



WELCOME TO ANDOVER EYE ASSOCIATES.

Thank you for choosing our practice for your eye care!

Since 1976, Andover Eye Associates has been recognized as one of the finest multi-specialty eye care practices in the Greater Boston area. Our ten ophthalmologists and two optometrists are ready to care for all your eye care needs. Our physicians specialize in a wide range of eye care, from routine eye exams and contact lens eye care to complex eye diseases such as cataract, glaucoma, retina, ocular plastics, pediatric, and neuro-ophthalmic conditions. We also offer sight-correcting LASIK surgery.

Our on-premise, full-service optical shop offers a wide array of the latest styles in eyeglasses. Our adjacent medical spa, GloMD, offers the most advanced cosmetic treatments, eyelid surgery, photo-facial rejuvenation, and laser hair removal.

Most insurance plans are accepted.

As a new Andover Eye patient, we ask that you please complete the enclosed forms and bring them with you to your first office visit. In addition, please bring your insurance card, photo ID, and a physician referral (if your insurance plan requires one). If you wear contacts, please bring any information you have regarding the contacts you are presently wearing.

We look forward to meeting you at your upcoming appointment with Dr. _____,
at _____ AM/PM on _____, 2010.

Our experienced and friendly staff is available to answer any questions you may have prior to your appointment.

Each doctor is independent. Andover Eye Associates, Inc. is a billing and administrative agency.



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.

Our goal is to take appropriate steps to attempt to safeguard any medical or other personal information that is provided to us. The Privacy Rule under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) requires us to: (i) maintain the privacy of medical information provided to us; (ii) provide notice of our legal duties and privacy practices; and (iii) abide by the terms of our Notice of Privacy Practice currently in effect.

WHO WILL FOLLOW THIS NOTICE

- This notice describes the practices of our employees and staff.

INFORMATION COLLECTED ABOUT YOU

In the ordinary course of receiving treatment and health care services from us, you will be providing us with personal information such as:

- Your name, address, and phone number
- Information relating to your medical history
- Your insurance information, coverage and a photo I.D.
- Information concerning your doctor, nurse, or other medical providers

In addition, we will gather certain medical information about you and will create a record of the care provided to you. Some information may be provided to us by such individuals or organizations that are part of your “circle of care” – such as the referring physician, your other care providers, your health plan, and close friends or family members.

HOW WE MAY USE AND DISCLOSE INFORMATION ABOUT YOU

We may use and disclose personal and identifiable health information about you for a variety of purposes. All of the types of uses and disclosures of information are described below, but not every use of disclosure in a category is listed.

Required disclosures. We are required to disclose health information about you to the Secretary of Health and Human Services, upon request, to determine our compliance with HIPAA and to you, in accordance with your right to access and right to receive an accounting of disclosures, as described below.

For Treatment. We may use health information about you in your treatment. For example, we may use your medical history, such as any presence or absence of diabetes, to assess the health of your eyes.

For Payment. We may use and disclose health information about you to bill for our services and to collect payment from you or your insurance company. For example, we may need to give a payer information about your medical condition so that it will pay us for the eye examinations or other services that we have furnished to you. We may also need to inform your payer of the treatment you are going to receive in order to obtain prior approval or to determine whether the service is covered.



Notice of Privacy Practices Written Acknowledgement Form

I, _____
(Patient's printed name)

have been provided a copy of Andover Eye Associates' Notice of Privacy Practices and I have had the opportunity to read the Notice.

I authorize Andover Eye Associates to release my personal health information to the following individual(s):

You may list as many individuals as you wish. Please print.

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

I understand that I may change this list at any time.

Patient Signature

Date



PHYSICIAN NOTICE TO MEDICARE PATIENTS

Medicare program standards under section 1862 (a) (a) of the Medicare law will deny payment for:

“Refraction – the determination of the best corrective lenses to be prescribed or a change in your glasses prescription (CPT Code 92015),”

For the following reason: ***NON-COVERED SERVICE***

BENEFICIARY AGREEMENT

I have been notified by my physician that he/she believes that, in my case, Medicare will deny payment for refraction for the reason stated above. I agree to be personally and fully responsible for the payment.

(Refraction fee is \$35.00 as of 1/1/08).

Beneficiary Signature

Date



Date: _____

PATIENT INFORMATION

Last Name: _____ First Name: _____ M.I. _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work: _____ Cell: _____

Email Address: _____ @ _____

Social Security Number: _____

Sex: Male _____ Female _____ Marital Status: S M D W

Date Of Birth: _____ Age: _____

Employer: _____

Family Doctor: _____

Referring Doctor: _____

Primary Insurance: _____ I.D. Number: _____

Secondary Insurance: _____ I.D. Number: _____

Insured Name: _____ Insured Date Of Birth: _____

Insured Social Security Number: _____

Insured Employer: _____

Pharmacy Name /Address: _____

How did you hear about us? (Circle one) **Yellow Pages** **Word of Mouth** **Website****Referring Physician** **Ora** **Newspaper** **Insurance Co.** **Former Patient****Who Should We Contact In The Case Of An Emergency?**

Name: _____ Phone: _____

*** Relationship: _____

If The Patient Is A Minor, The Following Must Be Completed By The Parent Or Guardian:

Parent/Guardian Name: _____ Date Of Birth: _____

Relationship To Patient: _____

Social Security Number: _____

Signature: _____ Date: _____

For Health Care Operations. We may use and disclose information about you for the general operation of our business. For example, we sometimes arrange for auditors or other consultants to review our practices, evaluate our operations, and tell us how to improve our services. In addition, we may use and disclose your health information to review the quality of service provided to you.

Public Policy Uses and Disclosures. There are a number of public policy reasons why we may disclose information about you which are described below:

We may disclose health information about you when we are required to do so by the federal, state or local law.

We may disclose protected health information about you in connection with certain public health reporting activities.

We may disclose protected health information about you in connection with certain public health reporting activities. For instance, we may disclose such information to a public health authority authorized to collect or receive PHI for the purposes of preventing or controlling disease, injury or disability, or at the direction of a public health authority, to an official of a foreign government agency that is acting in collaboration with a public health authority. Public health authorities include state health departments, the Center for Disease Control, the Food and Drug Administration, the Occupational Safety and Health Administration and the Environmental Protection Agency, to name a few.

We are also permitted to disclose protected health information to a public health authority or other government authority authorized by law to receive reports of child abuse or neglect. Additionally, we may disclose protected health information to a person subject to the Food and Drug Administration's power for the following activities: to report adverse events, product defects or problems, or biological product deviations; to track products, to enable product recalls, repairs or replacements; or to conduct post marketing surveillance. We may also disclose a patient's health information to a person who may have been exposed to communicable disease or to an employer to conduct an evaluation relating to medical surveillance of the workplace or to evaluate whether an individual has a work-related illness or injury.

We may disclose a patient's health information where we reasonably believe a patient is a victim of abuse, neglect or domestic violence and the patient authorizes the disclosure or it is required or authorized by law.

We may disclose health information about you in connection with certain health oversight activities of licensing and other health oversight agencies which are authorized by law. Health oversight activities include audit, investigation, inspection, licensure or disciplinary actions, and civil, criminal, or administrative proceedings, as well as, actions or any other activity necessary for the oversight of 1) the health care system, 2) governmental benefit programs for which health information is relevant to determining beneficiary eligibility, 3) entities subject to governmental regulatory programs for which health information is necessary for determining compliance with program standards, or 4) entities subject to civil rights laws for which health information is necessary for determining compliance.

We may disclose your health information as required by law, including in response to a warrant, subpoena, or other order of a court or administrative hearing body or to assist law enforcement identify or locate a suspect, fugitive, material witness or missing person. Disclosures for law enforcement purposes also permit us to make disclosures about victims of crimes and the death of an individual, among others.

We may release a patient's health information 1) to a coroner or medical examiner to identify a deceased person or determine the cause of death, and 2) to funeral directors. We may release your health

information to organ procurement organizations, transplant centers, and eye or tissue banks, if you are an organ donor.

We may release your health information to workers' compensation or similar programs, which provide benefits for work-related injuries or illnesses, without regard to fault.

Health information about you may be disclosed, when necessary, to prevent a serious threat to your health and safety or the health and safety of others.

We may use or disclose certain health information about your condition and treatment for research purposes where an Institutional Review Board or a similar body, referred to as a Privacy Board, determines that your privacy interests will be adequately protected in the study. We may use and disclose our health information to prepare or analyze a research protocol and for other research purposes.

If you are a member of the Armed Forces, we may release health information about you for activities deemed necessary by military command authorities. We may release health information about foreign military personnel to their appropriate foreign military authority.

We may disclose your protected health information for legal or administrative proceedings that involve you. We may release such information upon order of a court or administrative tribunal. We may release protected health information in the absence of such an order, and in response to a discovery or other lawful request, if efforts have been made to notify you or secure a protective order.

If you are an inmate, we may release protected health information about you to a correctional institution where you are incarcerated, or to law enforcement officials in certain situations, such as where the information is necessary for your treatment, health or safety, or the health or safety of others.

Finally, we may disclose protected health information for national security and intelligence activities and for the provision of protective service to the President of the United States and other officials or foreign heads of state.

Our Business Associates. We sometimes work with outside individuals and businesses that help us operate our business successfully. We may disclose your health information to these business associates so that they can perform the tasks that we hire them to do. Our business associates must agree that they will respect the confidentiality of your personal and identifiable health information.

Disclosures to Persons Assisting in Your Care or Payment for Your Care. We may disclose information to individuals involved your care or in the payment for your care. This includes people and organizations that are part of your "circle of care" – such as your spouse, your other doctors, or and aide who may be providing services to you. We may also use and disclose health information about a patient for disaster relief efforts and to notify persons responsible for a patient's care about a patient's location, general condition, or death. Generally, we will obtain your verbal agreement before using or disclosing health information in this way. However, under certain circumstances, such as in an emergency situation, we may make these uses and disclosures without your agreement.

Appointment Reminders. We may use and disclose medical information to contact you as a reminder that you have an appointment, either by phone or mail.

Treatment Alternatives. We may use and disclose your personal health information in order to tell you about or recommend possible treatment options, alternatives, or health-related services that may be of interest to you.

OTHER USES AND DISCLOSURES OF PERSONAL INFORMATION

We are required to obtain written authorization from you for any other uses and disclosures of medical information other than those described above. If you provide us with such permission, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose personal information about you for the reasons covered by your written authorization, except to the extent that we have already relied on your original permission.

INDIVIDUAL RIGHTS

You have the right to ask for restrictions on the way we use and disclose your health information for treatment, payment and health care operation purposes. You may also request that we limit our disclosures to persons assisting your care or payment for your care. We will consider your request, but we are not required to accept it.

You have the right to request that you receive communications containing your protected health information from us by alternative means or at alternative locations. For example, you may ask that we only contact you at home or by mail.

Except under certain circumstances, you have the right to inspect and copy medical, billing and other records used to make decisions about you. If you ask for copies of this information, we may charge you a fee for copying and mailing.

If you believe that information in your records is incorrect or incomplete, you have the right to ask us to correct the existing information or add missing information. Under certain circumstances, we may deny your request, such as when the information is accurate and complete.

You have a right to receive a list of certain circumstances when we have used or disclosed your medical information. We are not required to include in the list uses and disclosures for your treatment, payment for services furnished to you, our health care operations, disclosures to you, disclosures you give us authorization to make, and uses and disclosures before April 14, 2003, among others. If you ask for this information from us more than once every twelve months, we may charge you a fee.

You have a right to a copy of this notice in paper form. You may ask us for a copy at any time. You may also obtain a copy of this through our website.

To exercise any of your rights, please contact us in writing at Janet E. Bonzagni, Andover Eye Associates, 138 Haverhill Street, Suite 104, Andover, MA 01810. When making a request for amendment, you must state a reason for making the request.

CHANGES TO THIS NOTICE

We reserve the right to make changes to this notice at any time. We reserve the right to make the revised notice effective for personal health information we have about you, as well as any information we receive in the future. In the event there is a material change to this notice, the revised notice will be posted. In addition, you may request a copy of the revised notice at any time.

COMPLAINTS/COMMENTS

If you have any complaints concerning our privacy practices, you may contact the Secretary of the Department of Health and Human Services, at 200 Independence Avenue, S.W., Room 509F, HHH Building, Washington, D.C. 20201 (e-mail: ocrmail@hhs.gov). You may also contact us at:

Janet E. Bonzagni, Andover Eye Associates, 138 Haverhill Street, Ste. 104, Andover, MA 01810
978- 475-0705.

You will not be retaliated against or penalized by us for filing a complaint.

To obtain more information concerning this notice, you may contact our Privacy Officer, Janet E. Bonzagni, at Andover Eye Associates, (978) 475-0705.

This notice is effective as of April 14, 2003.

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PATIENT HISTORY RECORD

Date: _____

Patient Name: _____

Birth Date: _____

Personal Physician: _____

Occupation: _____

Referring Physician: _____

What brings you in to see us today? _____

Date of last eye exam? _____ Previous Eye Physician: _____

Please answer the following questions about **your** medical status and history:

Please circle any of the following that you are being treated for or have been treated for in the past:

- | | | |
|---------------------|--------------------|-----------------------|
| Diabetes | Strabismus | Retinal Disease |
| High blood pressure | Cataract | Macular degeneration |
| Tuberculosis | Cancer | Blindness |
| Lupus | Glaucoma | Heart disease |
| Amblyopia | Serious eye injury | Arthritis /Rheumatoid |
| Other: _____ | Other: _____ | |

Have you ever had any eye surgery or other surgery?

No ___ If YES, Please explain: _____

Do you take **medications** or vitamin supplements?

No ___ If YES, Please complete attached medication form.

Do you take any **eye drops** or **medication for your eyes**?

No ___ If YES, Please list: _____

Do you have any drug or food allergies?

No ___ If YES, Please explain: _____

Please circle any of the following problems that you are currently experiencing, or have experienced:

- | | | |
|---------------------------------|---------------------|--------------------------------|
| Vision changes: Gradual//Sudden | Irregular Heartbeat | Anxiety |
| Eye Irritation | Abdominal | Allergies |
| Muscle aches | Skin rashes | Heartburn |
| Joint Pain | Excessive dry skin | Headaches |
| Fatigue | Weakness//Numbness | Chronic fever |
| Hearing loss | Coughing/Wheezing | Chest pain |
| Sinus Problems | Shortness of breath | Unexpected weight gain or loss |

Has anyone in your family ever been diagnosed with any of the following? Please circle.

Diabetes	Strabismus	Retinal Disease
High blood pressure	Cataract	Macular degeneration
Tuberculosis	Cancer	Blindness
Lupus	Glaucoma	Heart disease
Amblyopia	Serious eye injury	Arthritis/Rheumatoid
Other: _____	Other: _____	

Do you smoke? If Yes, how much? _____

Drink alcohol? If Yes, how much? _____

Do you wear glasses? If Yes: Reading or Distance No _____

Do you wear contact lenses? No: _____ Yes: _____

If Yes, which type? _____ Soft Lenses _____ Rigid gas permeable lenses _____ Hard lenses

PLEASE BRING BRAND, BASE CURVE & DIAMETER AND PRESCRIPTION INFORMATION (SEE YOUR CONTACT LENS BOX) TO YOUR VISIT

How often do you throw them away? _____

How many years have you worn contact lenses? _____

Do you sleep in your contacts? _____ No _____ Yes: How often? _____

Do you wish to be fit for contact lenses or renew your contact lens prescription? _____ No _____ Yes

IMPORTANT: For a **Contact Lens Fitting** or **Contact Lens Prescription Renewal**, there will be a fitting charge in addition to the standard examination fee that may or may not be covered by your insurance plan. Patient is responsible for any of these charges not covered by your insurance. These fees will be due at the time of service. Please speak to your insurance provider regarding complete details on this.

Please be sure to bring your list of Medications, Glasses and/or Contact Lenses with you.

Please bring sunglasses with you, as your eyes will be dilated.

Signature: _____

Date: _____



POLICIES AND PROCEDURES

Identity Theft Prevention And Detection And Red Flags Rule Compliance Policy

It is the policy of Andover Eye Associates, Inc. to follow all federal and state laws and reporting requirements regarding identity theft. Specifically, this policy outlines how Andover Eye Associates, Inc. will (1) identify, (2) detect and (3) respond to “red flags.” A “red flag” as defined by this policy includes a pattern, practice, or specific account to record activity that indicates possible identity theft.

It is the policy of Andover Eye Associates, Inc. that this identity theft prevention and detection and Red Flags Rule compliance program is approved by Andover Eye Associates, Inc., as of May 1, 2009, and that the policy is reviewed and approved no less than annually.

It is the policy of Andover Eye Associates, Inc. that Janet E. Bonzagni is assigned the responsibility of implementing and maintaining the Red Flags Rule requirements. Furthermore, it is the policy of Andover Eye Associates, Inc. that this individual will be provided sufficient resources and authority to fulfill these responsibilities. At a minimum, it is the policy of Andover Eye Associates, Inc. that, there will be one individual or job description designated as the privacy official.

It is the policy of Andover Eye Associates, Inc. that pursuant to the existing HIPAA Security Rule, appropriate physical, administrative and technical safeguards will be in place to reasonably safeguard protected health information and sensitive information related to patient identity from any intentional or unintentional use or disclosure.

It is the policy of Andover Eye Associates, Inc. that its business associates must be contractually bound to protect sensitive patient information to the same degree as set forth in this policy. It is also the policy of Andover Eye Associates, Inc. that business associates who violate their agreement will be dealt with first by an attempt to correct the problem, and if that fails by termination of the agreement and discontinuation of services by the business associate.

It is the policy of Andover Eye Associates, Inc. that all members of our workforce have been trained by the May 1, 2009 compliance date on the policies and procedures governing compliance with the Red Flags Rule. It is also the policy of Andover Eye Associates, Inc. that new members of our workforce receive training on these matters within a reasonable time after they have joined the workforce. It is the policy of Andover Eye Associates, Inc. to provide training should any policy or procedure related to the Red Flags Rule materially change. Furthermore, it is the policy of Andover Eye Associates, Inc. that training will be documented, indicating participants, date and subject matter.

Procedures

I. Identity red flags. In the course of caring for patients, Andover Eye Associates, Inc. may encounter inconsistent or suspicious documents, information or activity that may signal identity theft. Andover Eye Associates, Inc. identifies the following as potential red flags below:

1. A complaint or question from a patient based on the patient's receipt of:
 - A bill for another individual;
 - A bill for a product or service that the patient denies receiving;
 - A bill from a health care provider that the patient never patronized, or
 - A notice of insurance benefits (or explanation of benefits) for health care services never received.
2. Records showing medical treatment that is inconsistent with a physical examination or with a medical history as reported by the patient.
3. A complaint or question from a patient about the receipt of a collection notice from a bill collector.
4. A patient or health insurer report that coverage for legitimate hospital stays is denied because insurance benefits have been depleted or a lifetime cap has been reached.
5. A complaint or question from a patient about information added to a credit report by a health care provider or health insurer.
6. A dispute of a bill by a patient who claims to be the victim of any type of identity theft.
7. A patient who has an insurance number but never produces an insurance card or other physical documentation of insurance.
8. A notice or inquiry from an insurance fraud investigator for a private health insurer or a law enforcement agency, including but not limited to a Medicare or Medicaid fraud agency.

II. Detect red flags. Andover Eye Associates, Inc. practice staff will be alert for discrepancies in documents and patient information that suggests risk of identity theft or fraud. Andover Eye Associates, Inc. will verify patient identity, address and insurance coverage at the time of patient registration/check-in.

Procedure:

1. When a patient calls to request an appointment, the patient will be asked to bring the following at the time of the appointment:
 - Driver's license or other photo ID;
 - Current health insurance card; and
 - Utility bills or other correspondence showing current residence if the photo ID does not show the patient's current address. If the patient is a minor, the patient's parent or guardian should bring the information listed above.
2. When the patient arrives for the appointment, the patient will be asked to produce the information listed above. **This requirement may be waived for patients who have visited the practice within the last six months.**
3. If the patient has not completed the registration form within the last six months, registration staff will verify current information on file and, if appropriate, update the information.

4. Staff should be alert for the possibility of identity theft in the following situations:
 - The photograph on a driver's license or other photo ID submitted by the patient does not resemble the patient.
 - The patient submits a driver's license, insurance card, or other identifying information that appears to be altered or forged.
 - Information on one form of identification the patient submitted is inconsistent with information on another form of identification or with information already in the practice's records.
 - An address or telephone number is discovered to be incorrect, non-existent or fictitious.
 - The patient fails to provide identifying information or documents.
 - The patient's signature does not match a signature in the practice's records.
 - The Social Security number or other identifying information the patient provided is the same as identifying information in the practice's records provided by another individual, or Social Security number is invalid.

III. Respond to Red Flags. If an employee of Andover Eye Associates, Inc. detects fraudulent activity or if a patient claims to be a victim of identity theft, Andover Eye Associates, Inc. will respond to and investigate the situation. If the fraudulent activity involves protected health information (PHI) covered under the HIPAA security standards, Andover Eye Associates, Inc. will also apply its existing HIPAA security policies and procedures to the response.

Procedure

If the potentially fraudulent activity (a red flag) is detected by an employee of Andover Eye Associates, Inc.:

1. The employee should gather all documentation and report the incident to his or her immediate supervisor [or designated compliance officer/privacy official, if applicable].
2. The supervisor [or designated compliance officer/privacy official, if applicable] will determine whether the activity is fraudulent or authentic.
3. If the activity is determined to be fraudulent, then Andover Eye Associates, Inc. should take immediate action. Actions may include:
 - Cancel the transaction;
 - Notify appropriate law enforcement;
 - Notify the affected patient;
 - Notify affected physician(s); and
 - Assess impact to practice.

If a patient claims to be a victim of identity theft:

1. The patient should be encouraged to file a police report for identity theft if he/she has not done so already.
2. The patient should be encouraged to complete the ID Theft Affidavit developed by the FTC, along with supporting documentation.
3. Andover Eye Associates, Inc. will compare the patient's documentation with personal information in the practice's records.
4. If following investigation, it appears that the patient has been a victim of identity theft; Andover Eye Associates, Inc. will promptly consider what further remedial act/notifications may be needed under the circumstances.

5. The physician will review the affected patient's medical record to confirm whether documentation was made in the patient's medical record that resulted in inaccurate information in the record. If inaccuracies due to identity theft exist, a notation should be made in the record to indicate identity theft.
6. The practice medical records staff will determine whether any other records and/or ancillary service providers are linked to inaccurate information. Any additional files containing information relevant to identity theft will be removed and appropriate action taken. The patient is responsible for contacting ancillary service providers.
7. The following investigation, it does not appear that the patient has been a victim of identity theft, Andover Eye Associates, Inc. will take whatever action it deems appropriate.

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CONFIDENTIAL

HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information

You are being asked to sign this Privacy Authorization Form to allow Ora, Inc. access to protected health information (PHI). Ora, Inc. is an internationally renowned clinical research and development group that specializes in the development of ophthalmic (eye), topical medications and medical devices.

In order to determine if you are qualified for and/or interested in participating in clinical research trials that Ora might conduct, you will need to agree to the terms of this authorization.

I, _____, authorize Ora, Inc. and/or their administrative and clinical staff to use and disclose the PHI listed above to sponsoring drug companies or contract research organizations.

This authorization is to allow Ora, Inc. to use the information above to determine if you may be eligible for future research studies. Prior to disclosing any other PHI (like your past or present medical conditions or medications you are currently taking) for a study Ora will ask for your authorization and you would be asked to sign a separate Authorization similar to this.

This Authorization is for research and has no expiration date.

You have the right to revoke this authorization, in writing, at any time by sending a written notification to Ora's Privacy Contact at PrivacyContact@oraclinical.com or:

Ora, Inc.
 300 Brickstone Square
 Andover, MA 01810

There will be no re-disclosure of your PHI by Ora until you have signed a further authorization.

Ora will not condition treatment, payment, enrollment or eligibility for benefits (as applicable) on whether or not you provide authorization to release your protected health information to Ora unless your treatment is related to research conducted with Ora.

If you choose to sign this form, you will receive a copy of this signed authorization for your records.

_____	_____
Printed Name of Patient or Legally Authorized Representative	Date
_____	_____
Signed Name of Patient or Legally Authorized Representative	Date

Description of Legally Authorized Representative Authority	