PATIENT REGISTRATION FORM

IF FORM IS NOT COMPLETE WE CANNOT BILL YOUR INSURANCE

ACCOUNT # ____________________

Billing Code: ______________ **Resp Dr. #** ____________ ☐ **New Pt.** ☐ **Update**

PATIENT NAME: __________________________________ **RESPONSIBLE PARTY FOR MINOR:** ________________________________

ADDRESS: ____ **APT #** ________ **CITY, ST, ZIP:** ____________________________________

PRIMARY PH: ____________________ **CELL / ALT PH:** _____________________ **EMAIL:** __________________ **SEX**: ☐ Male ☐ Female

PT. SS # ___________________ **RESP PARTY SS #:** ______________________ **RELATIONSHIP TO PT**: ☐ Self ☐ Spouse ☐ Parent ☐ Other

BIRTHDATE: _______________ **AGE:** __________ **REFERRED BY:** ____

PRIMARY CARE PHYSICIAN & ADDRESS: ____

IF INJURY IS RELATED TO AN ACCIDENT, Was it an: ☐ **Auto Accident** ☐ **Job Related Injury** **DATE OF INJURY:** ____________________

IS PATIENT: ☐ **SINGLE** ☐ **MARRIED** ☐ **OTHER** **IS PATIENT**: ☐ **EMPLOYED** ☐ **STUDENT** ☐ **RETIRED**

PT. EMPLOYER NAME AND ADDRESS: ____

PERSON TO CONTACT IN CASE OF EMERGENCY: ____

PHONE / ADDRESS OF PERSON ABOVE: ____

WHAT ARE YOU BEING SEEN FOR: _______________________________________ **FIRST DATE OF SYMPTOMS**: ____________

ALLERGIES: ____ **ARE YOU PREGNANT**? ☐ Yes ☐ No

INSURANCE INFORMATION:

☐ **INDUSTRIAL / WORKMAN'S COMPENSATION**

PRIMARY INSURANCE
INSURANCE CO. NAME: ______________________________

INS CO. ADDRESS: ______________________________

____

POLICY HOLDER NAME: ______________________________

RELATIONSHIP TO PT: ______________________________

EMPLOYER: ______________________________

POLICY NO. ____________ GROUP/CLAIM NO.: ____________

POLICY HOLDER SEX: ☐ F ☐ M BIRTHDATE: ____________

SECONDARY INSURANCE:
INSURANCE CO. NAME: ______________________________

INS CO. ADDRESS: ______________________________

____

POLICY HOLDER NAME: ______________________________

RELATIONSHIP TO PT: ______________________________

EMPLOYER: ______________________________

POLICY NO. ____________ GROUP/CLAIM NO.: ____________

POLICY HOLDER SEX: ☐ F ☐ M BIRTHDATE: ____________

AUTHORIZATION TO RELEASE AND/OR OBTAIN INFORMATION AND RECORDS: I hereby authorize this physician/clinic to release and/or obtain any information required in the course of my examination or treatment. This includes sending records by fax machine. I agree that this office may release records pertaining to my treatment to my insurance company or other third parties responsible for payment of my medical charges, including review activities related to my physician's participation with my health plan. I also authorize records to be mailed to me upon my verbal request.

SIGNED (patient or parent, if minor): ____ **DATE:** ____________

AUTHORIZATION TO PAY: I hereby authorize payment directly to the business office of this physician/clinic for the surgical and/or medical benefits, if any, otherwise payable to me for services. I understand that I am financially responsible for the charges not covered or paid by my insurance in a timely manner.

SIGNED: ____ **DATE:** ____________

AUTHORIZATION TO TREAT MINOR: I hereby authorize the physician (s), physician assistants, technicians or other authorized medical personnel of Spine Institute of Arizona to treat the above patient.

SIGNED Patient (or Legal Guardian): ____ **DATE:** ____________

© Spine Institute of Arizona, 1/09

SPINE INSTITUTE OF ARIZONA

Acknowledgment of Receipt of Notice of Privacy Practices

I, ____, acknowledge that I have received a copy of Spine Institute of Arizona's 'Notice of Privacy Practices'. This Notice described how Spine Institute of Arizona may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

____	____
Patient or Legally Authorized Individual Signature	Date
____	____
Printed Name if signed on behalf of the patient	Relationship (parent, legal guardian, personal representative, etc.)

SPINE INSTITUTE OF ARIZONA

Documentation of Good Faith Efforts

To Obtain Acknowledgment of Receipt of Notice of Privacy Practices

Patient Name: ____

Date of Patient Encounter: ____

The patient presented to the office and was provided with a copy of the office's Notice of Privacy Practices. A good faith effort was made to obtain from the patient or patient's representative, if applicable, a written acknowledgment of his/her receipt of the Notice. However, such acknowledgment was not obtained because:

☐ Patient refused to sign.

☐ Patient Representative refused to sign.

☐ Patient was unable to sign or initial because:

____

____

☐ The patient had a medical emergency, and an attempt to obtain the acknowledgment will be made at the next available opportunity.

☐ Other reason (describe below):

____

____

Signature of Employee Completing Form: ____

Date: ______________________

Effective Date of this Notice: April 14, 2003

SPINE INSTITUTE OF ARIZONA

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Spine Institute of Arizona may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Spine Institute of Arizona's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Spine Institute of Arizona reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Spine Institute of Arizona's Privacy Officer at 9735 North 90th Place, Scottsdale, Arizona 85258.

With my consent, Spine Institute of Arizona may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Spine Institute of Arizona may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With my consent, Spine Institute of Arizona may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Spine Institute of Arizona restrict how it uses or discloses my PHI to carry out TPO.

However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Spine Institute of Arizona's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Spine Institute of Arizona may decline to provide treatment to me.

____
Signature of Patient or Legal Guardian

____________________________________ ________________________
Patient's Printed Name Date

____
Print Name of Patient or Legal Guardian

SPINE
INSTITUTE
OF ARIZONA

9735 North 90th Place
Scottsdale, Arizona 85258
TEL 602/953.9500
FAX 602/953.1782

Authorization for Disclosure of My Health Information to

My Spouse / Significant Other / Parent / Family Member

I, ______________________________, hereby authorize that my Spouse / Significant Other / Parent / Family Member(s) may obtain or receive copies of my Protected Health Information to include, but is not limited to; office notes, prescriptions, imaging films.

Unless I revoke this authorization earlier, this authorization will expire six years from the date signed.

Name(s) of Spouse/Significant Other/Parent/Family Member(s)	Relationship
____	______________
____	______________
____	______________
____	______________
____	______________
____	______________

PLEASE NOTE: *Your Spouse/Significant Other/Parent/Family Member(s) will be required to show legal I.D. prior to being able to obtain your Protected Health Information.*

______________________________ ______________________

Signature of Patient or Legal Guardian Date

____

Patient or Legal Guardian's Printed Name

© Spine Institute of Arizona, 01/05

SPINE INSTITUTE of Arizona

9735 NORTH 90TH PLACE
SCOTTSDALE, ARIZONA 85258
PHONE: 602-953-9500
FAX: 602-953-1782

FINANCIAL STATEMENT

It is the policy of the Spine Institute of Arizona to collect co-pays and any outstanding patient balances before each visit. If you cannot pay your co-pay and any outstanding balance your appointment will be rescheduled.

Our business office will bill your medical insurance for the services rendered in our office. Payment is not guaranteed by your insurance. You are ultimately responsible for all charges. The insurance process normally takes approximately 60-90 days. You will receive monthly financial statements to include any outstanding charges on your account. Once insurance has processed payment, your financial statement will reflect any deductibles and/or co-insurance due from you as per your insurance.

It is your responsibility to know and understand your insurance policy and benefits. We will bill secondary insurance as a courtesy.

Our providers are not contracted with any AHCCCS / Medicaid insurance programs. You will be responsible for outstanding balances.

If your insurance has lapsed, is inactive, or for any reason does not cover the expenses that you have incurred at the Spine Institute of Arizona, you will be responsible for the full charges that have been billed to your insurance company. Payment for these charges must be received within 30 days from receipt of your bill.

If you choose to pay by check and your check does not clear, you will be responsible for paying the bank administrative charge of $25.00 plus the amount of your original check.

If we have had no response or contact from you within 60 days to pay off your balance, the Business Office will turn your account over to our collection agency. The collection agency will assess a 25% collection fee due in addition to your original balance.

SELF-PAY PATIENT POLICY:
We do see patients on a self-pay basis. The charge for services will be collected prior to the service being rendered. Cash, debit card with VISA/MasterCard guarantee, or credit card payment is the only accepted form of payment for self-pay patients. Sorry, no personal checks are accepted.

INJECTIONS/SURGICAL PROCEDURE POLICY:
If you become a candidate for injections or surgery, it is our policy to collect any deductible or co-insurance that may be due in advance. Cash, debit card with VISA/MasterCard guarantee, or credit card payment are the only accepted forms of pre-payment for these services. Sorry, no personal checks are accepted. Payment must be received no later than 48 hours prior to the injection or one (1) week prior to surgery or your procedure will be cancelled. To determine any financial responsibility to the facility, please contact the facility prior to your procedure.

DISABILITY / MEDICAL LEAVE FORM POLICY:
If you need a disability / medical leave form filled out there will be a $20.00 charge for each form. By signing this agreement, you understand that you will need to prepay the $20.00 charge for this form to be completed and subsequently released.

Thank you for your understanding of our financial policies at the Spine Institute of Arizona. If you have any questions, please do not hesitate to give our Business Office a call at 602-953-9500.

________________________________ ________________
Patient Signature Date

© Spine Institute of Arizona 03/09

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www.spineaz.com

Spine Institute of Arizona

CAUTIONS REGARDING THE USE OF LONG-TERM NARCOTICS

1. Narcotics are drugs that act like morphine. These include drugs: Lortab, Percocet, Demerol, Darcon, Ultram, Tylenol #3, and others.
2. The drug you have been prescribed is extremely dangerous, capable of being abused, and an over-dose can be lethal
3. When taken in excess, the individual will first become sleepy, fall asleep, will be difficult or unable to arouse and finally, will stop breathing. The level of sedation depends upon the amount of drug ingested.
4. Keep these drugs in a locked box.
5. Be responsible for the drug. No early refill will be given.
6. These drugs can cause physical dependence. This means when you stop taking the drug you will experience a withdrawal reaction. Physical dependence occurs after approximately one week on the drug. This does not mean the drug cannot be stopped; however, it usually must be tapered in order to avoid withdrawal symptoms. A withdrawal reaction can be characterized by severe nausea, vomiting, diarrhea, abdominal pain, muscle aches, low-grade fever, tremor, rapid heart rate, sweating, and chills.
7. Physical dependence is not the same as addiction. Physical dependence means that if you stop the drug suddenly, you will develop a withdrawal reaction (nausea, diarrhea, sweats, shaky, and flu-like symptoms). Addiction is a psychological diagnosis characterized by cravings for the drug, uncontrollable use of the drug even when it causes harm to you and others.
8. There are numerous side effects, which can occur as a consequence of the use of these medications. These include:
   A. Sedation. If you experience this side effect, even slightly, you should not be driving an automobile until the effect wears off. It generally takes one to two weeks for this side effect to wear off. You should then be safe to operate an automobile. If confusion, mental changes or excessive sleepiness occur, report this to your physician or present to the nearest emergency room immediately.
   B. Constipation. If this occurs you will not adapt to this effect. You should drink eight 8 ounce glasses of water per day, take daily doses of Senokot S or Dulcolax, use milk of Magnesia no more than every third day for no bowel movement and notify your physician that you are experiencing this complication. People over the age of 60 are especially at risk for this complication.
   C. Urinary retention. This means it is difficult to start your stream. Males over the age of 60 are especially at risk for this complication.
   D. Itching. These drugs can cause itching in some patients.
   E. Sweating. Profuse sweating can occur at any time with the use of these medications.
   F. Nausea and vomiting. If this occurs, notify your physician.
   G. Decreased sex drive.
   H. Mild suppression of the immune response.

I understand these cautions and am willing to take the drugs as prescribed by my doctor.

Patient____________________________ Date______________________________

Witness____________________________ Date______________________________

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Spine Institute of Arizona

AGREEMENT FOR CONTROLLED SUBSTANCE PRESCRIPTION

As a patient at the Spine Institute of Arizona, you may or may not be prescribed a controlled substance. If you are prescribed a controlled substance, we ask that you agree to our controlled substance protocol. If you will not accept our protocol, we cannot treat you and you will need to work with another physician.

Controlled substance medications (i.e. narcotics, tranquilizers, and barbiturates) are very useful, but they have high potential for misuse and are therefore closely controlled by the local state and federal government. They are intended to relieve pain, to improve function and/or ability to work, not simply to feel good. If I am prescribed such medication, I agree to the following:

1. I am responsible for my controlled substance medications. If the prescription of medication is lost, misplaced, or stolen, or if I use it up sooner than prescribed, I understand that it will not be replaced.
2. I will not request or accept controlled substance medication from any other physician or individual while I am receiving such medication from the Spine Institute of Arizona physicians.
3. Refills of controlled substance medication:
   A. Will be made only during regular office hours Monday through Friday 9 am to 4 pm. Refills will not be made at night, on holidays, or weekends. I will call at least seventy-two (72) hours ahead for all prescription refill requests. prescription. Refill calls made on Friday will be filled the following week.
   B. Will not be made if I "run out early." I am responsible for taking medication in the dose prescribed and for keeping track of the amount remaining.
   C. Will not be made as an "emergency", such as on Friday afternoon because I suddenly realize I will "run out tomorrow."
4. If requested, I will bring in the containers of all medications prescribed by my physician, even if there is no medication remaining. These will be the original containers from the pharmacy for each medication.
5. Upon request from my physician, if narcotic abuse is suspected, I may be asked to submit to a urine drug screen. If I decline, it will be the sole discretion of the Spine Institute of Arizona to discontinue my narcotic pain medication.
6. I understand that the main treatment goal is to improve my ability to function and/or work. In consideration of that goal and the fact that I am being given potent medication to help me reach that goal, I agree to help myself by following my doctor's instructions regarding my health care.

Controlled substances are known to cause psychological dependence (addiction), which I understand is real. I know that some persons may develop a tolerance to medications in which my body does not respond as well to the medication, and I feel the need to have more or a higher dose of the medication. I know that I can become physically dependent on the medication. This will occur if I am on the medication several weeks, and when I stop the medication I must do so under medical supervision, or I may have withdrawal symptoms.

Effective April 26, 2018 all medical prescribers must comply with the 2018 Arizona Opioid Epidemic Act. This means that any medication that you are prescribed must meet the requirements of this new law. If you have been receiving medication from the Spine Institute of Arizona the quantity, dosage, or frequency of your prescription may be adjusted to meet these new requirements.

I have read this agreement. I understand that if I do not follow the rules of this agreement, I will no longer be able to obtain medications from the Spine Institute of Arizona.

Patient_________________________________ Date_____________________________

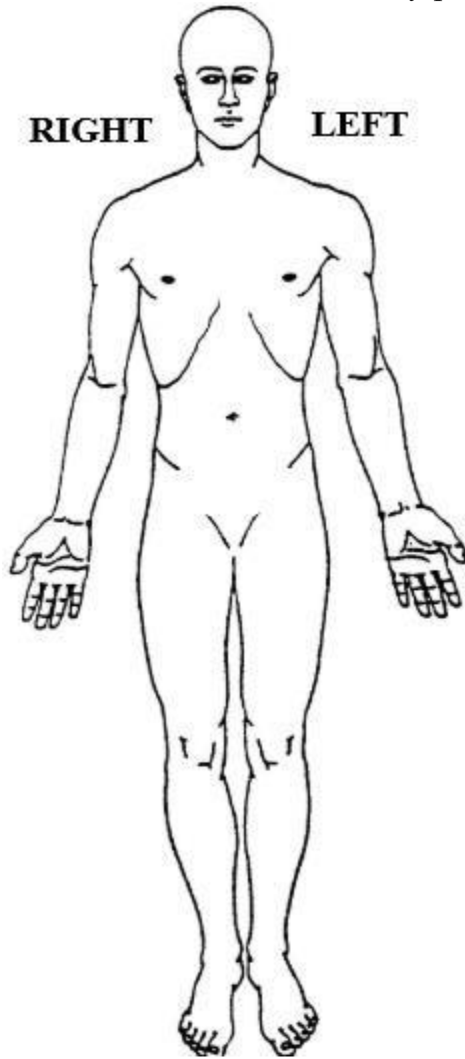
Witness_________________________________ Date_____________________________

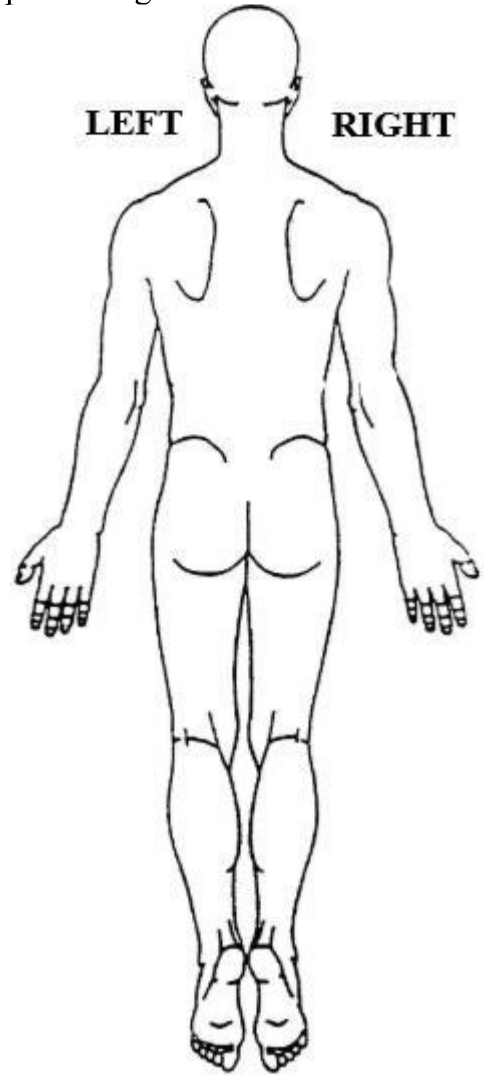
SPINE INSTITUTE *of Arizona*

Patient Name: ______________________________

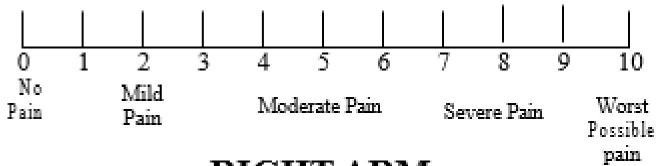
Date: ______________________________

Place an "X" on the body part(s) where you are experiencing pain.
Place a "0" on the body part(s) where you are experiencing numbness.

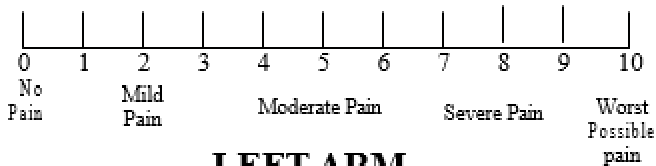




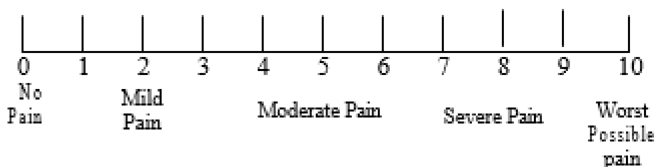
NECK



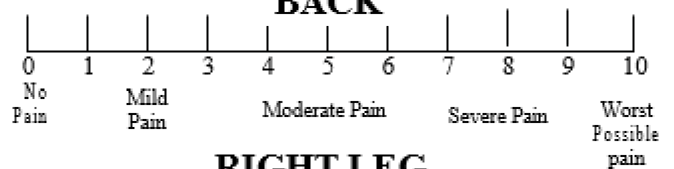
RIGHT ARM



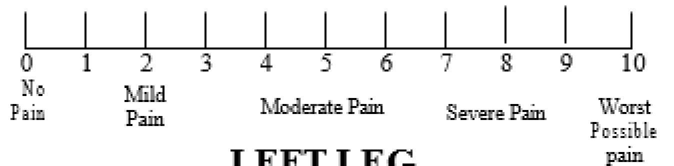
LEFT ARM



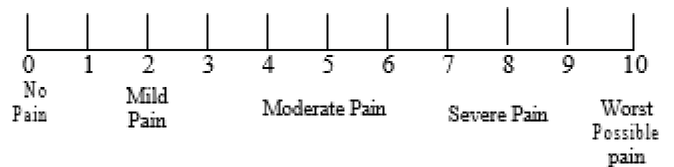
BACK



RIGHT LEG



LEFT LEG



SYMPTOM REVIEW

Have you experienced any of the following conditions in the past month?
If so, please place a check mark in front of any/all of the following you have experienced.
If you have experienced any of these symptoms, please consult with your family doctor.

H.E.E.N.T.

- ☐ Blurred vision
- ☐ Dry eyes
- ☐ Hard of hearing
- ☐ Nasal congestion
- ☐ Sore throat
- ☐ Cough
- ☐ Other: _____________

PULMONARY

- ☐ Shortness of breath
- ☐ Other: ___________

ABDOMINAL

- ☐ Abdominal pain
- ☐ Other: ___________

INTEGUMENTARY

- ☐ Moles
- ☐ Skin Rash
- ☐ Other: ___________

NEUROLOGIC

- ☐ Tremors
- ☐ Other: ___________

GASTROINTESTINAL

- ☐ Abdominal pain
- ☐ Other: ___________

CARDIOVASCULAR

- ☐ Chest pain
- ☐ Other: ___________

GENERAL

- ☐ Fevers
- ☐ Chills
- ☐ Night sweats
- ☐ Stress
- ☐ Poor sleep
- ☐ Swelling of feet
- ☐ Swollen glands
- ☐ Problem with blood clots
- ☐ Weight loss
- ☐ Weight gain
- ☐ Other: ___________

CURRENT WORK STATUS

- ☐ Full Time
- ☐ Regular Duty
- ☐ Other: ___________
- ☐ Restrictions:____

____
____
____

SPINE INSTITUTE of Arizona

Patient Name: ______________________________

Date: ______________________________

This form must be fully completed at each office visit.
We are required to have documentation of medications and allergies for each office visit.
Due to those requirements, we are unable to accept forms with “no change” or “same” answers on this form.

CURRENT MEDICATIONS	DOSAGE	FREQUENCY
1.		
2.		
3.		
4.		
5.		
6.		
7.		

ALLERGIES

1.
2.
3.
4.
5.
6.
7.

PHARMACY

Pharmacy Name:
Address:
Phone:

AUTHORIZATION FOR SPINE INSTITUTE OF ARIZONA TO USE OR DISCLOSE MY MEDICAL INFORMATION

Entity Releasing Information	
Facility:	
Address:	
City, State	Zip Code
Fax:	Phone:

Entity Receiving Information	
Entity/Individual:	
Address:	
City, State	Zip Code
Fax:	Phone:

Patient Information: Patient Name:______________________ Date of Birth: ______________

Address:______________________ Phone Number: ______________

______________________ SSN: ______________

Dates Requested: FROM:______________________ TO:______________________

There May be a FEE Associated with your Request for Records

Records Being Requested:

☐ My Authorization- You may use or disclose the following health care information (check all that apply):

☐ All my health information including, but not limited to, AIDS/HIV and Other Communicable Disease Information, Behavorial Health Care / Psychiatric Care / Psychotherapy Notes, Alcohol and/or Drug Abuse Treatment

☐ All radiologic studies in Spine Institute of Arizona's possession. (I understand and agree that I am financially responsible for the following Fees associated with my request: I understand that there is a copying charge of $7. 00 per x-ray for my Spine Institute of Arizona x-rays films.)

☐ All of my health information except the following:

____

____

☐ **Other Records:** ☐ Billing Record

THIS AUTHORIZATION EXPIRES ON DATE:______________________

Per HIPAA Regulation an authorization for disclosure of Protected Health Information MUST have an expiration date. Your expiration date may not exceed six years form the initial date of authorization.

Delivery of Records: **Paper Requests** ☐ Mail ☐ Pick Up ☐ Fax **Electronic Requests:** ☐ Patient Portal ☐ CD

(Complete ONLY if requesting records via Patient Portal)

Email Address for Patient Portal

Purpose: ☐ Self ☐ Continuing Care ☐ Other (please specify):______________________

<u>My Rights:</u> I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment), except: to take part in a research study; or to receive health care when the purpose is to create health information for a third party.

I understand that I may revoke this authorization in writing at any time. However, I understand that a revocation is not effective to the extent that my physician has relied *on* the use or disclosure of health information or if the authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest the claim. Two ways to revoke this authorization are: to fill out a revocation form available from the office; or write a dated letter to the office.

Once the office discloses health information, the person or organization that receive s it may re-disclose it, as privacy laws may no longer protect it.

I understand that this office has requested this authorization, I have a right to inspect or copy the information to be used or disclosed.

______________________________ ______________________

Patient or legally authorized individual signature Date

______________________________ ______________________

Printed Name if signed on behalf of patient Relationship (parent, legal guardian, personal representative, etc)

Spine Institute of Arizona

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Certified Physician Assistant

Megan E. Ashby, CMPE
Business Development

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Fax 602/953.1782
www.spineaz.com

Dear Patient,

Spine Institute of Arizona and its providers participate in an electronic health information exchange with other health care providers, hospitals, labs, and radiology centers. The Health Information Exchange, or HIE, is a way of sharing health information through secure, electronic means. With your permission our participation in the HIE does two things:

- Allows Spine Institute of Arizona to disclose our confidential health information about you to other providers who are treating you and request your information through the HIE.
- It allows other providers to electronically disclose your confidential health information to the Spine Institute of Arizona through the HIE for treatment and care coordination.

This consent is to obtain your permission to share and receive a limited summary of your medical health record from and to healthcare providers and facilities who are involved with your treatment via the HIE. The summary may include (as applicable) the following information:

- Patient Demographics
- Vital Signs
- Medications & Allergies
- Lab Tests & Results
- Procedures
- Immunizations
- Implanted Devices
- Functional Status
- Miscellaneous Orders & Advice
- Referral Information
- Diagnosis
- Care Team Members

This information is sent over the internet in a secure, encrypted and reliable way among health care professionals and it can be compared to sending a secured email. The HIE enables medical professionals to coordinate care, benefitting both providers and patients. Your choice to opt-out of the HIE will not affect your ability to access medical care. Opting out will not prevent Spine Institute of Arizona from sharing your health information with authorized entities when necessary or required by federal and state law. If you chose to opt out of the HIE the Spine Institute of Arizona will still have the authority to use and disclose protected health information to carry out treatment, payment and healthcare operations through other non-HIE mediums to coordinate your treatment.

☐ Opt-In - The Spine Institute of Arizona may share and receive my health information via the HIE

☐ Opt-Out – The Spine Institute of Arizona may not share or receive my health information through the HIE

___________________________ ___________________________
Patient Name Date

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Patient Signature

Main Office
9735 North 90th Place
Scottsdale, Arizona 85258

West Valley Office
18700 N. 64th Dr, Suite 202
Glendale, Arizona

East Valley Office
16515 South 40th Street, Suite 119
Ahwatukee, Arizona

Prescott Office
3655 Crossings Drive
Prescott, Arizona

Surgery ♦ Pain Management ♦ Rehabilitation ♦ Physical Therapy ♦ Spinal Mobilization & Manipulation

Spine Institute of Arizona

Edward J. Dohring, M.D.
Board Certified Orthopaedic Surgeon
Fellowship Trained Spine Surgeon

Paul R. Gause, M.D.
Board Certified Orthopaedic Surgeon
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Mark J. Wang, M.D.
Board Certified Orthopaedic Surgeon
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John H. Faryna, M.D.
Board Eligible Orthopaedic Surgeon
Fellowship Trained Spine Surgeon

Allan L. Rowley, M.D.
Board Certified
Physical Medicine and Rehabilitation
Interventional Pain Management

Vibhooti H. Dave, D.O.
Board Certified
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Electrodiagnostic Medicine (EMG's)

Brock P. Auten, D.C.
Board Certified Chiropractic Physician
Board Certified Physiotherapist

Bill Balogh, P.A.
Physician Assistant

Donna M. Lahey, R.N.F.A.
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Registered Nurse First Assist

Jennifer R. Watry, PA-C
Certified Physician Assistant

Megan E. Ashby, CMPE
Business Development

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Dear Patient:

We are pleased to announce that the Spine Institute of Arizona Patient Portal is now available. This online tool gives you the flexibility to access your health information and other resources at your leisure – any time of day and from any location.

As a patient of Spine Institute of Arizona enrolling in the Patient Portal will allow you to:

- Update your personal information
- View medications, allergies and vital signs
- Send and receive direct messages with your provider
- View certain chart documents
- Upload files to your medical record
- Share portal documents to other health providers you select
- We are always working on new enhancements to the portal and new features will be added as they become available.

Also, the Patient Portal is completely secure, so you can be confident that your private information is protected.

☐ Please enroll me in the patient portal. A portal invitation will be sent to my email address that I provide below.

____________________________ ________________________
Patient Name Date

____
Email

____
Patient Signature

☐ I elect to Opt-out of the patient portal at this time.

____________________________ ________________________
Patient Name Date

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