PREFERREDCARE
MEDICAL CENTER • LTD

PATIENT INFORMATION
(Please Print)

Last Name:	First Name:		MI:
Preferred Name: (if different)	Birthdate:	Sex: M F	SSN:
Permanent Address: (street #, city, state, zip)			
Home Phone: [ ] Preferred	Cell Phone: [ ] Preferred		
Work Phone:	Email:	Employer Name:	
Are you transferring care from your previous provider? [ ] Y [ ] N		Employer Address:	
Primary Care Provider (PCP):	PCP Office/Phone:		
Emergency Contact:	Responsible Party if under 18yrs		
Emergency Contact Phone:	Responsible Party Phone:		
Relationship to Patient:	Relationship:		

GENERAL INFORMATION

Ethnicity: [ ] Hispanic/Latino [ ] Non-Hispanic/Latino [ ] Other _____	**Race:** [ ] Asian [ ] American Indian/Alaska Native [ ] Black/African American [ ] Pacific Islander [ ] White/Caucasian [ ] Hispanic [ ] Other _____	**Primary Language:** [ ] English [ ] Spanish [ ] Other _____
OK to leave messages **at home**?: [ ] YES [ ] NO	OK to leave messages **on cell?:** [ ] YES [ ] NO	
OK to leave messages **at work**: [ ] YES [ ] NO	OK to contact by **email?**: [ ] Yes [ ] NO	
Pharmacy: (Name and Address)	Pharmacy Phone #:	
What is your occupation:	Work Activity: [ ] Sitting [ ] Standing [ ] Light Labor [ ] Heavy Labor	
How did you hear about our office: [ ] Newspaper [ ] Brochure [ ] Internet [ ] Friend/Family: Name _____ [ ] Other_____		

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MEDICAL, FAMILY, AND SOCIAL HISTORY

Patient's Full Name:	**Date of Birth:**	**Today's Date:**

Medication Allergies	Medication	Reaction

Current Medications Include vitamins and OTC. (Use back if needed)	Name	Dose (mg, ml…)	Route (oral, topical…)	Frequency (times/day)

Surgical History Please list all surgeries you have had.	Type of Surgery	Date of Surgery

Medical History Have you ever been diagnosed with any of the following:

- ☐ Abnormal Heart Rhythm
- ☐ AID/HIV
- ☐ Allergies/Hay Fever
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorder/Blood Clot
- ☐ Breast Lump
- ☐ Cancer: Type _____
- ☐ Car Accident
- ☐ Chicken Pox
- ☐ COPD
- ☐ Depression
- ☐ Diabetes
- ☐ Fainting/Dizziness/Vertigo
- ☐ Fractures
- ☐ Frequent Infections
- ☐ Gallbladder Disease
- ☐ Glaucoma
- ☐ Goiter/Thyroid Disease
- ☐ Headache/Migraine
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Menstrual Dysfunction
- ☐ Measles
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Nervousness/Anxiety
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Parkinson's Disease
- ☐ Prostate Problem
- ☐ Rheumatic Fever
- ☐ Seizure Disorder
- ☐ Sexually Transmitted Disease
- ☐ Sleep Disorder
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Whooping Cough

Social History		
	Tobacco Use: [ ] Yes [ ] Not currently [ ] Never	Caffeine: Amount/day _____
	Drug Use: [ ] Yes [ ] Never [ ] Not currently	Exercise: How long/how often _____
	Alcohol Use: [ ] No [ ] Yes: Type _____How Much? _____How Often? _____	

Family History	Father	Mother	Child	Sibling	Grandfather Paternal (P), Maternal (M)	Grandmother Paternal (P), Maternal (M)	Other (Please Specify)
Heart Disease							
Cancer							
Stroke							
Diabetes							
High Blood Pressure							

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PREFERREDCARE

Review of Systems

Patient's Full Name:	Date of Birth:	Today's Date:

Form Completed By: [ ] Patient [ ] Parent/Guardian/Other: Name _____ Relation _____

What is your main complaint or reason for visit? _____

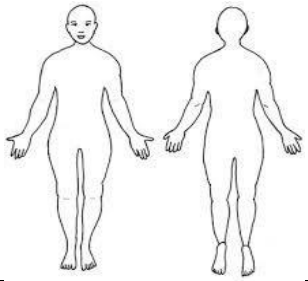
When did this start? _____

Are symptoms [ ] Constant or [ ] Intermittent?

Are symptoms getting Progressively Worse? [ ] Yes [ ] No

Rate your pain: 1-10 (10 is the worst pain you have ever had): _____

Please mark an X on the diagram at the location of your symptoms.



Quality: [ ] sharp [ ] dull [ ] ache [ ] burning [ ] tinging [ ] throbbing

Does your pain radiate? [ ] YES [ ] NO

Are your symptoms related to an injury? [ ] YES [ ] NO

Symptoms related to work/auto accident? [ ] YES [ ] NO

Have you used anything to relieve your symptoms? [ ] YES [ ] NO
If yes, what have you tried? _____

Did this help? [ ] YES [ ] NO [ ] Temporarily

Indicate what activities make symptoms worse:
[ ] Sitting [ ] Standing [ ] Walking [ ] Bending [ ] Lying Down

Symptoms interfere with:
[ ] Work [ ] Sleep [ ] Daily Routine [ ] Recreation

PLEASE MARK THE BELOW SYMPTOMS THAT YOU ARE **CURRENTLY** EXPERIENCING

CONSTITUIONAL
Fever [ ] Yes [ ] No
Chills/Sweats [ ] Yes [ ] No
Fatigue [ ] Yes [ ] No
Weight gain/loss [ ] Yes [ ] No
Difficulty Sleeping [ ] Yes [ ] No

CHILDREN-BABIES ONLY
Decreased Activity [ ] Yes [ ] No
Inconsolable/Fussy [ ] Yes [ ] No
Increased Crying [ ] Yes [ ] No
Drinking/Eating Less [ ] Yes [ ] No
Pulling at Ears [ ] Yes [ ] No
Diaper Rash [ ] Yes [ ] No
Attends Daycare [ ] Yes [ ] No

EYES
Eye Pain [ ] Yes [ ] No
Sensitivity to Light [ ] Yes [ ] No
Redness [ ] Yes [ ] No
Vision Changes [ ] Yes [ ] No

EARS-NOSE-THROAT-MOUTH
Sore Throat [ ] Yes [ ] No
Nasal Congestion [ ] Yes [ ] No
Runny Nose [ ] Yes [ ] No
Ear Pain/Ache [ ] Yes [ ] No
Foreign Body in Nose [ ] Yes [ ] No
Tooth Pain [ ] Yes [ ] No

RESPIRATORY
Cough [ ] Yes [ ] No
*With sputum? [ ] With Blood? [ ]
Shortness of Breath [ ] Yes [ ] No
Wheezing [ ] Yes [ ] No
Pain with cough/breath [ ] Yes [ ] No

CARDIOVASCULAR
Chest Pain [ ] Yes [ ] No
Palpitations [ ] Yes [ ] No
Heart Racing [ ] Yes [ ] No
Leg Swelling [ ] Yes [ ] No
Difficulty Breathing [ ] Yes [ ] No

SKIN-HAIR-NAILS
Rash [ ] Yes [ ] No
Skin Redness [ ] Yes [ ] No
Cold Feet/Hands [ ] Yes [ ] No
Itching [ ] Yes [ ] No
Cut, bumps, bruise [ ] Yes [ ] No Finger or Toe Problem [ ] Yes [ ] No

GENITOURINARY/GYN
Pain/Pressure/Discomfort with Urination [ ] Yes [ ] No
Blood in Urine [ ] Yes [ ] No
Kidney Pain [ ] Yes [ ] No
Vaginal Discharge [ ] Yes [ ] No
Penile Discharge [ ] Yes [ ] No
Female Only:
Pregnant [ ] Yes [ ] No
Breast Feeding [ ] Yes [ ] No
Method of Birth Control: _____
Last Menstrual Period: _____

NEUROLOGICAL
Headache [ ] Yes [ ] No
Dizziness [ ] Yes [ ] No
Loss of Consciousness [ ] Yes [ ] No
Numbness/Tingling [ ] Yes [ ] No
Seizure [ ] Yes [ ] No
Weakness [ ] Yes [ ] No

GASTROINTESTINAL
Abdominal Pain [ ] Yes [ ] No
Indigestion/Reflux [ ] Yes [ ] No
Nausea [ ] Yes [ ] No
Vomiting [ ] Yes [ ] No
Diarrhea [ ] Yes [ ] No
Constipation [ ] Yes [ ] No
Black/Bloody Stool [ ] Yes [ ] No
Hemorrhoid [ ] Yes [ ] No
Rectal Problem [ ] Yes [ ] No

MUSCULOSKELETAL
Back Pain [ ] Yes [ ] No
Neck Pain [ ] Yes [ ] No
Muscle Ache [ ] Yes [ ] No
Bone Pain [ ] Yes [ ] No
Joint Pain [ ] Yes [ ] No
Joint Swelling [ ] Yes [ ] No
Extremity Swelling/Pain [ ] Yes [ ] No

HEMATOLOGY-ENDOCRINE
Easy Bruising [ ] Yes [ ] No
Prolonged Bleeding [ ] Yes [ ] No
Swollen Glands [ ] Yes [ ] No
Excessive Thirst [ ] Yes [ ] No
Excessive Hunger [ ] Yes [ ] No

PSYCHOLOGIC
Sadness [ ] Yes [ ] No
Depression [ ] Yes [ ] No
Anxiety/Nervousness [ ] Yes [ ] No
Irritability [ ] Yes [ ] No
Mood Swings [ ] Yes [ ] No

OTHER
Please Specify:

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PREFERREDCARE
MEDICAL CENTER • LTD

Patient Consent Form

NOTICE OF PRIVACY POLICY HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPPA) ACKNOWLEDGEMENT

By signing below, you consent to the use of your Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. You consent that Preferred Care Medical Center, LTD. (PCMC) can use and disclose medical information to treat you and to seek payment from third parties for this treatment. You also consent to disclosure of PHI to insurers and providers outside of PCMC, when necessary, so that these insurers and/or providers may treat you, seek payment for that treatment, and so that they can perform their health care operations. You may refuse all or part of this consent. If you refuse the use of your medical information for use of payment from your insurance company, you will be responsible for your bills. This consent will be valid for the entire duration of treatment by PCMC unless you request that consent be revoked. Initials: _____

FINANCIAL RESPONSIBILITY

By signing below, you agree to pay PCMC accounts on yourself and/or your dependent(s) for the services rendered when they are presented to you. If you have medical insurance on yourself and/or your dependent(s), you authorize those benefits to be paid directly to PCMC. **All co-payments to will be paid to the receptionist prior to your appointment.** My signature states that I understand that I am responsible for any balance that the insurance company does not cover.

Initials: _____

INSURANCE RELEASE OF INFORMATION

By signing below, you authorize PCMC to release any medical information that may be necessary for processing your insurance claim to your insurance company. You further assign any benefits payable on your behalf to PCMC. You are financially responsible for any balance not covered by your insurance carrier.

Initials: _____

CANCELLATION/NO SHOW POLICY

ALL PATIENTS

Our goal is to help as many patients as we can as efficiently as we can. Please help us help others.

Due to an increased demand for open appointment times and an increase in No Shows for scheduled appointments, unfortunately, we now need to enforce a Cancellation Policy.

Unlike other offices, we do NOT anticipate cancellations by double booking our appointments.

In order to treat our patients in a smooth, efficient manner and cut down on wait times, it is important to not only show up for your scheduled appointment, but to try to be on time!

We UNDERSTAND that things come up, just please let us know as soon as possible, sot that we can move you to a different time slot and fill that spot with another patient!

Furthermore, failure to show up for a scheduled appointment or call to cancel an appointment with less than 1 hours' notice, will result in a charge of $25 that will be charged directly to your account.

From all of us here at Preferred Care Medical Center, we Thank You for understanding!

Initials: _____

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CHIROPRACTIC INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic procedures, including various modes of physio therapy, diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether sig\notaries to this form or not.

I have had an opportunity to discuss with the Doctor of Chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures.

I understand and I am informed that, as is with all Healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all Healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I further understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded if I wish to cancel the treatment.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited self-administered, over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent to cover the entire course of treatment for my present condition and for any further condition(s) for which I seek treatment.

Name of Patient: _____

Signature of Patient/or Guardian: _____

Doctor of Chiropractic Name: _____

Signature of Doctor of Chiropractic: _____

Date: _____

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Surprise Billing Protection Form

This document describes your protections against unexpected medical bills. It also asks if you'd like to give up those protections and pay more for out-of- network care.

IMPORTANT: You aren't required to sign this form and shouldn't sign it if you didn't have a choice of providers when receiving care. For example, if a doctor was assigned to you with no opportunity to make a change.

Getting care from this provider or facility will likely cost you more.

What is "surprise billing"?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network. "Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit. "Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're never required to give up your protection from surprise billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

Ask your health care provider or patient advocate if you're not sure if these protections apply to you. If you sign this form, be aware that you may pay more because:

- You're giving up your legal protection from higher bills.
- You may owe the full costs billed for the items and services you get.
- Your health plan might not count any of the amount you pay towards your deductible and out- of-pocket limit. Contact your health plan for more information.

Before deciding whether to sign this form, you can contact your health plan to find an in-network provider or facility. If there isn't one, you can also ask your health plan if they can work out an agreement with this provider or facility (or another one) to lower your costs.

See page 3 for your cost estimate.

By signing, I understand that I'm giving up my federal consumer protections and may have to pay more for out-of-network care. I choose the following:

☐ *Bill my in-network insurance benefits. I acknowledge I am responsible for any deductibles, co-pays, co-insurance and other services not covered by in-network benefits.*

☐ *Bill my out-of-network insurance benefits. I acknowledge I am responsible for any deductibles, co-pays, co-insurance and other services not covered by out-of-network benefits.*

☐ *Bill me directly. I agree to opt out of billing insurance and choose to pay the discounted cash price charged directly to me. I acknowledge I am financially responsible for all services rendered.*

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With my signature, I'm agreeing to get the items or services from (select all that apply):

☐ *Dr Carrie Musselman, DC*

☐ *Dr Samuel Hendricks, DC*

☐ *Allison Rocke, LMT*

☐ *Preferred Care Medical Center, Ltd.*

With my signature, I acknowledge that I'm consenting of my own free will and I'm not being coerced or pressured. I also acknowledge that:

- I'm giving up some consumer billing protections under federal law.
- I may have to pay the full charges for these items and services or have to pay additional out- of-network cost-sharing under my health plan.
- I was given a written notice on *[enter date of notice]* that explained my provider or facility isn't in my health plan's network, described the estimated cost of each service, and disclosed what I may owe if I agree to be treated by this provider or facility.
- I got the notice either on paper or electronically, consistent with my choice.
- I fully and completely understand that some or all the amounts I pay might not count toward my health plan's deductible or out-of-pocket limit.
- I can end this agreement by notifying the provider or facility in writing before getting services.

IMPORTANT: You don't have to sign this form. If you don't sign, this provider or facility might not treat you, but you can choose to get care from a provider or facility that's in your health plan's network.

_____ or _____

Patient's signature | Guardian/authorized representative's signature

_____ _____

Print name of patient | Print name of guardian/authorized representative

_____ _____

Date and time of signature | Date and time of signature

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Take a picture and/or keep a copy of this form. It contains important information about your rights and protections.

More details about your total cost estimate

The amount below is only an estimate; it isn't an offer or contract for services. This estimate shows the full estimated costs of the items or services listed. It doesn't include any information about what your health plan may cover. This means that **the final cost of services may be different than this estimate. Please remember you may be charged for a new patient visit *if you haven't been seen for over one year after your initial visit.***

Contact your health plan to find out if your plan will pay any portion of these costs, and how much you may have to pay out-of-pocket.

Service code	Description	Estimated in-network amount	Estimated OON amount	Estimated cash amount
99213	New patient exam (first visit)	$ 144.00	$ 144.00	$ 75.00
72040,72070, 72100	Complete spine xrays and radiology report (first visit)	$ 613.00	$ 613.00	$ 65.00
98941, 98940	Chiropractic adjustment (per visit)	$ 58.00	$ 58.00	$ 44.00
98943	Extremity adjustment	$ 40.00	$ 40.00	$ 4.00
97032	Electrical stimulation	$ 52.00	$ 52.00	$ 5.20
97010	Use of Hot/Cold Pack	$ 32.00	$ 32.00	$ 3.20
97012	Use of Roller Table	$ 37.00	$ 37.00	$ 3.70
97035	Use of Ultrasound	$ 51.00	$ 51.00	$ 51.00
97530	Performance of Graston Procedure	$ 83.00	$ 83.00	$ 83.00
97124	Massage Therapy (1 hr)	$ 80.00	$ 80.00	$ 65.00
99211	Re-Exam (one time only)	$ 79.00	$ 79.00	$ 45.00
	Typical new patient cash amount (for first visit):			**$ 184.00**

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NECK BOURNEMOUTH QUESTIONNAIRE

Patient Name _____ Date _____

Instructions: The following scales have been designed to find out about your neck pain and how it is affecting you. Please answer ALL the scales, and mark the ONE number on EACH scale that best describes how you feel.

1. Over the past week, on average, how would you rate your neck pain?

   No pain_____Worst pain possible

   0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your neck pain interfered with your daily activities (housework, washing, dressing, lifting, reading, driving)?

   No Interference_____Unable to Carry out Activity

   0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your neck pain interfered with your ability to take part in recreational, social, and family activities?

   No interference_____Unable to carry out Activity

   0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

   Not at all anxious_____Extremely Anxious

   0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

   Not at all Depressed_____Extremely Depressed

   0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your neck pain?

   Have made it no worse_____Have made it much worse

   0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been able to control (reduce/help) your neck pain on your own?

   Completely control it_____No Control Whatsoever

   0 1 2 3 4 5 6 7 8 9 10

_____

Examiner

OTHER COMMENTS:_____

With Permission from: Bolton JE, Humphreys BK: The Bournemouth Questionnaire: A Short-form Comprehensive Outcome Measure. II. Psychometric Properties in Neck Pain Patients. JMPT 2002; 25 (3): 141-148

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BACK BOURNEMOUTH QUESTIONNAIRE

Patient Name _____ Date _____

Instructions: The following scales have been designed to find out about your back pain and how it is affecting you. Please answer ALL the scales, and mark the ONE number on EACH scale that best describes how you feel.

1. Over the past week, on average, how would you rate your back pain Over the past week, on average, how would you rate your neck pain?

No pain_____Worst pain possible

0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your back pain interfered with your daily activities (housework, washing, dressing, walking, climbing stairs, getting in/out of bed/chair)?

No Interference_____Unable to Carry out Activity

0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your back pain interfered with your ability to take part in recreational, social, and family activities?

No Interference_____Unable to Carry out Activity

0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling? Not at all anxious Extremely anxious

Not at all anxious_____Extremely Anxious

0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not at all Depressed_____Extremely Depressed

0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your back pain?

Have made it no worse_____Have made it much worse

0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been able to control (reduce/help) your back pain on your own?

Completely control it_____No Control Whatsoever

0 1 2 3 4 5 6 7 8 9 10

_____
Examiner

OTHER COMMENTS:_____

With Permission from: Bolton JE, Breen AC: The Bournemouth Questionnaire: A Short-form Comprehensive Outcome Measure. I. Psychometric Properties in Back Pain Patients. JMPT 1999; 22 (9): 503-510.

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Medical Information Release Form

(HIPAA Release Form)

Name: _____ **Date of Birth:** ____/____/____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____

[ ] Child(ren)_____

[ ] Other_____

[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell Number:_____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

The best time to reach me is (*day*)_____ between (*time*)_____

Signed: _____ Date: ____/____/_____

Witness:_____ Date: ____/____/_____

https://images.sampleforms.com/wp-content/uploads/2017/02/Free-HIPAA-Medical-Release-Form.jpg 1/

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