ASSOCIATED FAMILY PHYSICIANS
OF BOCA RATON, P.L.

MARILYN B. CABRAL
Administrator

MEDICAL STAFF

OWEN A. BARRUW, M.D., F.A.C.P.
Board Certified in Internal Medicine

DUSHYANT J. UTAMSINGH, M.D.
Board Certified in Internal Medicine

RADHIKA P. PHADKE, M.D., PHD.
Board Certified in Endocrinology

MICHELLE WILSON, M.D.
Board Certified in Family Medicine

SAMANTHA L. BURSTELL, DNP, FNP-BC
Board Certified Nurse Practitioner

NATASHA DESTIN, DNP, FNP-BC
Board Certified Nurse Practitioner

Date: _____

Patient's Name : _____ Marital Status :_____

Age : _____ Sex : M F Date of Birth: _____

Address : _____

Apartment / Suite #: _____

City: _____ State: _____ Zip Code : _____-- _____

Race: ☐ White ☐ Black or African American ☐ Asian ☐ Native Hawaiian or other Pacific Islander ☐ American Indian or Alaska Native ☐ not reported Refusal ☐ not reported don't know ☐ not reported not ascertained

Ethnicity: ☐ Latino / Hispanic ☐ Non-Hispanic or Latino ☐ Other ☐ Not Reported / Refused

Home Phone : ( ) _____--_____

Cell Phone: ( ) _____--_____

Referred By : _____ Employed : Y / N Student : Y / N Retired: Y / N

Drivers License Employer: _____
(Please give drivers license to receptionist)

Other Address (if applicable) : _____

Apartment / Suite #: _____

City: _____ State: _____ Zip Code : _____-- _____

PRIMARY INSURANCE
INSURANCE COMPANY NAME: _____
Please Present Card To Receptionist
Below information is relating to **subscriber** (insured, not necessarily patient):
CHECK BOX IF SAME AS ABOVE
Relationship to subscriber: _____ self _____ spouse _____ child _____other (pls. explain)

NAME OF SUBSCRIBER: _____

DATE OF BIRTH : _____

SUBSCRIBER'S ADDRESS: Address : _____

Apartment / Suite #: _____

City: _____ State: _____ Zip Code : _____-- _____

SUBSCRIBER'S EMPLOYER _____

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Board Certified Nurse Practitioner

Patient's Name : _____

SECONDARY INSURANCE (if applicable)
INSURANCE COMPANY NAME: _____
Please Present Card To Receptionist
Below information is relating to **subscriber** (insured, not necessarily patient):
CHECK BOX IF SAME AS ABOVE

Relationship to subscriber: _____ self _____ spouse _____ child _____ other (pls. explain)

NAME OF SUBSCRIBER: _____

HOME # ( ) _____ -- _____ DATE OF BIRTH : _____

SUBSCRIBER'S ADDRESS : _____

_____ _____--_____
City State Zip Code

SUBSCRIBER'S EMPLOYER: _____

PLEASE BE CONSIDERATE. FAILURE TO CANCEL AN APPOINTMENT WITHIN 24 HOURS OF APPOINTMENT TIME or NO SHOW WILL RESULT IN A $ 50.00 FEE.
Do you have a Health Care Surrogate? Y / N **If yes please furnish a copy for your medical record.**
Do you have a living will? Y / N **If yes, please furnish a copy for your medical record. If you would like literature on Advance Directives please ask your Health Care Provider.**
Primary Language Spoken: ( ) English ( ) Spanish ( ) French ( ) Other _____

Name of an emergency contact: _____

Phone number ( )_____-- _____

Relationship _____

Payment is required at the time services are rendered.

LIFETIME AUTHORIZATION
I, authorize the healthcare providers and staff of Associated Family Physicians of Boca Raton, P.L. to render medical care to me or my minor child that they deem necessary. I guarantee payment of any and all charges for services provided. If your account is sent to outside collections there will be a 35% collection fee added to your account.

_____
SIGNATURE OF PATIENT or authorized person if minor DATE

if Minor Relationship: _____

VISIT OUR WEBSITE: www.afpdocs.org
2025 Patient Demographic Form master file

Name:_____ **Date of birth:**_____

ASSOCIATED FAMILY PHYSICIANS
OF BOCA RATON, P.L.

Patient Medical History **Today's Date:**_____

□Y □N Migraine Headache	□Y □N Prostate Disorders
□Y □N Renal Disorders	□Y □N Gout
□Y □N Eye Disorders	□Y □N Osteoarthritis
□Y □N Chronic Obstructive Pulmonary Dx	□Y □N Osteoporosis
□Y □N Asthma	□Y □N Neurologic Disorders
□Y □N Tuberculosis	□Y □N Seizure Disorder
□Y □N Coronary Artery Dx	□Y □N Alzheimer's Dementia
□Y □N Acute Myocardial Infarction	□Y □N Psychiatric Disorders
□Y □N Essential Hypertension	□Y □N Depression
□Y □N Hyperlipidemia	□Y □N Anxiety Disorder
□Y □N Atrial Fibrillation	□Y □N Anemia
□Y □N Stroke Syndrome	□Y □N Cancer
□Y □N Heartburn	**Other:**_____
□Y □N Ulcers	**Other:**_____
Y □N Crohn's Disease	**Other:**_____
□Y □N Ulcerative Colitis	**Family History**
□Y □N Irritable Bowel Syndrome	Please check all applicable Please Circle
□Y □N Hepatitis B	□ Heart Disease Grandparents Mother Father
□Y □N Hepatitis C	□ Cancer Grandparents Mother Father
□Y □N HIV Infection	Type _____
□Y □N Diabetes Mellitus	□ Diabetes Grandparent(s) Mother Father
□Y □N Thyroid Disorder	□ Mental Health Grandparent(s) Mother Father
	□ Other: _____ Grandparent(s) Mother Father

Name:_____ **Date of birth:**_____

Substance Use	**Relational**
□Y □N Alcohol Use - Social – Every Day - Rarely	□Y □N Single
□Y □N Tobacco Use - Social – Every Day - Rarely	□Y □N Living with Significant Other
□Y □N Vape Use - Social – Every Day – Rarely	□Y □N Marital History
□Y □N Marijuana - Social – Every Day – Rarely	□Y □N Divorced
□Y □N Previous History of smoking	□Y □N Widow
□Y □N Previous History of vaping	
□Y □N Illicit Drug Use	Other:_____
□Y □N Coffee - _____Cups/Day	
□Y □N Caffeine Use	

Living Conditions	**Other Social History**
	Primary Language:_____
□Y □N Living with parents	□Y □N Work
	Occupation:_____
□Y □N Caretaker of another person	□Y □N Student
	□Y □N Travel_____
□Y □N Resides in AFL	□Y □N Seatbelt Use
	□Y □N Smoke Detector use
□Y □N Living Alone	□Y □N Firearm Safety Awareness
Other:_____	
Sexual Orientation	**Gender Identity**
□ Straight	Male/Man
□ Gay	Female/Woman
Bisexual	□ Transgender Male/ Female to Male
□ Lesbian	□ Transgender Female / Male to Female
Queer	□ Genderqueer; Neither Exclusively Male or
□ Something Else	Female
Questioning	□ Decline
□ Decline	□ Something Else
	Sex Assigned at Birth
	Male
	Female
	Intersex
	Decline

Name:_____ **Date of birth:**_____

Surgical History	**Date**
□Y □N Reported Prior Surgical	_____
□Y □N Adverse Reaction Anesthesia	
□Y □N Cataracts	_____
□Y □N Tonsillectomy	_____
□Y □N Thyroid Surgery	_____
□Y □N Lung Surgery	_____
□Y □N Coronary Artery Bypass	_____
□Y □N Heart Valve Replacement	_____
□Y □N Pacemaker Placement	_____
□Y □N AAA Repair	_____
□Y □N Varicose Vein Ligation	_____
Other:	_____
Other:	_____

	Date
□Y □N Appendectomy	_____
□Y □N Cholecystectomy	_____
□Y □N Hernia Repair	_____
□Y □N Orthopedic Surgery	_____
□Y □N Knee Replacement	_____
□Y □N Total Hip Replacement	_____
□Y □N TURP	_____
□Y □N Prostatectomy	_____
□Y □N Breast Augmentation	_____
□Y □N Lumpectomy	_____
□Y □N Mastectomy	_____
□Y □N Cesarean Section	_____
□Y □N Hysterectomy	_____
□Y □N Tubal Ligation	_____

Preventative	**Date**
Mammogram	_____
Pap Smear	_____
Colorectal Screening	
Fecal Occult Blood	_____
Sigmoidoscopy	_____
Colonoscopy	_____
Cologuard	_____
Other Preventative	
EKG	_____
AAA/US	_____
Chest Xray(CXR)	_____
Bone Density	_____
PSA	_____
Other:	_____

Vaccinations	
Td Vaccine	_____
Tdap Vaccine	_____
Zostavax Vaccine	_____
Shringrix	_____
Pneumonvax	_____
Prevnar	_____
Vaxneuvance	_____
Hepatitis B Vaccine	_____
Pfizer Vaccine dose 1	_____
Pfizer Vaccine dose 2	_____
Moderna Vaccine dose1	_____
Moderna Vaccine dose 2	_____
Johnson & Johnson Vaccine	_____

Name:_____ Date of birth:_____

Care Team Providers:		Name	Phone Number
Primary Care Provider:	N/A		
Cardiologist:	N/A		
Gastroenterologist:	N/A		
Rheumatologist:	N/A		
Obstetrician / Gynecologist:	N/A		
Neurologist:	N/A		
Pulmonologist:	N/A		
Urologist:	N/A		
Dermatologist:	N/A		
Psychiatrist / Psychologist:	N/A		
Oncologist / Hematologist:	N/A		
Ophthalmologist / Optometrist :	N/A		
Other:			
Other:			

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Board Certified Nurse Practitioner

Today's date _____ **2025**

PLEASE LET US KNOW HOW YOU WOULD LIKE CONFIDENTIAL MEDICAL INFORMATION CONVEYED TO YOU?

☐ Call home phone ( ) _____
Can we leave medical information on your answering machine / voicemail? Yes or NO

☐ Call cell phone ( ) _____
Can we leave medical information on your answering machine / voicemail? Yes or NO

☐ Can we leave medical information with a designated person? Yes or NO
If yes, please give us the individual's complete name, date of birth and relationship:

_____
Name date of birth Relationship

By signing, below I understand this authorization form to release confidential information will remain in effect until I revoke the authorization in writing.

_____
Patient's Name (Guardian if minor)

_____
Patient's Signature (Guardian if minor) Date

LOCAL PHARMACY

NAME: _____ PHONE # ( ) _____

MAIL ORDER PHARMACY

NAME: _____ PHONE # ( ) _____

9910 SANDALFOOT BLVD., SUITE 1 • BOCA RATON, FL 33428-6692
TELEPHONE (561) 883-3030 • FACSIMILE (561) 852-7611
www.afpdocs.org

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Patients: By dating and signing below this will help us coordinate your health care. By signing, below I understand this authorization form to release confidential information will remain in effect until I revoke the authorization in writing.

I, authorize any Physician, Hospital, Diagnostic Facility, Health Provider, or Insurance Carrier to release any information on my behalf to Associated Family Physicians of Boca Raton, P.L.

Print Patient's Name _____ Date of Birth _____

Patient's Signature (Guardian if minor) _____ Date _____

I, authorize Associated Family Physicians of Boca Raton, P.L. to release any information on my behalf to any Physician, Hospital, Diagnostic Facility, Health Provider, or Insurance Carrier.

Print Patient's Name _____ Date of Birth _____

Patient's Signature (Guardian if minor) _____ Date _____

I, authorize Associated Family Physicians of Boca Raton, P.L., their doctors and employees to release any medical information on my behalf to the following: (e.g. family members)

1. Print Name _____ Relationship _____

2. Print Name _____ Relationship _____

Print Patient's Name _____ Date of Birth _____

Patient's Signature (Guardian if minor) _____ Date _____

file: release of medical information

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ASSOCIATED FAMILY PHYSICIANS OF BOCA RATON, P.L.

Only complete if you are on Medicare or Medicare Advantage

To Our Valued Patients:

Healthcare fraud and abuse have been identified as a national problem costing taxpayers literally billions of dollars each year. We want you to know that all of our employees, managers, and doctors continually undergo training so t hat they may understand and comply with government rules and regulations regarding Medicare. We strive to achieve the very highest standards of ethics and integrity in performing services for our Medicare patients.

It is our policy to properly determine accurate compensation for our services in accordance with the governmental rules, laws, and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper Medicare expenditures. As a part of this plan, we have implemented a Compliance Program that we believe will help us prevent any Medicare service or billing errors.

Our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. We welcome your input regarding any billing or service problem so that we may remedy the situation promptly.

MEDICARE LIFETIME BENEFICIARY CLAIM AUTHORIZATION
(SIGNATURE ON FILE)

NAME OF BENEFICIARY (PATIENT) _____ MEDICARE NUMBER _____

"I request that payment of Medicare benefits be paid on my behalf to the Provider of medical services, for services provided to me. I authorize the release of medical information about me to the Health Care Financing Administration and it's agents, any information needed to determine benefits payable for these services.

I understand my signature requests that payment be made directly to the Provider of medical services. I authorize the release of medical information necessary to pay the claim. In Medicare assignment cases, I understand that I am responsible for my annual deductible, Co-insurance (20% of the approved amount), and any non-covered services provided to me. All other charges will be adjusted off. I understand the amount of payment I'm responsible for is due at the time services are rendered."

PATIENT'S SIGNATURE _____ DATE _____

Medicare and Medicare Advantage authorization forms.docx.

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ASSOCIATED FAMILY PHYSICIANS OF BOCA RATON, P.L.

LIFETIME AUTHORIZATION

" I authorize the release of any medical information necessary to process a claim or any insurance related claim made on my behalf. I assign the benefits payable for services to the healthcare provider furnishing the services. I authorize such healthcare provider to submit a claim to my insurance company on my behalf." I authorize the healthcare provider and staff of Associated Family Physicians of Boca Raton, P.L. to render medical care to me or my minor child that they deem necessary.

A photocopy of this authorization shall be considered as effective and valid as the original.

_____
PATIENT'S NAME

X_____
PATIENT'S SIGNATURE (authorized person if minor) DATE

Authorization forms

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www.afpdocs.org

ASSOCIATED FAMILY PHYSICIANS
OF BOCA RATON, P.L.

Account # _____

Dear Patients:

We use an automated system for appointment confirmations and appointment recalls. Please let us know how you would like to be contacted.

Please select only **one** option please.

Print Name:

Text Message: ◯ yes ◯ no

If yes, what phone number: ( ) _____ - _____

Email: ◯ yes ◯ no

If yes, your email:

Home Phone Number: ◯ yes ◯ no

If yes, what phone number: ( ) _____ - _____

9910 Sandalfoot Blvd., Suite 1 Boca Raton, FL 33428-6692
561-883-3030 * fax 561-852-7611 * www.afpdocs.org

Date: _____

PATIENT PORTAL YOU WILL BE ABLE TO:

- **Securely message your care team**
- **Review appointments**
- **Request prescription refills or view lab results**
- **Send your records to other healthcare providers**
- **Log in from any web browser, including mobile**
- **The office will send a link to your email. This link expires after 24 hours. Kindly, complete the registration upon receipt of the link.**

IF YOU WISH TO BE ABLE TO ACCESS OUR PATIENT PORTAL PLEASE COMPLETE THE FOLLOWING.

PRINT YOUR COMPLETE NAME BELOW

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

ENTER YOUR DATE OF BIRTH

☐☐-☐☐-☐☐☐☐

ENTER YOUR PREFERRED EMAIL ADDRESS

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

ASSOCIATED
FAMILY
PHYSICIANS
OF BOCA RATON, P.L.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Associated Family Physicians of Boca Raton, P.L. reserves the right to modify the privacy practices outlined in the notice.

I have received a copy of the Notice of Privacy Practices for:

Associated Family Physicians of Boca Raton, P.L.

9910 Sandalfoot Blvd., Suite 1

Boca Raton, FL 33428-6692

561-883-3030

Name of Patient (Please Print)

Signature of Patient

Date

Signature of Patient's Representative (Required if the patient is a minor or an adult who is unable to sign this form)

Relationship of Patient Representative to Patient

USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION

Other Permitted and Required Uses and Disclosures will be made **only with your consent, authorization** or opportunity to object unless required by law. Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes. We may not sell your protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your protected health information. We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes.

You may revoke the authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply) – Pursuant to your written request, you have the right to inspect or copy your protected health information whether in paper or electronic format. Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

You have the right to request a restriction of your protected health information – This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to your requested restriction except if you request that the physician not disclose protected health information to your health plan with respect to healthcare for which you have paid in full out of pocket.

You have the right to request to receive confidential communications – You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to request an amendment to your protected health information – If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures – You have the right to receive an accounting of disclosures, paper or electronic, except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of the request.

You have the right to receive notice of a breach – We will notify you if your unsecured protected health information has been breached.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint.**

MARILYN B. CABRAL	561-883-3030	hipaa@afpdocs.org
HIPAA COMPLIANCE OFFICER	Phone	email

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number. Please sign the accompanying "Acknowledgment" form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

HIPAA Notice of Privacy Practices

Revised 2013

Effective as of April/14/2003
Revised March/26/2013

ASSOCIATED FAMILY PHYSICIANS OF BOCA RATON, P.L.
9910 SANDALFOOT BLVD., SUITE 1
BOCA RATON, FL 33428-6692
561-883-3030

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.

This Notice of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you. If we use or disclose your protected health information for fundraising activities, we will provide you the choice to opt out of those activities. You may also choose to opt back in.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

ALLERGY PROFILE

Name: _____ Phone: _____ DOB: _____ Date: _____

Please check all symptoms that you experience occasionally or more than once a day:

☐Sneezing ☐Runny Nose ☐Postnasal Drip ☐Hives/Rash ☐Vomiting
☐Headaches ☐ Itchy/Watery eyes ☐ Wheezing ☐ Cough ☐Diarrhea
☐Nasal Congestion ☐Shortness of Breath ☐ Itching ☐ Swollen lips, tongue, face, etc.

Have you tried over the counter allergy medication(s)? (Antihistamines, Decongestants):

☐Yes ☐No Which medications have you tried? _____

Have you ever been allergy tested? ☐Yes Date: _____ ☐No

----------**PHYSICIAN USE ONLY**----------

Physician Recommendations: ☐ Allergy Testing ☐ No recommendation

☐ **Allergic Rhinitis Unspecified** J30.9 ☐ **Allergic Conjunctivitis** H10.45 ☐ **Asthma Mild Persistent** J45.30
☐ **Chronic Rhinitis** J31.0 ☐ **Rash** R21 ☐ **Asthma Mild Intermittent** J45.20
☐ **Urticaria – Idiopathic** L50.1 ☐ **Atopic Dermatitis** L20.81 ☐ **Asthma Moderate Persistent** J45.40
☐ **Urticaria – Allergic** L50.0 ☐ **Angioedema** T78.3 A D S ☐ **Asthma Other** J45.998
☐ **Sinusitis Chronic (NOS)** J32.9 ☐ **Allergic Gastro** K52.2

☐ Michelle N. Wilson, M.D. ☐ Radhika Phadke, M.D. ☐ Dushyant J. Utamsingh M.D.
☐ Owen A. Barruw, M.D., F.A.C.P ☐ Samantha L. Burstell, FNP-BC ☐ Other: _____

X_____ X_____

Provider Signature **Documented in Chart**