



Patient Registration Form

Last Name: _____ First Name: _____ Middle Name: _____

Preferred Name: _____

Previous Name (if applicable): _____

Date of Birth (MM/DD/YYYY): _____

Sex: _____ Male _____ Female

Social Security Number: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Mobile Phone: _____ Home Phone: _____

Work Phone: _____ Email: _____

Contact Preference: (Mobile / Home / Work) Consent to Text Messages (Yes/No)

Preferred Pharmacy: _____

Primary Insurance: _____

Insurance ID Number: _____

Group Number: _____

Policy Holder Name: _____

Policy Holder Date of Birth: _____

Secondary Insurance: _____

Insurance ID Number: _____

Group Number: _____

Policy Holder Name: _____

Policy Holder Date of Birth: _____

Primary Language: _____ English _____ Spanish _____ Other

Race: _____ Ethnicity: _____ Marital Status: _____

Emergency Contact Name: _____ Phone: _____

Guardian Name (if patient is a minor): _____

Relationship: _____ Guardian's Date of Birth: _____

Guarantor Name (financially responsible for minor patient*): _____

Relationship: _____ Phone: _____ Guarantor's Date of Birth: _____

*Legal documents/court orders may be required

INSURANCE AUTHORIZATION AND ASSIGNMENT

I authorize the release of information concerning my healthcare (or my child's healthcare, if the patient is a minor), advice or treatment used for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to HealthStar Physicians of Hot Springs, PLLC.

Signature of Patient or Guardian

Date



PATIENT HISTORY FORM

(Please fill in as much as possible)

Patient Name: _____ Date of Birth: _____ Height: _____ Weight: _____

Reason for visit today: _____

Previous PCP and Specialists (list any primary care or specialists, such as cardiology, orthopedics, pulmonary, etc):

List all drug and non-drug allergies: _____

List all current prescription medications:

Name	Dose (mg)	How Often	Name	Dose (mg)	How Often
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

List all current and past medical conditions:

List all past surgeries and procedures:

Date: _____ Specify type of surgery and body location: _____ Performing physician: _____

List any family medical history:

Father: _____ Paternal Grandfather: _____
Mother: _____ Paternal Grandmother: _____
Brother: _____ Maternal Grandfather: _____
Sister: _____ Maternal Grandmother: _____

Personal History:

Do you smoke? Yes or No How much per day? _____ For how long? _____ Quit date? _____

Do you use smokless tobacco? Yes or No How much per day? _____ For how long? _____

Do you drink alcohol? Yes or No How often? _____ Type of alcohol _____

Have you ever tested positive for any STD's or communicable diseases? _____ If yes, list _____

Do you have any history of substance use or abuse? Yes or No If yes, list _____

(All of the above information is to enable us to provide you with better healthcare. It is part of your private medical record and is not shared with anyone without your express permission.)

Marital Status: _____ Any children & how many? _____

Are you currently employed? _____ What type of work and where? _____



New Patient Health Screening & Preventive Care History

Welcome to our practice! To help us provide the best care possible and avoid repeating tests unnecessarily, please tell us about any recent screenings, tests, or preventive care you may have completed.

Patient Name: _____ **Date of Birth:** _____

Preventive Screenings & Tests

Please check **Yes**, **No**, or **Not Sure**, and provide dates and locations if known.

Screening / Test	Yes	No	N/A	Date Completed	Where Was This Done?
Medicare Annual Wellness Visit	☐	☐	☐	_____	_____
Colorectal Cancer Screening (Colonoscopy, Cologuard, FIT Test)	☐	☐	☐	_____	_____
Breast Cancer Screening (Mammogram)	☐	☐	☐	_____	_____
Cervical Cancer Screening (Pap Smear / HPV Test)	☐	☐	☐	_____	_____
Lung Cancer Screening (Low-dose CT, if applicable)	☐	☐	☐	_____	_____
Bone Density Test (DEXA Scan)	☐	☐	☐	_____	_____



CONSENT TO TREAT

PATIENT NAME: _____ DATE OF BIRTH: _____

1. Consent to Care

I voluntarily consent to routine medical care at HealthStar Physicians of Hot Springs, PLLC ("HealthStar"), at any of its clinic locations. Routine care may include medical history, physical examination, laboratory and other diagnostic tests, immunizations and injections, prescribed medications, minor in-office procedures, and other treatment my provider considers advisable. My provider will explain my care, and I may ask questions at any time. HealthStar will ask for separate written consent before any procedure that carries significant risk.

2. Your Care Team

My care may be provided by physicians, advanced practice registered nurses (APRNs), physician assistants, nurses, medical assistants, and other trained staff working under appropriate supervision. I may ask the name and credentials of anyone providing my care.

3. Telehealth

Some visits may take place by secure video or telephone. Telehealth visits carry the same privacy protections as in-person visits, but have limits, since my provider cannot physically examine me. My provider may ask me to come in person when needed. I may decline a telehealth visit and request an in-person visit. Normal insurance cost-sharing may apply.

4. Care Management Programs

I may be offered care management services, such as chronic care management, advanced primary care management, or remote patient monitoring, that include care between visits. If I enroll, I understand:

- only one practitioner may bill for certain of these services in a given period;
- copays, coinsurance, or deductibles may apply;
- I may stop at any time, effective at the end of the calendar month.

HealthStar will explain each program and document my agreement before I enroll.

5. Emergencies

HealthStar clinics are not emergency departments. If I have an emergency in the clinic, staff will provide immediate care within their abilities, call 911, and arrange transfer to an appropriate facility.

6. No Guarantee

Medicine is not an exact science. No one has made any guarantee to me about the results of any examination or treatment.

7. My Right to Refuse or Withdraw

I may refuse any recommended test or treatment. My provider will explain the possible risks of refusing, and I may be asked to sign an informed refusal. I may withdraw this consent at any time by giving written notice to HealthStar. Withdrawal does not affect care already provided.

8. Minors and Patients with a Legal Representative

If the patient is a minor or has a legal guardian or other legal representative, the person signing below consents to care on the patient's behalf and confirms their legal authority to do so. HealthStar will honor a minor's own consent where Arkansas law allows it.

Other adults the parent or guardian authorizes to bring a minor patient for routine visits:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

9. Duration

This consent stays in effect for all visits at any HealthStar location until I withdraw it in writing. HealthStar may ask me to sign an updated consent periodically.

My signature confirms that I have read this form or had it read to me, that my questions were answered, and that I consent to treatment as described above.

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE

TODAY'S DATE

PRINTED NAME (IF NOT THE PATIENT)

RELATIONSHIP TO PATIENT

FOR OFFICE USE ONLY

Staff witness: _____ Initials: _____ Date: _____ Scanned to athenaOne: ☐

Patient declined to sign / withdrew consent (note reason): _____



HIPAA Notice of Privacy Practices Acknowledgement & Virtual Scribe Consent

Patient Name: _____ DOB: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided with, or offered, a copy of the Notice of Privacy Practices describing how my protected health information (PHI) may be used and disclosed in accordance with the Health Insurance Portability and Accountability Act (HIPAA).

I understand that my health information may be used for treatment, payment, and healthcare operations. I understand that I have rights regarding my PHI, including the right to access, request amendments, and request restrictions, subject to applicable law.

ACKNOWLEDGEMENT OF USE OF VIRTUAL SCRIBE / DOCUMENTATION SERVICE

To support accurate clinical documentation and effective patient-provider communication, providers in this practice may use a secure Virtual Scribe service to aid in the documentation of your visit. The Virtual Scribe's role is limited to documentation support only and does not include participation in your care, diagnosis, or treatment decisions. All information is protected in accordance with HIPAA privacy and security standards.

If you prefer not to have a Virtual Scribe used during your visit, please notify our staff and your provider at any time. Your decision will not affect your care.

AUTHORIZATION TO DISCUSS PROTECTED HEALTH INFORMATION (PHI)

I authorize this practice to discuss my protected health information with the following individuals:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

This authorization is voluntary and remains in effect until I revoke it in writing.

PATIENT ACKNOWLEDGEMENT AND SIGNATURE

Patient or Legal Representative Signature: _____

Printed Name: _____

Relationship (if not patient): _____ Date: _____



Financial Policies and Procedures Agreement

HealthStar Physicians of Hot Springs — Patient Acknowledgment and Consent Form

Welcome to our HealthStar Physicians of Hot Springs. Our commitment is to provide high-quality healthcare in a compassionate, transparent environment. To ensure clarity and mutual understanding, we ask all patients to review and sign this Financial Policies and Procedures Agreement. This document outlines your responsibilities and our procedures related to billing, insurance, payments, and medical records. If you have any questions about these policies, our staff is available to assist you.

By signing this agreement, you acknowledge that you have read, understood, and agreed to the following terms:

1. Payment at Time of Service

Policy: All patients are expected to pay for services rendered at the time of their appointment, unless prior arrangements have been made with our billing office. This includes copays, coinsurance, deductibles, and any outstanding balances from previous visits.

Procedures:

- Payments can be made by cash, check, debit, credit card, or HSA card.
- Patients with commercial or private insurance must pay their plan-required copay and/or coinsurance at check-in.
- Any outstanding balances must be paid before scheduling future appointments unless a payment plan is in place.

2. Fees and Collections

Our fees are based on the complexity of your visit and the procedures performed. We strive to keep our fees competitive and transparent.

Collections Policy:

- Accounts not resolved within 60 days may be referred to an outside collection agency.
- Patients are responsible for all costs associated with collection efforts, including reasonable attorney fees.
- If your account is sent to collections, you may be discharged from the practice.

3. Copays and Deductibles

Policy: Copays and deductibles are determined by your insurance carrier. It is your responsibility to know your plan's requirements.

Procedures:

- Copays are collected at the time of service.
- Deductibles and coinsurance amounts will be billed after your claim is processed by your insurance company.
- If your deductible has not been met, you may be asked to pay estimated charges for your visit.

4. Required Patient Health Insurance Policy or Summary Plan Description

Policy: All patients with commercial or private insurance must provide a current insurance card and, if requested, a summary plan description.

Procedures:

- Please bring your insurance card to every visit and notify us promptly of any changes in coverage.
- Failure to provide accurate insurance information may result in denied claims and full patient responsibility for charges.
- We recommend that you familiarize yourself with your policy's benefits, limitations, and exclusions.

5. Placing a Credit or Debit Card on File

Policy: For convenience and security, we require a valid credit or debit card to be placed on file for all patients.

Procedures:

- Your card will be securely stored and only charged for authorized outstanding balances.
- Your insurance will be billed and after payment according to your policy, you will receive an email 5 days prior to your card being charged for any remaining balance you are responsible for. If there is not a remaining balance, you will not be notified. If you do not put an email on file, you will not be notified, but your card will be charged.
- You have the right to pay with an alternate method within the 5 days.
- If your payment method cannot be processed for any reason, please contact us to make other arrangements.
- Patients with Medicare, Medicare Advantage/Supplements, Medicaid, Medicaid PASSE, or ARKids are exempt but must pay applicable copays and pre-determined costs.

6. Under Aged Guarantor

Policy: For patients under the age of 18, a parent or legal guardian is required to act as the financial guarantor. The guarantor assumes full responsibility for the payment of all services to the minor, including copays, coinsurance, deductibles, and outstanding balances.

Procedures:

- A parent or legal guardian must be present at registration to provide information and sign as guarantor.
- The guarantor will receive all billing statements and is responsible for prompt payment according to our financial policies outlined in this document.
- If custody or guardianship arrangements exist, documentation must be provided to clearly establish the party responsible for billing purposes.
- All payment arrangements, including payment plans, must be made by the guarantor on behalf of the minor patient.

7. Elective Procedure/Non-Covered Procedures

Policy: Procedures deemed elective or non-covered by your insurance plan must be paid in full at the time of service.

Procedures:

- We will provide an estimate of charges prior to your procedure.
- It is your responsibility to confirm coverage with your insurance carrier.
- If your insurance denies a claim for non-covered services, you will be responsible for payment.

8. Submission of Claims

Policy: As a courtesy, we submit claims to contracted commercial and private insurance plans. Submission does not guarantee payment or coverage.

Procedures:

- We will submit claims based on the information you provide.
- If your plan rejects or denies a claim, you will be billed for the full amount.
- Patients are responsible for following up with their insurance carrier regarding claims.

9. Payment Options

Policy: We accept multiple forms of payment for your convenience.

Procedures:

- Accepted payment methods: cash, check, Visa, Mastercard, Discover, American Express, HSA and FSA cards.
- Payment plans may be arranged for large balances; terms must be approved by our billing office.
- Returned checks are subject to a \$30 fee.

10. Medicare Patients

Policy: We accept Medicare patients and will bill Medicare for covered services.

Procedures:

- You are responsible for Medicare deductibles and coinsurance.
- If you have supplemental insurance, please provide documentation at each visit.
- For non-covered services, payment is required at the time of service.

11. Non-Contracted or Out-of-Network Insurances

Policy: If your insurance plan is not contracted or is out-of-network, you may be responsible for higher out-of-pocket costs.

Procedures:

- We may collect payment in full at the time of service and provide you with a receipt for self-submission.
- Our staff can assist with claim forms, but reimbursement depends on your insurer's policies.

12. Self-Pay

Policy: Patients without insurance or who choose not to use insurance are considered self-pay.

Procedures:

- Self-pay patients must pay for services in full at the time of visit.
- Quotes for routine visits and procedures are available upon request.
- Payment plans may be arranged for certain services; please discuss with our billing office in advance.

13. Missed/Late Appointments

Policy: Missed/Late appointments or late cancellations impact our ability to serve patients and may result in a fee.

Procedures:

- Appointments must be canceled at least 24 hours in advance.
- Failure to cancel in a timely manner or no-shows may result in a \$25 fee.
- Repeated missed appointments may result in discharge from the practice.
- If you are running late, please contact our office immediately so that we may determine whether we can see you that day or reschedule.
- Late arrivals greater than 15 minutes will be cancelled and rescheduled for another time.

14. Referrals

Policy: Certain insurance plans require referrals for specialist care.

Procedures:

- It is your responsibility to ensure that your plan authorizes referrals before scheduling with a specialist.
- We require a minimum of 3 business days to process referral requests.
- Incomplete, inaccurate, or late requests may delay care.

15. Medical Records Fees

Policy: Requests for copies of medical records are subject to fees as permitted by state and federal law.

Procedures:

- The fee is \$12.50 for the first 25 pages, plus \$0.25 for each additional page.
- Records will be provided within 15 business days of the request.
- Fees must be paid in full before records are released.

16. Authorization to Release Information

Policy: Patient information may be released as required for treatment, payment, and healthcare operations, or as otherwise authorized by law.

Procedures:

- By signing below, you authorize our practice to release medical and billing information to your insurance carrier, referring providers, collection agencies, and other entities as necessary for processing claims and payments.
- You may revoke this authorization in writing at any time, except to the extent that action has already been taken.
- All disclosures comply with HIPAA regulations and applicable privacy laws.

Patient Acknowledgment and Signature

I have read and understand the Financial Policies and Procedures outlined above. I agree to comply with these policies as a condition of receiving care. I understand that I am responsible for payment of services not covered by my insurance, as well as any fees assessed according to these policies.

Thank you for taking the time to review our policies. We appreciate your trust in our practice and look forward to serving you and your family's healthcare needs.

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

Patient Name (print)	Patient Signature (or responsible party)
Date of Birth	Date Signed



ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PURSUE ERISA AND OTHER LEGAL AND ADMINISTRATIVE CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE AND /OR HEALTH BENEFIT PLAN (INCLUDING BREACH OF FIDUCIARY DUTY) AND DESIGNATION OF AUTHORIZED REPRESENTATIVE.

I hereby assign and convey directly to HealthStar Physicians of Hot Springs, as my designated authorized representative, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, and/or medications rendered or provided by the above-named health care provider, regardless of its managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the above-named health care provider to release all medical information necessary to process my claims. Further, I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to the above-named health care provider any and all Plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from the abovenamed health care provider or its attorneys in order to claim such medical benefits.

In addition to the assignment of the medical benefits and/or insurance reimbursement above, I also assign and/or convey to the above named health care provider any legal or administrative claim or chose an action arising under any group health plan, employee benefits plan, health insurance or tort feisor insurance concerning medical expenses incurred as a result of the medical services, treatments, therapies, and/or medications I receive from the above-named health care provider (including any right to pursue those legal or administrative claims or chose an action). This constitutes an express and knowing assignment of ERISA breach or fiduciary duty claims and other legal and/or administrative claims.

I intend by this assignment and designation of authorized representative to convey to the above-named provider all of my rights to claim (or place a lien on) the medical benefits related to the services, treatments, therapies, and/or mediations provided by the above-named health care provider, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). The assignee and/or designated representative (above-named provider) is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chose in action or right against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. The above-named provider as my assignee and my designated authorized representative may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense.

This lifetime assignment will remain in effect until revoked by me in writing. It is valid for all administrative and judicial reviews under PPACA (health care reform legislation), ERISA, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if it were the original.

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

Patient Name (print)	Patient Signature (or responsible party)
Date of Birth	Date Signed



LATE TO APPOINTMENT POLICY

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family.

If you are an established patient and you arrive 15 minutes late or more to your appointment you will likely be asked to reschedule unless the physician's schedule can still accommodate you. Priority will be given to the patients who arrive on time and you may have to be worked in between them. This may mean you will have a considerable wait. If this is not convenient for you, you may choose to reschedule. One or two late patients cause the entire daily schedule to fall behind. This is an inconvenience to everyone. We strive to see every patient as close to their appointment time as possible.

Likewise, if you are a new patient and you arrive **at** the scheduled appointment time and not early to complete your forms as instructed and it takes more than 15 minutes to complete the forms and the registration process, you may also be asked to reschedule.

MISSED APPOINTMENT OR "NO-SHOW" POLICY

While we make every effort to provide a reminder call or text at least 24 hours before your appointment, it is **your responsibility** to remember your appointment. After three (3) missed appointments, the practice may at its discretion choose to discontinue your care.

Print Patient Name

____/____/____
Date

Signature Patient/Guardian

HealthStar Physicians of Hot Springs

Medication Policy

Please be advised that if you are on any of the following medications or are on a pain contract, or pain management from another physician, you must continue to receive your medication from that physician. **Our office WILL NOT routinely prescribe these medications.** We want to be upfront with you regarding this so that we can eliminate any confusion. There may be other medications not listed below that may also be included in this policy. This will be at the discretion of your provider.

BRAND NAME	GENERIC NAME
Xanax, Vallum, Ativan	Alprazolam, Diazepam, Lorazepam
Anexsia, Bencap HC, Ceta-Plus, Co-Gesic, Doiacet, Dolagesic, Dolorex, Forte, Duocet, Hy-Phen, Hydrocet, Hydrogesic, Lorcet, Lorcet HD, Lorcet Plus, Lortab, Margesic-H, Norco, Panacet, Polygesic, Stagesic, T-Gesic, Ugesic, Vanacet, Vicodin, Vicodin ES, Vicodin HP, Zydone	Hydrocodone
M-Oxy, OxyContin, Oxyfast, OxyIR, Percolone, Roxicodone, Endocet, Percocet, Roxicet, Rolilox, Tylox	Oxycodone
Mephergan	Meperidine
Astramorph PF, DepoDur, Duramorph, Infumorph, Kadian, Morphesian, MS Contin, MSIR, Oramorph, Roxanol, Roxanol 100	Morphine
Rela, Soma	Carisoprodol

If you have any questions, feel free to ask your provider.

SIGNATURE OF PATIENT OR GUARDIAN

TODAY'S DATE



SOCIAL NEEDS SCREENING

Are you worried or concerned that in the next two months you may not have stable housing that you own, rent, or stay in as a part of a household?

- ☐ Yes
☐ No

Thinking about the place you live. Do you have problems with any of the following? (Check all that apply)

- | | | |
|--|--|--|
| ☐ Bug Infestation | ☐ Inadequate heat | ☐ Water leaks |
| ☐ Mold | ☐ Oven or stove not working | ☐ None of these |
| ☐ Lead paint or pipes | ☐ No or not working smoke detectors | |

Within the past 12 months, you worried that your food would run out before you got money to buy more?

- ☐ Often true
☐ Sometimes True
☐ Never True

Within the past 12 months, the food you bought just didn't last and you didn't have money to get more?

- ☐ Often true
☐ Sometimes True
☐ Never True

Do you put off or neglect going to the doctor because of distance or transportation?

- ☐ Yes
☐ No

Within the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?

- ☐ Yes
☐ No
☐ Already shut off

Do problems getting child care make it difficult for you to work or study?

- ☐ Yes
☐ No

Do you have a job?

- ☐ Yes ☐ No

Do you have a high school degree?

- ☐ Yes ☐ No

How often does this describe you? I don't have enough money to pay my bills:

- ☐ Never
☐ Rarely
☐ Sometimes
☐ Often
☐ Always



Abuse Screening Questionnaire

Patient Name: _____ DOB: _____ Date: _____

How often does anyone, including family, physically hurt you?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Fairly Often
- ☐ Frequently

How often does anyone, including family, insult or talk down to you?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Fairly Often
- ☐ Frequently

How often does anyone, including family, threaten you with harm?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Fairly Often
- ☐ Frequently

How often does anyone, including family, scream or curse at you?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Fairly Often
- ☐ Frequently



HEALTH LITERACY SCREENING QUESTION

HOW CONFIDENT ARE YOU FILLING OUT MEDICAL FORMS BY YOURSELF?

- ☐ 1 – EXTREMELY
- ☐ 2 – QUITE A BIT
- ☐ 3 – SOMEWHAT
- ☐ 4 – A LITTLE
- ☐ 5 – NOT AT ALL



Informed Consent for Laboratory Testing

I, _____, understand that I have chosen to utilize the services of HealthStar Physicians of Hot Springs for laboratory testing. I hereby acknowledge that HealthStar is not equipped to perform stat labs and that my laboratory samples may be sent to an off-site laboratory for testing.

I understand that while waiting for lab results, there may be potential risks to my health, including the possibility of adverse health events, and that HealthStar cannot be held responsible for such events.

I acknowledge that I have been informed of the limitations of HealthStar's laboratory services and have had the opportunity to ask any questions I may have had.

I consent to the laboratory testing procedures as explained to me by HealthStar staff and agree to assume full responsibility for any risks and/or adverse health events that may occur while waiting for lab results.

Patient's Name: _____

Patient's Signature: _____

Date: _____

Witness's Signature (if applicable): _____

Date: _____