Today’s Date \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_

PATIENT INFORMATION

|  |  |  |
| --- | --- | --- |
| Patient’s Name: Last First Middle |  Male Female | Marital Status (Circle One) Single/Married/Divorced/Separated/Widowed  |
| Driver License# & State | Patient’s Date of Birth \_\_\_/\_\_\_/\_\_\_\_\_ | Spouse/Parent Name | Spouse/Parent Home & Work Phone #’s ( ) - ( ) - | Patient’s Current Age |
| Street Address City State Zip Code | Social Security # | Home Phone # ( ) - |
| Alternate Address: P.O. Box # City State Zip Code | Work Phone # ( ) - |
| Occupation | Employer | Cell Phone # ( ) - |
| I chose Dr. Baker because/was referred by (Please check all that apply): Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance Plan Hospital Website Family Member Friend Location Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Name of other family members seen as patients in this office: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

INSURANCE INFORMATION (PLEASE PRESENT YOUR INSURANCE CARD TO THE RECEPTIONIST)

|  |  |  |  |
| --- | --- | --- | --- |
| Person Responsible for Bill (Guarantor): | Guarantor’s Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_ | Address (if different): | Home/Cell Phone #s ( ) - ( ) - |
| Is Guarantor a patient here? Yes No |
| Occupation | Employer | Employer Address | Work Phone # ( ) - |
| Please list primary insurance company name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| Subscriber’s Name | Subscriber’s S.S.# | Subscriber’s Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_ | Policy/Member ID# | Group # |
| Insured’s Driver License # & State | Patient’s Relationship to Subscriber Self Spouse Child Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

IN CASE OF EMERGENCY

NAME RELATIONSHIP TO PATIENT

|  |  |  |  |
| --- | --- | --- | --- |
|  |  | Home/Cell Phone #s ( ) -  | Work Phone # ( ) - |
|  |  | Home/Cell Phone #s ( ) -  | Work Phone # ( ) - |

**MEDICAL CARE:** I authorize Dan R. Baker, MD or designee to provide myself or my child with reasonable and proper medical care according to today’s standards.

**MEDICAL INFORMATION:**  I hereby authorize Dan R. Baker, MD to release any information they have acquired in the course of my or my child’s medical treatment to my insurance company or companies or any third party payor so that they may obtain payment for medical services rendered.,

**INSURASNCE AUTHORIZATION:** I hereby authorize Dan R. Baker, MD or staff of this office to furnish information to my insurance carriers concerning myself or my child’s illness and treatments.

**ASSIGNMENT OF BENEFITS:** I authorize the insurance company or any third party payor to pay any benefits due, directly to this office should they accept assignment on my claim. **I ALSO AGREE THAT I AM FINANCIALLY RESPONSIBLE FOR THE ACCOUNT EVEN THOUGH MY INSURANCE MAY BE PENDING ON ALL OR A PORTION OF THE CHARGES.**

X \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 PATIENT/GUARDIAN SIGNATURE DATE

**ADULT HEALTH HISTORY, PAGE 1**

(16 years and older)

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Check all items that apply to you and fill in blanks as needed. Complete all sections.*

|  |  |
| --- | --- |
| **Past Medical History:** (Please include dates) **o N/A** o Acne o ADD o ADHD o Allergies(other than drug)\_\_\_\_\_\_\_\_\_\_\_\_\_\_ o Anemia o Other blood problems o Anesthesia complications o Arthritis, rheumatoid o Osteoarthritis o Asthma o Cancer/Tumor, explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ o COPD o Emphysema o Other lung disease:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ o Depression o Anxiety o Suicide attempts o Diabetes, type 1 o Type 2, how long:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ o Drug abuse o Alcohol abuse o Epilepsy (seizures) o Glaucoma o Cataracts, L or R eye(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ o Gout o Headaches, type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ o Hearing loss o Deafness  | o Heart disease o Heart disease o Hepatitis, A\_\_\_\_ or B\_\_\_\_\_ or C\_\_\_\_ o High cholesterol o HIV or AIDS o Hypertension (high blood pressure) o Hypothyroid (low) o Hyperthyroid (high) o Irritable Bowel Syndrome o Colon disease o Kidney disease o Kidney stone o Pap smear, Abnormal o Post menopausal, year of last period\_\_\_\_\_\_\_ o Psychiatric treatment, in-patient or out-patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ o Reflux (GERD) o Ulcer disease o Sexually transmitted disease (STD)\_\_\_\_\_\_\_\_ o Skin disease o Eczema o Psoriasis o Stroke o Tuberculosis (TB), last chest x-ray\_\_\_\_\_\_\_\_ o Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |

|  |  |
| --- | --- |
|  **Past Surgical & Hospitalization History:** (Please include dates) **o N/A** o Angioplasty\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ o Appendectomy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ o Back, procedure: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ o Blood transfusion, year \_\_\_\_\_\_\_\_\_\_\_\_\_\_ o Fracture\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_o Gallbladder \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | o Hernia, R or L, type \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ o Knee, R or L, procedure \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ o Tonsillectomy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ o Vasectomy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ o Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_o Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

 **Current specialists: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Previous physicians: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ADULT HEALTH HISTORY, PAGE 2**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Drug Allergies:** o No Known Drug Allergies

 Name of Drug Reaction

|  |
| --- |
|  |
|  |
|  |

**Current Medications:** (prescriptions, birth control pills, over-the-counter, herbs, vitamins):

|  |  |
| --- | --- |
| Medication Strength/Dose Frequency  | Medication Strength/Dose Frequency  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

**Immunizations:** o Tetanus Booster \_\_\_\_\_\_\_\_\_\_ o Flu Vaccine \_\_\_\_\_\_\_\_\_\_ o Other \_\_\_\_\_\_\_\_\_\_\_\_\_

(Date received) o Pneumonia \_\_\_\_\_\_\_\_\_ o Hepatitis B \_\_\_\_\_\_\_\_\_ o TB skin test \_\_\_\_\_\_\_\_\_\_\_\_\_

**Social History:**

Marital Status: o Married o Divorced o Single o Separated o Widowed

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

***Please check appropriate spots for each of the following items:***

Tobacco use: o No o Yes ( o Cigarettes o Chew/snuff , ? per day\_\_\_\_\_; how long\_\_\_) o Quit, when\_\_\_\_\_\_

Alcohol use: o No o Yes (Quantity: number of drinks or bottles of beer per week\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

Caffeine: o No o Yes (Quantity: number of cups/glasses/cans per day of coffee, tea or soda \_\_\_\_\_\_\_\_\_\_\_\_\_\_)

Recreational drugs: o No o Yes (what drugs do you use\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

Sexually Active: o No o Yes

Seat Belt Use: o No o Yes

**Family History: Living Deceased**

 Age Health Status or Illnesses Age Cause of death & Illnesses

|  |  |  |
| --- | --- | --- |
| Father |  |  |
| Mother  |  |  |
| Father's father  |  |  |
| Father's mother  |  |  |
| Mother's father |  |  |
| Mother's mother |  |  |
| Brothers |  |  |
| Sisters |  |  |
| Children |  |  |

o Adopted – Family history unknown

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_

Provider Reviewed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_

PRINTED NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**THE EPWORTH SLEEPINESS SCALE**

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent time. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation:

|  |
| --- |
| 0 = no chance of dozing |
| 1 = slight chance of dozing |
| 2 = moderate chance of dozing |
| 3 = high chance of dozing |

|  |  |
| --- | --- |
| **SITUATION** | **CHANCE OF DOZING** |
| Sitting and reading |  |
| Watching television |  |
| Sitting, inactive, in a public place (e.g. a theater or a meeting) |  |
| As a passenger in a car for an hour without a break |  |
| Lying down to rest in the afternoon when circumstances permit |  |
| Sitting and talking to someone |  |
| Sitting quietly after lunch without alcohol |  |
| In a car, while stopped for a few minutes in traffic |  |
| **TOTAL** |  |

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

To check your sleepiness score, total the points and bring with you to your appointment with Dr. Baker to discuss possible treatments and remedies.

Welcome to our office. We are dedicated to providing you the best possible care and service. Your complete understanding of our office and financial policies is an essential element of your care. The following information

is being provided to you in an effort to reduce confusion and misunderstanding regarding services provided by our

office. In order to ensure that all our patients understand our policies, please read the following and initial where indicated. We encourage you to ask questions about any of these policies. Please request a copy if needed for

future reference. Thank you.

**APPOINTMENT TIME LENGTHS**

When you call for an appointment our scheduling staff will ask you questions in order to determine the appropriate length appointment slot. At the time of the visit, if you have additional concerns you wish to discuss with the provider you may

be asked to schedule an additional visit to thoroughly address additional needs. \_\_\_\_\_\_\_\_\_\_(initial)

## NO SHOW/LATE CANCELLATION FEE

If you do not show up for an appointment or fail to cancel an appointment at least 24 hours in advance, you may be charged a fee of $50.00. With three no shows you may be terminated from the practice. Many of our patients wish to schedule back-to-back appointments with other family members. As our schedules permit we will try to accommodate this request. However, for families that abuse this request by not showing up for their appointments, or who cancel at the last minute, back-to-back appointments will not be available. \_\_\_\_\_\_\_\_\_\_(initial)

**REFILL POLICY**

For all refills please contact our office several days before you run out of a medication. There are times when a refill will require a follow up visit in order to be filled and we do not want to have you run out of a medication. If the medication is a continuing medication that we fill for you, please remember that it will be quickest to text or call our office. You may contact your pharmacy but this can result in a delay. \_\_\_\_\_\_\_\_\_\_(initial)

**TRIPLICATE PRESCRIPTION REFILL POLICY**

Please contact our office five business days prior to needing a refill for a medication requiring a triplicate prescription. These prescriptions may be picked up at our office after our staff notifies you it is ready. \_\_\_\_\_\_\_\_\_\_(initial)

**REFERRAL POLICY**

Some insurance company require prior authorizations (referrals). These referrals should be obtained prior to your appointment. Some insurance companies take up to one week to obtain authorization. A copy of the authorization will be required to be received by our office prior to your appointment. It is your responsibility to get this referral from your PCP’s office and have it to us in time for your appointment. Please do not wait until the day of your appointment to contact your Primary care physician for this referral \_\_\_\_\_\_\_\_\_\_(initial)

## RELEASE OF INFORMATION

Information regarding our patients is confidential. Therefore, no information will be released to anyone except the

patient without the patient’s written authorization. This includes spouses and parents of patients 18 years or older. Exceptions are made only in the case of an emergency or for specialty care. If a patient changes physicians, after receiving written authorization, records will be forwarded to the new physician at no charge. For records to be

released to an insurance company, attorney, or to the patient, a minimum charge of $25 must be paid prior to release of the records. \_\_\_\_\_\_\_\_\_\_(initial)

## FINANCIAL POLICIES

* We have contracted with many insurance companies to accept assignment of benefits. We will bill those plans with which we have an agreement and will require you to pay the co-pay or applicable deductible at the time of your appointment. If you are not prepared to make your co-payment at the time of your visit you may be asked to reschedule your appointment.
* If your health plan requires you to have a Primary Care Physician (PCP), it is your responsibility to assure that Dr. Baker is on file with your PCP and the referral is in place prior to your appointment. Otherwise, the incurred charges will not be paid by your health plan and therefore, will be your responsibility.
* If insurance eligibility cannot be verified at the time of an appointment, payment will be expected in full. If we are able to receive payment from your insurance plan you will be refunded.
* All health plans are not the same and do not cover the same services. We will make every effort to verify benefits and inform you if a service may not be covered by Medicare or other insurance, but it is ultimately your responsibility to know your benefits and to verify coverage. In the event your health plan determines a service to be “not covered” you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.
* Our office does not bill third-party payers, such as an automobile insurance company. If you wish to receive compensation from a third-party payer, services at our office must be paid in full at the time of service. We will provide you with the documentation needed for you to pursue your claim for reimbursement.
* Patients who do not have insurance are required to pay in full at the time of service. For your convenience we accept VISA and MasterCard, Discover and American Express. As special circumstances indicate, we will consider requests for planned payment schedules. Please discuss this with office staff prior to scheduling your appointment.
* For all services rendered to minor patients, the adult accompanying the patient at the time of the visit is responsible for payment.
* There will be a $25.00 service charge on all returned checks. Persons not responding to our request for payment within a reasonable period of time will be referred to the Office of the County Attorney. \_\_\_\_\_\_\_\_\_\_(initial)

I have read and have received answers to any questions regarding the office and financial policies initialed above.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| Printed Name | Signature | Date |

Circle relationship to patient:

Self Parent Guardian Family Member Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Acknowledgement of Review of

Notice of Privacy Practices

I have been given the opportunity to review this office’s Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Name of Patient or Personal Representative

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Description of Personal Representative’s Authority

# **IN REGARD TO YOUR CONFIDENTIALITY**

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**IF THE OFFICE NEEDS TO REACH YOU**

May our provider or office staff leave a message for you to contact our **( ) Yes ( ) No**

 office with someone at your home/cell telephone number?

May our provider or office staff leave a message for you to contact our **( ) Yes ( ) No**

 office on your home/cell telephone messaging system?

**\*\*if messaging system does not identify the patient by name, we will only leave a call back message\*\***

May our provider or office staff leave a message for you to contact our **( ) Yes ( ) No**

 office with someone at your work phone number?

May our provider or office staff share private health information **( ) Yes ( ) No**

 with family member or significant other?

May our provider or office staff inform any family members or **( ) Yes ( ) No**

 significant other of your referral information?

If yes, please list the names of those we have your permission to inform

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list the names of family members or a significant other you give permission to obtain access to your private health information documents or medications. Example: prescriptions/samples & any type of medical records

\*\***A VALID ID WILL BE REQUIRED EVERYTIME\*\***

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Cellular Telephones**

Please be aware that our providers are conduct some office business, including patient

management, over a cellular telephone. In some instances, there exists a risk that others may overhear these

conversations. Our provider tries to limit the use of cellular telephones to answering pages which in general are

emergencies.

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Signature Date**