OLYMPUS FAMILY MEDICINE

New Patient Registration Form

PATIENT INFORMATION

LEGAL NAME: _____
Last First MI

DATE OF BIRTH: _____/_____/_____ GENDER: Male Female SOC SEC #: _____-_____-_____
MM DD YYYY

CURRENT ADDRESS:

_____
Street Address Apartment Number

_____
City State Zip

Please Indicate Your Preferred Contact Method Below:

- Cell Ph: _____
- Home Ph: _____
- Work Ph: _____
- Email: _____

PARTNER NAME: _____ Marital Status: S M D W
Last First

EMERGENCY CONTACT: _____ Phone # _____
Last First MI

PREFERRED PHARMACY (Name & Address): _____

HOW DID YOU HEAR ABOUT US (circle)? Insurance Friend Family Member Internet Facebook Other

INSURANCE INFORMATION

Primary Insurance Plan

INSURANCE PLAN NAME: _____ Phone # _____

INSURANCE CARD: Member ID # _____ Group # _____
(Policy Number)

INS. PLAN ADDRESS: _____ Listed PCP: YES NO
Street Address

_____ _____
City State Zip (If yes, please indicate PCP name)

PRIMARY INSURED'S NAME: _____
Last First MI

PRIMARY'S DOB: ____/____/_____ PATIENT'S RELATIONSHIP TO PRIMARY: Self Child Spouse Other: _____
MM DD YYYY

Secondary Insurance Plan (If Applicable)

INSURANCE PLAN NAME: _____ Phone # _____

INSURANCE CARD: Member ID # _____ Group # _____
(Policy Number)

INS. PLAN ADDRESS: _____ Listed PCP: YES NO
Street Address

_____ _____
City State Zip (If yes, please indicate PCP name)

PRIMARY INSURED'S NAME: _____
Last First MI

PRIMARY'S DOB: ____/____/_____ PATIENT'S RELATIONSHIP TO PRIMARY: Self Child Spouse Other: _____

PRESENT HEALTH SYMPTOMS

Please review and mark **ALL** items that have applied to you **within the last month** (including today):

OVERALL:	☐ NONE	☐ WEIGHT LOSS	☐ WEIGHT GAIN	☐ FATIGUE	☐ LOSS OF APPETITE
EYES:	☐ NONE	☐ EYE PAIN	☐ DOUBLE VISION	☐ SEVERE REDNESS	☐ CRUSTING
EARS:	☐ NONE	☐ EAR PAIN	☐ HEARING LOSS	☐ RINGING IN EARS	☐ DIZZINESS
NOSE:	☐ NONE	☐ RUNNY NOSE	☐ NASAL CONGESTION	☐ NOSEBLEEDS	☐ SINUS PAIN/PRESSURE
MOUTH/THROAT:	☐ NONE	☐ SORE THROAT	☐ SORES IN MOUTH	☐ TOOTH PAIN	☐ HOARSENESS
		☐ PROBLEMS SWALLOWING			
CHEST/HEART:	☐ NONE	☐ CHEST PAIN	☐ RACING/POUNDING HEART	☐ LEG PAIN / LIMP W/ WALKING	
		☐ PROBLEMS BREATHING WITH LYING DOWN			
RESPIRATORY:	☐ NONE	☐ COUGH	☐ WHEEZING	☐ SHORTNESS OF BREATH	
		☐ COUGHING UP BLOOD OR MUCUS WITH BLOOD			
STOMACH:	☐ NONE	☐ HEARTBURN	☐ NAUSEA/VOMITING	☐ ABDOMINAL PAIN	☐ VOMITING UP BLOOD
BOWELS:	☐ NONE	☐ DIARRHEA	☐ CONSTIPATION	☐ BLACK/BLOODY STOOLS	
		☐ UNUSUAL CHANGE IN STOOL SIZE/SHAPE/COLOR			
URINARY TRACT:	☐ NONE	☐ BLOOD IN URINE	☐ INCREASED URINATION	☐ DIFFICULTY URINATING	
		☐ PAIN WITH URINATION	☐ WAKING TO URINATE _____ TIMES PER NIGHT		
REPRODUCTIVE:					
FEMALES:	☐ NONE	☐ MENSTRUAL PAIN	☐ BREAST PAIN	☐ VAGINAL DISCHARGE	☐ PAIN W/ INTERCOURSE
		☐ PREGNANT	☐ BREASTFEEDING	☐ FIRST DAY OF LAST MENSTRUAL PERIOD: _____	
MALES:	☐ NONE	☐ TESTICULAR PAIN	☐ PENILE DISCHARGE	☐ LUMP/ SWELLING IN SCROTUM/ TESTICLE(S)	
MUSC/SKEL:	☐ NONE	☐ BACK PAIN	☐ PAIN IN MUSCLES/JOINTS	☐ LIMITED RANGE OF MOTION IN JOINTS	
SKIN:	☐ NONE	☐ RASH	☐ REDNESS	☐ CHANGING MOLES/WARTS OR OTHER LESIONS	
		☐ SORES			
NEUROLOGICAL:	☐ NONE	☐ SEIZURES	☐ PROBLEMS WITH COORDINATION		
		☐ MEMORY/SENSORY PROBLEMS		☐ WEAKNESS / NUMBNESS / TINGLING	
ENDOCRINE:	☐ NONE	☐ UNUSUAL CHANGES WITH SKIN OR HAIR		☐ INCREASED SENSITIVITY TO TEMPERATURE CHANGES	
BLOOD:	☐ NONE	☐ BLEEDING GUMS	☐ FREQUENT NOSEBLEEDS	☐ SWOLLEN GLANDS	
		☐ SWOLLEN HANDS OR FEET		☐ UNUSUAL BRUISING	
IMMUNE:	☐ NONE	☐ SNEEZING	☐ ITCHY EYES	☐ FREQUENT SINUS, EAR OR RESPIRATORY INFECTIONS	
MENTAL HEALTH:	☐ NONE	☐ MOOD SWINGS	☐ EMOTIONAL CHANGES	☐ THOUGHTS OF HURTING SELF OR OTHERS	
		☐ ANXIETY/DEPRESSION			

PAST MEDICAL HISTORY

Please indicate any of the following medical conditions you **have now** or have **ever had** in the past:

☐ ASTHMA	☐ EMPHYSEMA	☐ CHRONIC BRONCHITIS	☐ SEASONAL ALLERGIES
☐ SINUS INFECTIONS	☐ ARTHRITIS	☐ OSTEOPOROSIS	☐ GOUT
☐ HIGH CHOLESTEROL	☐ HIGH BLOOD PRESSURE	☐ HEART ATTACK	☐ STROKE
☐ GLAUCOMA	☐ ANEMIA	☐ CHRONIC HEARTBURN	☐ GALL BLADDER DISEASE
☐ BLEEDING DISORDER	☐ ULCERS	☐ THYROID DISORDER	☐ DIABETES
☐ KIDNEY DISEASE	☐ TUBERCULOSIS	☐ HEPATITIS (type) _____	☐ DEPRESSION/ANXIETY
☐ MENTAL ILLNESS	☐ EPILEPSY/SEIZURES	☐ MIGRAINES	☐ ADHD
☐ CANCER (type): _____		☐ OTHER _____	

STD/HIV HISTORY & RISK FACTORS:

☐ NONE	☐ UNPROTECTED SEX	☐ IV DRUG USE
☐ OCCUPATIONAL EXPOSURE	☐ HIV / AIDS	☐ TRANSFUSION (Before 1980)
☐ HEPATITIS (type) _____	☐ CLOSE CONTACT WITH STD / HIV POSITIVE PERSON	
☐ HISTORY OF PREVIOUS STD (type) _____		

PREVIOUS SURGERIES AND/OR HOSPITALIZATIONS

SURGERY OR ILLNESS	HOSPITAL	YEAR

SOCIAL HISTORY

Please complete the following sections. This information is important for guiding medical decisions related to your care.

OCCUPATION / EMPLOYER: _____ RECENT CHANGE? YES ☐ NO ☐

EDUCATION: ☐ High School ☐ Some College ☐ Degree RELIGIOUS PREF: _____

EXERCISE HABITS: ☐ Rarely ☐ 1-3 times/ week ☐ >3 times/ week # OF CAFFEINATED BEVERAGES PER DAY: _____

PLEASE INDICATE YOUR ETHNIC ORIGIN:

☐ WHITE ☐ BLACK / AFRICAN AMERICAN ☐ AMERICAN INDIAN / ALASKA NATIVE

☐ ASIAN (Please Specify) ☐ HISPANIC / LATINO ☐ NATIVE HAWAIIAN / PACIFIC ISLANDER

☐ CHINESE ☐ VIETNAMESE ☐ INDIAN ☐ PERSIAN

☐ JAPANESE ☐ TAIWANESE ☐ PAKISTANI ☐ INDEONESIAN

☐ KOREAN ☐ CANTONESE ☐ ARMENIAN ☐ OTHER ASIAN

☐ 2 OR MORE ETHNIC ORIGINS: (Not Hispanic / Latino)

TOBACCO, ALCOHOL & DRUG HISTORY

RECREATIONAL DRUG USE? ☐ YES ☐ NO

CURRENT TOBACCO USE? ☐ YES ☐ NO

PAST TOBACCO USE? ☐ YES ☐ NO

TYPE OF TOBACCO? ☐ SMOKE ☐ DIP ☐ CHEW

AMOUNT DAILY (quantity): CIGARETTES: _____ PACK(S): _____ CAN(S): _____

YEARS OF USE: CIGARETTES: _____ PACK(S): _____ CAN(S): _____

HAVE YOU QUIT? ☐ YES, DATE (month/year): _____ ☐ NO

WOULD YOU LIKE TO QUIT? ☐ YES ☐ NO

ALCOHOL USE? ☐ YES ☐ NO

IF YES, NUMBER OF DRINKS IN AN AVERAGE: DAY: _____ WEEK: _____ MONTH: _____

ALLERGIES

Are you **allergic** to any medications or other substances? **Y** ☐ **N** ☐ If yes, please list item and reaction(s) below:

Medication	Reactions
Other Allergies	**Reactions**

CURRENT MEDICATIONS

Medication	Dosage	Frequency	Reason Prescribed

FAMILY MEDICAL HISTORY

Please complete the following table regarding the medical history of your family members:

	FATHER	PATERNAL GRANDFATHER	PATERNAL GRANDMOTHER	MOTHER	MATERNAL GRANDFATHER	MATERNAL GRANDMOTHER	☐ BRO ☐ SIS	☐ BRO ☐ SIS	☐ BRO ☐ SIS
Deceased?	☐	☐	☐	☐	☐	☐	☐	☐	☐
- If deceased, please list cause of death									
AGE (present or at time of death)									
HEALTH HISTORY									
ASTHMA	☐	☐	☐	☐	☐	☐	☐	☐	☐
HIGH CHOLESTEROL	☐	☐	☐	☐	☐	☐	☐	☐	☐
HIGH BLOOD PRESSURE	☐	☐	☐	☐	☐	☐	☐	☐	☐
HEART ATTACK/ HEART DISEASE	☐	☐	☐	☐	☐	☐	☐	☐	☐
STROKE	☐	☐	☐	☐	☐	☐	☐	☐	☐
DIABETES	☐	☐	☐	☐	☐	☐	☐	☐	☐
OBESITY	☐	☐	☐	☐	☐	☐	☐	☐	☐
GALLBLADDER DISEASE	☐	☐	☐	☐	☐	☐	☐	☐	☐
KIDNEY DISEASE	☐	☐	☐	☐	☐	☐	☐	☐	☐
THYROID DISORDER	☐	☐	☐	☐	☐	☐	☐	☐	☐
EPILEPSY/ SEIZURES	☐	☐	☐	☐	☐	☐	☐	☐	☐
ANEMIA/ BLEEDING DISORDER	☐	☐	☐	☐	☐	☐	☐	☐	☐
DEPRESSION / ANXIETY	☐	☐	☐	☐	☐	☐	☐	☐	☐
MENTAL ILLNESS	☐	☐	☐	☐	☐	☐	☐	☐	☐
TUBERCULOSIS	☐	☐	☐	☐	☐	☐	☐	☐	☐
ALCOHOLISM	☐	☐	☐	☐	☐	☐	☐	☐	☐
CANCER (type)_____	☐	☐	☐	☐	☐	☐	☐	☐	☐
ALLERGIES: (Please list below)	☐	☐	☐	☐	☐	☐	☐	☐	☐
_____	☐	☐	☐	☐	☐	☐	☐	☐	☐
_____	☐	☐	☐	☐	☐	☐	☐	☐	☐
_____	☐	☐	☐	☐	☐	☐	☐	☐	☐
_____	☐	☐	☐	☐	☐	☐	☐	☐	☐

Additional Information: _____

_____

_____

4461 Coit Road, Suite 307 · Frisco, TX 75035 · Ph. 972-377-0322 Fax 972-502-5515

OLYMPUS FAMILY MEDICINE

CONSENT FOR TREATMENT

I, _____, hereby authorize employees and agents, including physicians and physician assistants and nurse practitioners, of *Olympus Family Medicine* to render routine medical care to the patient indicated on this form and to fulfill the orders of the physicians; including consultants, associates, and assistants of the physicians' choice. If the doctor is unable to see me due to appointment availability, I may be offered an appointment with the physician assistant or nurse practitioner.

The duration of this consent is indefinite and continues until revoked in writing. I understand that by **not** signing this consent, *Olympus Family Medicine* will not be able to provide medical care, except in case of emergency.

If Patient is a Minor:

I, _____, give my consent and authorization for *Olympus Family Medicine*,
(Parent's Name)
including physicians, physician assistants, nurse practitioners and medical assistants, to provide medical evaluation and treatment to my child, _____, when I am not available.
(Minor's Full Name)

I understand such treatment may include invasive and minor surgical procedures and that the staff of *Olympus Family Medicine* will make reasonable attempts to contact me prior to initiating treatment if consent is needed.

The duration of this consent is indefinite and continues until revoked in writing or until the child reaches the age of eighteen. I understand that by **not** signing this consent, *Olympus Family Medicine* will not be able to provide medical care, except in case of emergency.

_____ _____
Signature of Patient, Parent or Legal Guardian Date

_____
Print Name of Patient

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OLYMPUS FAMILY MEDICINE

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF HEALTH INFORMATION PRACTICES

The Health Insurance Portability and Accountability Act (HIPAA) is a federal government regulation designed to ensure that you are aware of your privacy rights and how your medical information can be used by the staff of *Olympus Family Medicine* in providing and arranging your medical care.

Olympus Family Medicine is furnishing you with the attached notice, which provides information about how we may use and/or disclose protected health information about you for treatment, payment, heath care operations and as otherwise allowed by law.

HIPAA Notice Revised November 2016

HIPAA PRIVACY ACT INFORMATION RELEASE FORM

May *Olympus Family Medicine* release medical information to anyone other than you?

___ **YES**, please release information to the following: ___ **NO**, only release information to me.

Name: _____

Relationship: _____

Contact #: _____

Email: _____

Name: _____

Relationship: _____

Contact #: _____

Email: _____

Check which of the following we may leave detailed information:

____ Phone # _____

____ Voice Mail/ Answering Machine # _____

____ Email (non-encrypted) _____

By signing this form, you acknowledge that you have received a copy of *Olympus Family Medicine's* Notice of Health Information Practices and have provided instructions regarding release of your individual healthcare information.

_____ _____

Signature of Patient, Parent, or Legal Guardian Date

_____

Print Name of Patient

OLYMPUS FAMILY MEDICINE

Initial All Below **PAYMENT POLICY**

x_____ **Co-payments, Co-insurance and Deductibles:** **ALL** co-payments, co-insurance and deductibles MUST be paid at time of service. The amount paid when services are rendered is an estimated amount based on the information we receive from your insurance company. Final determination of charges will be made after your insurance has been filed. We will send you a statement for any remaining balance. For your convenience, we accept MasterCard, Visa, Discover, and American Express. **Procedures-** most insurance companies require patients to pay a separate Surgical Deductible for procedures such as cryo-surgery, biopsies, device insertion, and other surgical procedures. Check with your insurance BEFORE the procedure is performed. You are responsible for payment of the deductible at the time of service.

x_____ ***Note to Medicare Patients****:* Medicare has a 20% co-payment for office visits and a yearly deductible that must be paid at the time of service. Some secondary insurance may cover these expenses. Some of the services you receive may not be covered or may be deemed not medically necessary by Medicare or other insurance companies. We require an **Advanced Beneficiary Notice** (ABN) to be signed if there is a possibility that Medicare may deny service. You have the right to decline the service. You will be responsible for payment of all charges for services not covered by Medicare or your secondary insurance company.

x_____ **Insurance:** All patients must provide a valid Driver's License and an **active** insurance card at the time of service. If you fail to provide us with correct insurance information, you will be required to pay the full amount of the service.

x_____ ***You are responsible for knowing your insurance policy and benefits.*** Your health insurance policy is a contract between you and your insurance company. As a courtesy, we file your claim with your insurer if you agree to have payments made directly to *Olympus Family Medicine*. If your insurance company does not provide payment within **90** days of the filing date, YOU will be required to pay the full amount. If we later receive a check from your insurer, we will issue you a refund.

x_____ ***You are responsible for payment of all charges for services NOT covered by your insurance company.*** We do our best to determine your insurance benefits and coverage; however, due to the constant changes in insurance coverage, we cannot guarantee that Medicare or other insurance companies/policies will cover the services rendered. Your insurance company will make the final determination upon receipt of the claim.

x_____ **Appointment Cancellations:** Please provide a minimum of **24 hour** notice when cancelling an appointment. Late cancellations and missed appointments will be charged a **$50.00** fee.

x_____ **Billing:** Our billing is out-sourced to W*allace Medical Billing.* Any balances owed to *Olympus Family Medicine* are due upon receipt of the billing statement. Please call *Wallace Medical Billing* at 1-800-274-7068 for all billing inquiries. All billing questions concerning laboratory or radiology must be directed to the facility where services were performed (*LabCorp, Quest, etc*.).

x_____ **Delinquent Accounts:** If your account becomes delinquent after 30 days, you will be assessed a $5.00 fee per billing cycle, every 30 days. If payment is not made, your account will be turned over to a collection agency due to delinquency and you will be required to pay all balances in full **before** further services are rendered.

By signing this form I acknowledge that I understand and agree to the above payment policy. Authorization is hereby granted to release information contained in my medical record as may be necessary to process and complete my insurance claim. This authorization may include release of information regarding communicable diseases, such as Acquired Immune Deficiency Syndrome ("AIDS") and Human Immunodeficiency Virus ("HIV"). The duration of this authorization is indefinite and continues until revoked in writing. I understand that by not signing this form I am responsible for payment of services in full before services are rendered.

Our practice is committed to providing the best treatment to our patients. Thank you for understanding our payment policy.

_____ _____

Signature of Patient, Parent or Legal Guardian Date

_____

Print Name of Patient

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OLYMPUS FAMILY MEDICINE

PATIENT POLICIES

Office Hours: Mon - Thu 8:00 am – 5:00 pm Fri 8:00 am - 3:00 pm Closed for Lunch 12:00 pm - 1:00 pm

***Appointments**:* Please arrive 5 minutes before your appointment time to update any changes in contact information or insurance. We require **24** hour notice to cancel or reschedule an appointment. Failure to do so will result in a **$50** charge. No-shows will not be tolerated. Patients who repeatedly miss their appointments may have their care terminated with *Olympus Family Medicine*.

New Patients: Please arrive at least 15 minutes before your appointment time with the New Patient paperwork completed; otherwise, your appointment may need to be rescheduled. The additional time is needed to enter your information into our system.

Laboratory Results and Radiology Results: In general, all labs and radiology results will be discussed at routine follow up appointments. Routine results are typically available for the provider to review in 5 business days. Some specialty labs can take up to 10 business days. Your provider will determine if you need an appointment or if the results can be discussed over the phone. Results for sexually transmitted disease require an appointment. All billing questions concerning laboratory or radiology must be directed to the facility where services were ordered.

x_____ ***Medication Refills**:* We require **24** hours for routine medication refills. Please do NOT have the pharmacy fax a refill request to our office. Please do NOT let your medication run out before calling us for a refill. NO medications will be refilled on weekends. You MUST make an appointment for antibiotics. Do **NOT** call for narcotics.
Narcotics will NOT be prescribed without an appointment.

Pharmacy: If your insurance company requires you to use a specific pharmacy in order to receive prescription medicine benefits, please notify us.

Mail Order Pharmacy: If your insurance company requires prescriptions to be sent from the doctor's office to the mail-order pharmacy, please fill out ALL appropriate forms with the required information and we will fax them to the number you provide.

***Forms**:* All requests to fill out forms such as FMLA, disability, leave of absence from work, jury duty exemptions, and others require an office visit. The physician or provider reserves the right to deny signing requested forms.

***Referrals**:* If you need a referral, we will submit the referral paperwork to a specialist. If the specialist has NOT contacted you within **3 days**, please call us. Before booking an appointment with a specialist, YOU are responsible for checking that the specialist or facility is in-network on your insurance plan. We may send referrals to the physician or facility of your choice. **All HMOs** require a referral BEFORE seeing a specialist and require 72 hours to process.

***Call backs**:* The doctor will NOT take calls for non-urgent conditions during regular business hours. Returned calls and messages are typically conducted at the end of the business day; however, the provider will call you within **24 hours.** Please leave a detailed message along with your name and phone number.

***Medical Records**:* Medical records will be released after a signed release is received from the patient. Patients requesting copies of medical records will be charged $25.00. ALL medical record requests will be addressed within 10 business days of receipt of both the patient release and payment.

***Billing**:* Our billing is out-sourced to Wallace Medical Billing. Please call 1-800-274-7068 for all billing inquires. All billing questions concerning laboratory or radiology must be directed to the facility where services were ordered (*LabCorp, Quest, etc*.).

***Insurance**:* It is YOUR responsibility to know your benefits. Please notify the receptionist of any insurance changes when arriving for your appointment. We file your insurance as a courtesy to you. **ALL payments are due at the time of service** including copays, co-insurance, and deductibles.

OLYMPUS FAMILY MEDICINE

PATIENT POLICIES - *continued*

Inclement Weather: In the case of inclement weather, we follow the Frisco ISD policy for closures and delayed openings. We will call you to reschedule your appointment on the first business day we are open.

Annual Physicals: Please allow 8-12 weeks to schedule an annual physical. One week prior to your appointment, please come in for lab work. The focus of an annual physical is preventive care. The provider will review your lab work, perform a physical assessment, answer questions, update your treatment plan, and refill maintenance medications for chronic conditions. Acute issues will not be addressed at an annual physical appointment. You must schedule a follow-up appointment to discuss those conditions.

By signing this form, you acknowledge that you have read and understand *Olympus Family Medicine's* Patient Policies.

_____ _____

Signature of Patient, Parent or Legal Guardian Date

_____

Print Name of Patient

AUTHORIZATION FOR RELEASE OF RECORDS

I hereby authorize:

_____

(Entity/Person from Whom Records are Requested)

_____

(Full and Complete Address)

_____

(Phone Number and Fax Number if available)

to disclose my individually identifiable health information as described below, which may include information concerning communicable diseases such as Human Immunodeficiency Virus ("HIV") and Acquired Immune Deficiency Syndrome ("AIDS"), mental illness (except for psychotherapy notes), chemical or alcohol dependency, laboratory test results, medical history, treatment, or any other such related information. I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form. I understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance company or non-health care provider, the released information may no longer be protected by federal and state privacy regulations.

_____

Print Patient Name | Date of Birth | Social Security Number

Date(s) of service (if known):_____

Description of information to be released: (check all that apply)

____ Hospital admission records / Operative records / Billing records / Discharge records

____ Radiology reports & films ____ Consultation reports ____ Laboratory reports

____ Emergency Room records ____ Physician's orders ____ Physician's notes & Progress notes

____ History & Physical ____ Nurse's notes ____ Other: _____

Purpose of release of information: Continuity of care for primary care physician

The health information described herein shall be released to:

____ Hospital **__X__ Physician** ____ Insurance Company ____ Attorney ____ Patient ____ Other

Olympus Family Medicine
4461 Coit Road, Suite 307
Frisco, Texas 75035
Office: 972-377-0322 Fax: 972-502-9515

I understand that this authorization will expire by law 180 days from the date of this authorization unless I otherwise specify. I desire this authorization to be in effect until_____
(Expiration event/date)

I further understand that I may revoke this authorization at any time by notifying _____in
(Person/Entity from Whom Records are Requested)

writing at _____. I also understand that the written revocation must
(Address)

be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

_____ _____

Signature of Patient or Patient's Representative | Date

_____

Printed name of Patient's Representative

_____ _____

Relationship to Patient | or | Legal Authority (attach supporting documentation)