ELBERTA CLINIC NEW PATIENT INSTRUCTIONS

Thank you for your interest in joining our clinic. **Please be aware that we cannot fill or prescribe any controlled medications such as pain, anxiety, behavioral or sleep, due to new stricter regulations that have been placed on our providers.**

Please attach all copies of information requested below to your "new patient paperwork". If you are not able to supply copies, just present the items required when you deliver you new patient packet and we will be glad to make copies for you.

On the day of your first visit with us you will need to present the original cards (insurance and drivers license) to be scanned into our system. This information is obtained yearly or when any changes are made to your driver's license or insurance information. **Your packet will be reviewed only when all required information is supplied to our office.**

1. Insurance cards - we need a copy of the front and back of all cards.
2. Driver's license - we need a copy of the front and back. Only current and valid license will be accepted.

Prescription card - if you have a separate card from your main medical insurance. If you do then please have a copy of the front and back of the card.

We require all of our patients to have an annual wellness check-up performed by our Nurse Practitioners. This is generally required by most insurance companies. Research has found that when many illness are caught early you have a greater chance of survival.

Thank you,

The Elberta Clinic Staff

Elberta Clinic, PC

Patient Registration

Patient Information:

Patient Name: _____ Date of Birth: ____-____-_____

Address: _____ SS# _____

City: _____ State: _____ Zip: _____

Phone Numbers: Home: _____ Cell: _____ Work: _____

Email: _____

Race: Asian Black Hispanic / Latino White Other Language: English Spanish Other_____

Marital Status: S M D W Sex: M F Age: _____ Ethnicity: Non-Hispanic Hispanic Other _____

Employer: _____ Hours/Days at Work: _____

Address: _____ City: _____ State _____ Zip _____

Phone: _____ email: _____

Emergency Contacts:

Name: _____ Relationship: _____

Phone Numbers: Home: _____ Cell: _____

Name: _____ Relationship: _____

Responsible Party: If same as above skip this section

Name: _____ Date of Birth: _____-_____-_____

Address: _____ City: _____ State: _____ Zip: _____

Phone Numbers: Home: _____ Cell: _____ Work: _____

Email: _____

Additional Information:

If you have a Power of Attorney or Guardianship**, please provide a copy and list the name/names below**.

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone Numbers: Home: _____ Cell: _____ Work: _____

SELF OR PRIVATE PAY: Please read and sign if we are **NOT** filing insurance for you or the patient listed above.

I understand that I am financially responsible for all charges rendered to me or to the patient listed and agree to pay for such charges, present and future, at the time services are provided.

Signature of Patient or Responsible Party_____

****

HEALTH INSURANCE ASSIGNMENT AND RELEASE

I, the undersigned, have insurance with_____
(Name of Insurance Company)
and assign directly to the physician providing services to me at Elberta Clinic, P.C. all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

Signature of Insured/Guardian_____Date_____

****

(MEDICARE ONLY)
MEDICARE AND MEDIGAP AUTHORIZATION

I request that payment of authorized Medicare benefits and Medigap benefits, if applicable, be made either to me or on my behalf to the physician providing services to me at Elberta Clinic, P.C. for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on the other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. I understand that the deductible, coinsurance, and noncovered services will be my full responsibility.

Signature of Beneficiary_____Date_____

****

(ALL PATIENTS)
CONSENT FOR TREATMENT

I hereby grant authorization and consent for medical treatment and procedures for myself or the patient listed above, and understand that no guarantee or assurance has been made as to the results which may be obtained.

Signature of Patient or Guardian_____Date_____

INSURANCE: Patient's Name: _____

*PLEASE PRINT CLEARLY

*PLEASE ACKNOWLEDGE YOUR INSURANCE BY COMPLETEING ALL REQUESTED AREAS.

*ANY TRICARE MEMBERS MUST INCLUDE SUBSCRIBERS' SOCIAL SECURITY NUMBER (AS YOUR POLICY NUMBER) AND DATE OF BIRTH

*IF YOU HAVE COAVERAGE WITH DUAL MEDICARE, BE SURE TO ALSO INCLUDE MEDICARE POLICY NUMBER IN SPACE BELOW.

*PROVIDE THE SPELLING OF NAME EXACTLY THE WAY IT IS ON EACH INSURANCE CARD.

1ST: PRIMARY INSURANCE COVERAGE

NAME _____ INS. COMPANY _____

POLICY/ID NUMBER _____ GROUP NUMBER _____

CLAIM ADDRESS _____

SUBSCRIBERS'S NAME: _____ DATE OF BIRTH: _____

ADDRESS IF DIFFERENT: _____

2ND: SECONDARY INSURANCE COVERAGE

NAME _____ INS. COMPANY _____

POLICY/ID NUMBER _____ GROUP NUMBER _____

CLAIM ADDRESS _____

SUBSCRIBER'S NAME _____ DATE OF BIRTH _____

ADDRESS OF DIFFERENT: _____

3rd: INSURANCE TO PRIMARY INSURANCE

NAME _____ INS COMPANY: _____

POLICY/ID _____ GROUP _____

CLAIM ADDRESS _____

SUBSCRIBER'S NAME _____ DATE OF BIRTH _____

ADDRESS IF DIFFERENT: _____

MEDICARE # IF NOT PROVIDED ABOVE _____EFFECTIVE DATE _____

IN SIGNING BELOW, I ACKNOWLEDGE, TO THE BEST OF MY ABILITIES, THE INFORMATION IS CORRECT IN INFORMATION AS WELL AS PRIORITY.

NAME: _____ DATE: _____

THE ELBERTA FAMILY CLINIC, P.C.

POLICY 7

CONSENT FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR PAYMENT, TREATMENT AND HEALTH CARE OPERATIONS

By signing below, you hereby consent for this Practice to use or disclose information about yourself (or another person for whom you have the authority to sign) that is protected under federal law, for the sole purposes of treatment, payment and health care operations. You may refuse to sign this consent form.

You should read the Notice of Privacy Practices for PHI attached to this form before signing the Consent. The terms of the Notice may change from time to time, and you may always get a revised copy of it by asking the Privacy Officer for this Practice.

You have the right to request that the Practice restrict how PHI is used or disclosed to carry out treatment, payment, or health care operations. The Practice is not required to agree to requested restrictions, however; if the Practice agrees to your requested restrictions, the restriction is binding on it.

Information about you is protected under federal law, and you have the right to revoke this Consent, unless we have taken action in reliance on your authorization (as determined by our Privacy Officer). By signing below, you recognize that the protected health information used or disclosed pursuant to this Consent may be subject to re-disclosure by the recipient and may no longer be protected under federal law.

You may communicate with the following individuals regarding my condition or course of treatment:_____

You may communicate confidential information to me, including invoices for services, to the following address and/or phone numbers:_____

_____ _____

Individual Signature Date

As a personal representative, I have authority
to act for the individual because I am the individual's

_____

EFFECTIVE DATE APRIL 1, 2003

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU. The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures, we will elaborate on the meaning and provide more specific examples, if you request. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive at the practice may be billed to and payment may be collected from you, an insurance company or a third party. For example: we may disclose your record to an insurance company, so that we can get paid for treating you.

For Treatment. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you at the practice or the hospital. For example, we may disclose medical information about you to people outside the practice who may be involved in your medical care, such as family members, clergy or other persons that are part of your care.

For Health Care Operations. We may use and disclose medical information about you for health care operations. These uses and disclosures are necessary to run the practice and ensure that all of our patients receive quality care. We may also disclose information to doctors, nurses, technicians, medical students, and other practice personnel for review and learning purposes. For example, we may review your record to assist our quality improvement efforts.

WHO WILL FOLLOW THIS NOTICE. This notice describes our practice's policies and procedures and that of any health care professional authorized to enter information into your medical chart, any member of a volunteer group which we allow to help you, as well as all employees, staff and other practice personnel.

POLICY REGARDING THE PROTECTION OF PERSONAL INFORMATION. We create a record of the care and services you receive at the practice. We need this record in order to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the practice, whether made by practice personnel or by your personal doctor. The law requires us to: make sure that medical information that identifies you is kept private; give you this notice of our legal duties and privacy practices with respect to medical information about you; and to follow the terms of the notice that is currently in effect. Other ways we may use or disclose your protected healthcare information include: appointment reminders; as required by law; for health-related benefits and services; to individuals involved in your care or payment for your care; research; to avert a serious threat to health or safety; and for treatment alternatives. Other uses and disclosures of your personal information could include disclosure to, or for: coroners, medical examiners and funeral directors; health oversight activities, inmates; law enforcement; lawsuits and disputes; military and veterans; national security and intelligence activities; organ and tissue donation; protective services for the President and others; public health risks; and worker's compensation.

NOTICE OF INDIVIDUAL RIGHTS

You have the following rights regarding medical information we maintain about you:

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you. To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by, or for, the practice. To request an amendment, your request must be made in writing and submitted to the Privacy Officer and you must provide a reason that supports your request. We may deny your request for an amendment.

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. We may deny your request to inspect and copy in certain very limited circumstances.

Right to a Paper Copy of this Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. You must make your request in writing and you must specify how or where you wish to be contacted.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. ***We are not required to agree to your request.*** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to the Privacy Officer.

CHANGES TO THIS NOTICE. We reserve the right to change this notice. We will post a copy of the current notice in the practice's waiting room.

COMPLAINTS. If you believe your privacy rights have been violated, you may file a complaint with the practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the practice, contact **Laura Kichler, OM at 251-986-5057**. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

OTHER USES OF MEDICAL INFORMATION. Other uses and disclosures of medical information not covered by this notice or the laws that apply to use will be made only with your written authorization. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time.

If you have any questions about this notice or would like to receive a more detailed explanation, please contact our Privacy Officer.

I acknowledge by signing below that I have received the Notice of Privacy Practices and Notice of Individual Rights.

_____ _____

Patient or Patient's Personal Representative **Date**

Terry A. Kurtts, M.D.
Joseph P. Walsh, M.D.
Carolyn Holman, CRNP

24980 State Street
P.O. Drawer 519
Elberta, AL 36530

251-986-7301
Fax: 251-986-5927
elclinic@gulftel.com

INSURANCE AGREEMENT

Due to many changes in insurance policies, it is no longer an easy task to interpret each individual policy. Although we try to stay aware of these changes, it is not always possible.

Therefore, we urge you, as the patient, to please check with your insurance company prior to any testing or surgery being performed. **It is your responsibility to know your individual coverage.** Failing to comply with this suggestion could result in you, the patient, being responsible for all costs incurred.

Please remember you insurance policy is between you and your insurance company and not with the insurance company and your doctor.

RELEASE, ASSIGNMENT & GUARANTEE OF PAYMENT

I authorize the release of my medical information to any pertinent party, in addition to any insurance companies for the processing of my claims.

I authorize and request payment of medical benefits directly to my physicians.

I agree this authorization will cover all medical services rendered until such authorization is revoked by me.

I authorize the use of fax in order to submit medical information to pertinent parties.

I agree that a photocopy of this form may be used in lieu of the original.

I understand that I am financially responsible for any balance that is not covered by my insurance carrier after 30 days.

Signature_____ Date _____

Witness _____

MEDICATION AND HISTORY SHEET:

Name:_____ Birth Date:_____ Date:_____

PLEASE LIST YOUR MEDICAL CONDITIONS:

_____

_____

_____

_____

_____

_____

_____

_____

_____

(example: diabetes since 1998)

PRIOR SURGERIES AND DATES:

_____

_____

_____

_____

_____

_____

_____

Comments:_____

_____

PLEASE LIST YOUR MEDICATIONS AND SUPPLEMENTS: include dose and frequency

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

(example: baby aspirin 81 mg once a day)

ALLERGIES AND REACTIONS:

_____

_____

_____

(Example: penicillin caused rash)

Tobacco use: yes/no

cigs/snuff how long?_____ years

packs per day?_____

Elberta Clinic

PATIENT MEDICAL HISTORY

Date:_____

Name: _____ Date of birth: _____ ☐single ☐married ☐divorced ☐widow(er)

Occupation: _____ Spouse's occupation: _____

Education: circle the last grade completed: high school 11 12 college post graduate

Have you lived outside of the U.S. in the last year? Yes/no Do you have pets? Yes/no

Who referred you to this clinic? _____

FAMILY HISTORY:

	Age	if living, health status?	age at death	if deceased, cause?
father				
mother				
Brother/sister				
Husband/wife				
Son/daughter				

Have any blood relatives ever had? How are/were they related?

Cancer (type)
diabetes
Heart trouble
tuberculosis
stroke
emphysema
High blood pressure
Mental illness
Suicide
Thyroid problems
High cholesterol
Alcohol/substance abuse
epilepsy
Birth defects
Other:

PAST MEDICAL HISTORY: (HAVE YOU EVER HAD?) Circle if yes

Chicken pox/mumps/whooping cough/measles/scarlet fever/mono

Hiatal hernia/ gall bladder problems/bleeding ulcers/inflammatory bowel disease/diverticular disease/abdominal cancer

Kidney stones/ bladder infections/ kidney failure/ bladder or prostate cancer/ sexually transmitted conditions

Abnormal moles/ skin cancers/ skin allergies/ rashes/ hives

Heart problems/ rhythm problems/blocked blood vessels/blood clots/ strokes/ angina/ heart failure/high blood pressure

Problems with surgeries/ blood clots after surgery/ free bleeding/ anemia or low iron/ frequent infections

Neurologic problems/ parkinson's disease/ stroke/ neuropathy/seizures or epilepsy/ migraine headaches

Lung problems/ pneumonias or recurrent bronchitis/ lung cancer/ clots in lungs/ asbestosis exposure/ TB/ asthma

Heavy periods/ lost pregnancies/ difficulty becoming pregnant/ menopausal issues/

Diabetes/ low blood sugar/ steroid use

Arthritis/ rheumatism/ bursitis/ rheumatoid/

x-ray therapy/ chemotherapy

depression/ nervous breakdown/ anxiety

Other:_____

IMMUNIZATIONS:

Do you get yearly flu shots? Yes/no date of last shot?_____ Have you had a shingles shot? Yes/no When?_____

Have you had a pneumonia shot? Yes/no when?_____ Have you had a whooping cough shot? Yes/no

Do you remember the year of your last tetanus shot? _____

HEALTH MAINTENENCE:

When was your last yearly blood work? _____

When was your last mammogram?_____ where did your have your mammogram done?_____

When was your last colonoscopy?_____ What doctor and facility?_____

Have you ever received a blood transfusion? Yes/no Have you had a bone density/DEXA scan?yes/no when?_____

When was your last female check or PAP smear? _____ When was your last male prostate check?_____

ALLERGIES:

What medicines or foods are you allergic to? What reaction do you have?

_____

_____

_____example: penicillin----hives/rash

Do you see any specialists? Please list who and what conditions:_____

_____

INJURIES: Have you ever had any?

Broken bones? Yes/no If yes, year?_____Surgery?_____

Concussion or head injury? Yes/no year?_____

Cuts/Sprains or dislocations? Yes/no year?_____

Whiplash or neck injury? Yes/no Year?_____

Other serious injuries? Yes/no year?_____

Serious car wreck? Year and injuries?_____

Do you have metal in your body or have a pacemaker?_____

HOSPITALIZATIONS/SURGERIES:

Surgery procedures and years performed

_____

_____

_____

_____

_____

Hospitalizations other than surgeries

_____

_____

_____

_____

_____

SOCIAL HISTORY

Do you smoke/dip? Yes/no If yes, how many packs a day for how many years_____packs/day_____years

Do you drink alcoholic beverages? If yes, type of alcohol, how much, how often?_____

Do you sleep well? Yes/no Snore? Yes/no Leg trouble at bedtime? Yes /no Do you drive fast? Yes/no

Wear a seat belt? Yes/no Do you gamble excessively? Yes/no

Do you have an exercise program? Describe:_____

Do you follow a special diet? Describe?_____

Women only:

Age at onset of menstruation?_____

Date of last period?_____

Is it possible you are pregnant?_____

Pregnancies: how many?_____

children born alive?_____Stillbirths?_____

c-sections?_____ breast fed?_____

MEDICATIONS:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Patient signature/date:_____

ELBERTA CLINIC, PC 24980 STATE ST. ELBERTA, AL 36530

Patient Name _____ **DOB:** _____ **Date**_____

PRESCRIPTION/CONTROLLED SUBSTANCE AGREEMENT

The purpose of this agreement is to prevent misunderstandings about the medications you have been or will be prescribed. This is to help both you and your doctor to comply with the law regarding controlled pharmaceuticals.

I understand that this Agreement is essential to the trust and confidence necessary n a doctor/patient relationship and that my doctor undertakes to treat me based on this Agreement.

I understand that if I break this agreement, my doctor will stop prescribing these medications.

In this case, my doctor will taper off the medicines over a period of several days, as necessary, to avoid withdrawal symptoms. Also, a drug dependence treatment program may be recommended.

I will communicate fully with my doctor about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medicine is helping to relieve the pain.

I will not use any illegal controlled substances, street drugs, marijuana, cocaine, etc.

I understand I am not to consume alcohol while on controlled substances.

I will not share, sell or trade my medications with anyone.

I will not attempt to obtain any controlled medicines, including opioid pain medicines, controlled stimulants, or antianxiety medicines from another doctor.

I will safeguard my medications from loss, theft or damage. Lost or stolen mediations will not be replaced even with a police report. Any attempts to alter a prescription is grounds for dismissal from the practice.

I will not be given refills early for any reason or circumstance. Vacations, going out of town or any other reason will not justify early refills.

I agree that refills of my prescriptions for controlled medicine will be made only at the time of an office visit. No refills will be available during weekends, evenings or without an office visit.

I agree to use _____ pharmacy, located at

_____, telephone number _____, for all my medications.

I authorize the doctor and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency, including this state's Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my controlled medications. I authorize my doctor to provide a copy of this agreement to my pharmacy. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

I agree that I will provide a blood or urine specimen when requestion by my doctor to determine my compliance with my mediation regimen.

I agree that I will use my medicine at a rate no greater than the prescribed rate and that use of my medicine at a greater rate will result in my being without medication for a period of time.

I will bring all unused medications to every office visit.

I agree to follow these guidelines that have fully explained to me. All of my questions and concerns regarding treatment have been adequately answered. A copy of this document has been given to me.

This agreement is entered into on this _____ day of _____, 20 ___.

Patient's signature _____

Physician's signature _____

Witnessed by _____

APPOINTMENT REMINDER CONSENT
TEXT MESSAGE AND/OR EMAIL NOTIFICATION

Patient Name: _____ Date of Birth: _____ MRN _____

Complete this form and sign below to give your permission for Elberta Clinic, PC to provide automatic appointment reminder service by email or by cell phone text message.

My CELL PHONE number is: _(_____)_____-_____

I recognize that normal text messaging rates may apply.

My Cell Phone Carrier is: (circle only one)

AT&T	Verizon	T-Mobile	Sprint PCS	Virgin Mobile	US Cellular
Nextel	Boost Mobile	Alltel	Straight Talk	Assurance Wireless	Consumer Wireless
Metro PCS	Cricket Wireless		Southern Link	H2O Wireless	

My email address is: _____

I understand that I will NOT be able to respond to text messages or emails. I understand that I will need to call the Clinic's main number 251.986.7301 to change/cancel my appointment 24 hours prior. I understand that I will need to update my information should I change it in the future to continue receiving text/email notifications. I further understand that the provider email system is not encrypted and that such email may be intercepted, hacked, or read by others; for this reason only the applicable names, times and dates of appointments, no other personal information about the patient will be included in the email.

Patient, Parent or Legal Guardian

Signature: _____ Date:_____

Printed Name: _____

Elberta Clinic, PC

24980 State Street
Elberta, AL 36530
251-986-7301

24 Hour Cancellation & "No Show" Fee Policy

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, Elberta Clinic, PC reserves the right to charge a fee of $25.00 for all missed appointments ("no shows") and appointments which, absent a compelling reason, are not cancelled with a 24-hour advance notice.

"No Show" fees will be billed to the patient. This fee is not covered by insurance, and must be paid prior to your next appointment. Multiple "no shows" in any 12 month period may result in termination from our practice.

Thank you for your understanding and cooperation as we strive to best serve the needs of all of our patients.

By signing below, you acknowledge that you have received this notice and understand this policy.

_____ _____

Printed Name Date

_____

Signature

ELBERTA CLINIC, PC

POLICY AGREEMENT

THE ELBERTA CLINIC STRIVES TO KEEP OUR PATIENTS HEALTHY. THEREFORE, WE HAVE INPLEMENTED A POLICY TO HOPEFULLY PREVENT CHRONIC DISEASE AND PROMOTE A HEALTHY LIFESTYLE.

IN ORDER TO DETECT DISEASES IN THEIR EARLY STAGE WE RECOMMEND AND ENCOURAGE ANNUAL WELLNESS VISITS AND HEALTH RISK ASSESSMENTS. THIS IS REQUIRED BY MOST INSURANCE COMPANIES AS WELL.

ONE OF OUR NURSE PRACTITIONERS WILL REVIEW THE PREVENTATIVE SCREENINGS THAT ARE DUE FOR YOUR AGE GROUP. SHE WILL DISCUSS THEM AND ANSWER ANY QUESTIONS OR CONCERNS YOU MAY HAVE. THIS MAY INCLUDE OUTPATIENT TESTING AND OR IN HOUSE VACCINATIONS. WE WILL SCHEDULE YOUR OUTPATIENT TEST AND NOTIFY YOU. IF YOU DON'T HEAR FROM US WITHIN A WEEK, PLEASE CALL 251-986-7301 AND PRESS OPTION 2.

WE ALSO REQUIRE ALL PATIENTS TO BRING THEIR MEDICATIONS TO EACH VISIT IN THE ORIGINAL BOTTLES. THIS IS IMPORTANT TO YOUR HEALTH AND TO PREVENT MEDICATION CONTRAINDICATIONS OR ADVERSE REACTIONS.

BY SIGNING BELOW, I ACKNOWLEDGE THE ABOVE REQUIREMENTS OF ELBERTA CLINIC.

NAME _____ DATE _____