Health Information (please check the reason(s) that apply):

___ Patient Request

___ Review Patient's current care

___ Treatment/ continued care

___ Payment for care, including insurance

___ Legal

___ Obtaining Social Security Disability or other public benefits

___ Other(specify): _____

I am requesting that the Dental Practice release my Protected Health Information to (please complete):

Organization name:	
Person name or title:	
Mailing address:	
Phone number:	

If you want your Protected Health Information to be provided to the organization/person by email, please provide the email address: _____.

If you want your Protected Health Information to be provided to the organization/person by fax, please provide the fax number: _____.

When your Protected Health Information is released as provided in this Authorization, the recipient may not have a legal obligation to protect its confidentiality and may redisclose it.

Expiration of this Authorization:

This Authorization will automatically expire one year after the date that I sign it unless I (the patient) indicate an earlier date or event here: _____.

Your rights with respect to this Authorization:

It is completely your decision whether or not to sign this Authorization. We cannot refuse to treat you if you choose not to sign this Authorization.

If you sign this Authorization, you can revoke it prior to the expiration date above by sending a note in writing to the Dental Practice to the address or email address indicated on the first page of this Authorization. The revocation will not have any effect, however, on actions taken in reliance on the Authorization prior to your revocation.

BY MY SIGNATURE, I CERTIFY THAT I HAVE READ AND UNDERSTAND THIS AUTHORIZATION. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY PROTECTED HEALTH INFORMATION AS DESCRIBED IN THIS AUTHORIZATION.

Patient Signature

Date

OR

Signature of Personal Representative

Authority of Personal Representative to Sign for Patient (check one):

Parent Guardian Power of Attorney Other:_____