

**EXCELLENT COMPREHENSIVE HEALTHCARE**

8010 Sunport Dr #116, 32809

Phone: (407) 917-0853 | Fax: (407) 641-8591 | [www.Drcadetsolutions.com](http://www.drcadetsolutions.com/)

**PATIENT REGISTRATION FORM**

Patient’s Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle (Initial): \_\_\_\_\_\_\_\_

Marital Status:  Single  Married  Divorced  Widowed  Separated

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Home  Cell  Okay to send appointment reminders via text message

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_ SSN: \_\_\_\_\_\_\_\_\_ - \_\_\_\_ - \_\_\_\_\_\_\_\_\_ Preferred Name : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sex Assigned at Birth:  Male  Female | Preferred Pronoun: \_\_\_\_\_\_\_ | Gender Identity:  Male  Female  Trans

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FINANCIAL INFORMATION**

Family Size: \_\_\_ Yearly Gross Income: \_\_\_\_\_\_ Initials: \_\_\_\_ FPL: \_\_\_\_% Sliding Fee Scale: \_\_\_\_\_\_\_ Eligibility Date: \_\_\_\_\_\_\_\_

**INSURANCE INFORMATION**

 Private Insurance  Medicaid  Medicare Part D  Other Initials: \_\_\_\_\_\_\_\_\_

**HOW DID YOU HEAR ABOUT US?**

 Insurance Plan  Physician/Provider \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Close to Home/Work  Family

 Hospital: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  PA Radio Talk Show/Social Media  Friend  Walk In

**MISCELLANOUS INFORMATION**

|  |  |  |  |
| --- | --- | --- | --- |
| **Preferred Language**   * English * Spanish * Haitian Creole/French * Portuguese * Other | **Race**   * Native/American Indian * Asian * Black/African American * White/Caucasian * Other | **Ethnicity**   * Hispanic or Latino * Non-Hispanic or Latino * Native American * Other | **Preferred Method of Communication**   * Cell Phone Text * Cell Phone Call * Home Phone Call * Email |

**I certify that the above information is a true and complete statement of my financial and insurance situation to the best of my knowledge. I understand that the information I have given is subject to verification by Positive Assistance, Inc. and every effort will be made to keep my information private and confidential. I also understand that I may request a review of the charge(s) if I feel it is inaccurate. For family planning and communicable disease services, I understand that I will not be denied service(s) because of inability to pay.**

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

**Signature of Patient Date**

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

**Staff Name, Signature, or Initials Date**

**SOCIAL HISTORY**

Please complete the following information by placing a check mark in the appropriate box(es) or by filling in the requested information.

Do you live:  Alone  with Spouse/Family  With others  Other/Describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been physically, sexually, or emotionally abused?  Yes  No

Have you ever used any of the following substances? Please check all that apply.

 Tobacco  Alcohol  Recreational/Street Drugs

Do you have flu-like symptoms?  Yes  No Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you sexually active?  Yes  No If yes, with  Men Only  Women Only  or Both

Sexual preference: Top, Bottom, or Verse?

Have you ever had a sexually transmitted infection/STI/STD?  Yes  No

If you had an STI/STD, what did you test positive for? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Was it treated?  Yes  No

Have you ever had sex either  Vaginal  Oral  Anal

Do you use a contact barrier such as a condom?  Never  Sometimes  Most of the times  Always

Do you have more than one sexual partner?  Yes  No How many sexual partners have you had? (Total/Lifetime): \_\_\_\_

Have you ever had sex with someone you did not know or with anyone you know to be HIV positive?  Yes  No

Do you ever inject a needle or “works” that are not yours exclusively?  Yes  No

Have you ever had sex in exchange for other things like money, drugs or a place to sleep?  Yes  No

Are you a women or a man who is trying to conceive a child with a partner who is HIV positive?  Yes  No

Are you having any sexual problems?  Yes  No If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PAST MEDICAL/SURGICAL HISTORY**

Please complete the following information by placing a check mark in the appropriate box(es) or by filling in the requested information.

Have you ever been hospitalized?  Yes  No Year: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had any serious injuries and/or broken bones?  Yes  No Year: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever received a blood transfusion?  Yes  No  Unknown Year: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had any surgeries?  Yes  No Describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Year: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**IMMUNIZATION HISTORY**

Have you ever received the following immunizations? Check all that apply Approximate Year: \_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Pneumococcal** (for Pneumonia) | **Hepatitis A** | **Hepatitis B** | **Tenanus/Diphtheria** | **Influenza** (Flu) | **COVID19** | **Monkeypox** | **MMR** | **Shingles** |
|  |  |  |  |  |  |  |  |  |

Have you ever had the following? Please check all that apply. Approximate Year: \_\_\_\_\_\_\_\_\_\_\_\_\_

 Anxiety, Depression or Mental Illness  Diabetes  High Blood Pressure  High Cholesterol or Triglycerides  Treatment for Alcoholism and/or drug abuse

**MEDICATIONS**

Are you currently taking any prescription and/or non-prescription medications, including vitamins, nutritional supplements, oral contraceptives, pain relievers, diuretics, laxatives, herbal remedies, and cold medications?  Yes  No

Name of Medication(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ALLERGIES**

Have you had hives, skin rash, breathing problems, or any other allergic reactions to any medications?

Name of Medication(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Describe allergic reaction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SYSTEM REVIEW**

Please indicate whether you have experienced the following symptoms during recent months, unless otherwise specified, by checking “Yes” or “No” for each question. Circle the symptom(s) you have experienced when multiple symptoms are listed in a question.

|  |  |  |
| --- | --- | --- |
| **Symptoms** | **Yes** | **No** |
| * Skin rash, sore, excessive bruising or change of a mole? |  |  |
| * Excessive thirst or urination? |  |  |
| * Significant headaches, seizures, slurred speech, or difficulty moving an arm or leg? |  |  |
| * Eye problems such as double or blurred vision, cataracts, or glaucoma? |  |  |
| * Diminished hearing, dizziness, hoarseness, or sinus problems? |  |  |
| * Experienced cough, shortness of breath, wheezing or asthma? |  |  |
| * Coughing up sputum or blood? |  |  |
| * Exposed to anyone with tuberculosis or Covid-19? |  |  |
| * Blacked out or lost consciousness? |  |  |
| * Chest pain or pressure, rapid or irregular heartbeats or known difficulty with heart value? |  |  |
| * Difficulty with swallowing, heartburn, nausea, vomiting or stomach trouble? |  |  |
| * Significant problems with constipation, diarrhea, blood/changes in bowel movements? |  |  |
| * Difficulty starting your urinary stream, completely emptying your bladder or leaking urine? |  |  |
| * Feel you are at risk for HIV/AIDS? |  |  |
| * Experiencing an unusually stressful situation? |  |  |
| **Questions 16 and 17 are to be answered by FEMALE PATIENTS only** | | |
| * Date of onset of your last menstrual period: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| * Number of: Pregnancies: \_\_\_\_\_\_\_\_\_ Live Birth(s): \_\_\_\_\_\_\_\_\_\_ Miscarriage(s)/Abortion(s): \_\_\_\_\_\_\_\_\_\_\_\_ | | |

**EMERGENCY CONTACT**

Please list your primary emergency contact person as well as their contact info, in case we need to contact them on your behalf in case of an emergency during your visit at the clinic.

Primary Emergency Contact Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**AUTHORIZATION**

I certify that I have read and understand the information on this form and have answered all of the questions accurately and to the best of my knowledge. I understand that providing incomplete information can be dangerous to my health. I authorize my insurance benefits be paid directly to CSBS physician. I understand that I am financially responsible for all services rendered on my behalf or on the behalf of my dependents, and for any balance not paid by my insurance policy. I also authorize CSBS to release information required to process my claims.

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

**Signature of Patient Date**

**NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT FORM**

First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Client ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Facility/Site/Program: Excellent Comprehensice Care

I have received a copy of the PA Notice of Privacy Practices Form PA 150-741, 09/20.

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

**Signature of Patient Date**

If the individual has a representative with legal authority to make health care decisions on the individual’s behalf, the notice must be given to and acknowledgment obtained from the representative. If the individual or representative did not sign above, staff must document when and how the notice was given to the individual, why the acknowledgement could not be obtained, and the efforts that were made to obtain it.

|  |
| --- |
| \_\_\_\_\_\_ Face to Face Meeting  \_\_\_\_\_\_ Mailing  \_\_\_\_\_\_ Emailing  \_\_\_\_\_\_ Other |

Notice of Privacy Practices given to the individual on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date**

**Reason Individual or Representative did not sign this form:**

\_\_\_\_ Individual or Representative chose not to sign

\_\_\_\_ Individual or Representative did not respond after more than one attempt

\_\_\_\_ Email receipt verification

\_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Good Faith Efforts: The following good faith efforts were made to obtain the individual’s or representatives signature. Please document with detail (e.g., date(s), time(s), individuals spoken to and outcome of attempts) the efforts that were made to obtain the signature, More than **one** attempt must have been made.

\_\_\_\_ Face to Face Presentation(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ Telephone contact(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ Mailing(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INITIATION OF SERVICES**

**PART I: CLIENT-PROVIDER RELATIONSHIP CONSENT**

Client First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Client Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Agency: Cadet’s Solutions for the Body and Soul (CSBS), LLC DBA Excellent Comprehensive Healthcare

Agency Address: 1603 South Hiawassee Rd. Orlando, Florida 32835

I consent to entering into a client-provider relationship. I authorize Excellent Comprehensive Healthcare staff and their representatives to render routine health care. I understand routine healthcare is confidential and voluntary and may involve medical office visits including obtaining medical history, examination, administration of medication, laboratory tests and/or minor procedures. I may discontinue the relationship at any time.

**PART II: DISCLOSURE OF INFORMATION CONSENT (Treatment, payment or healthcare operations purposes only)**

I consent to the use and disclosure of my medical information; including medical, dental, HIV/AIDS, STD, TB, substance abuse prevention, psychiatric/psychological, and case management, for treatment, payment and healthcare operations.

**PART III: MEDICARE PATIENT CERTIFICATION, AUTHORIZATION TO RELEASE, AND PAYMENT REQUEST**

(this only applies to Medicare patients)

As Client/Representative signed below, I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize the above agency to release my medical information to the Social Security Administration or its intermediaries/carriers for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician’s services to the above named agency and authorize it to submit a claim to Medicare for payment.

**PART IV: ASSIGNMENT OF BENEFITS (this only applies to third-party payers)**

As Client/Representative signed below, I assign to the above name agency all benefits provided under any health care plan or medical expense policy. The amount of such benefits shall not exceed the medical charges set forth by the approved fee schedule. All payments under this paragraph are to be made to the above agency. I am personally responsible for charges not covered by this assignment.

**PART V: MY SIGNATURE BELOW VERIFIES THE ABOVE INFORMATION AND RECEIPT COPY OF THE NOTICE OF PRIVACY RIGHTS.**

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

**Client/Representative Signature Self or Representative’s Relationship to Client Date**

**PART VI: WITHDRAWAL OF CONSENT**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ WITHDRAW THIS CONSENT, effective \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Client/Representative Signature Date**

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**AUTHORIZATION TO DISCLOSE CONFIDENTIAL INFORMATION**

**INFORMATION MAY BE DISCLOSED BY**

Person/Facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INFORMATION MAY BE DISCLOSED TO**

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**INFORMATION TO BE DISCLOSED**

\_\_General Medical Record(s), including STD, HIV and TB \_\_\_ Progress Notes \_\_\_ History and Physical Results

\_\_\_ Immunizations \_\_\_ Family Planning \_\_\_ Prenatal Records

\_\_\_ Consultations \_\_\_ Other

\_\_\_ Diagnostic Test Reports (Specify Type of Test(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I specifically authorize release of information relating to:** (Initial Selection)

\_\_\_ HIV test results for non-treatment purposes

\_\_\_ Psychiatric, Psychological or Psychotherapeutic notes

\_\_\_ Substance Abuse Service Provider Client Records

**PURPOSE OF DISCLOSURE**

\_\_\_ Continuity of Care \_\_\_ Personal Use \_\_\_ Other (specify) Case Management

**EXPIRATION DATE:** This authorization will expire (insert date or event) \_\_\_\_\_\_\_\_\_\_\_\_\_\_. I understand that if I fail to specify an expiration date or event, this authorization will expire twelve (12) months from the date on which it was signed.

**REDISCLOSURE:** I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

**CONDITIONING:** I understand that completing this authorization form is voluntary. I realize that treatment will not be denied if I refuse to sign this form.

**REVOCATION:** I understand that I have the right to revoke this authorization at any time. If I revoke this authorization, I understand that I must do so in writing and that I must present my revocation to the medical record department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company, Medicaid and Medicare.

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

**Client/Representative Signature Date**

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

**Printed Name Representative’s Relationship to Client \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Witness (optional) Date**

**Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**