northlakes COMMUNITY CLINIC

DENTAL

Ashland - Balsam Lake - Hayward
Iron River - Minong - Washburn - Turtle Lake

ph. (888) 834-4551 **northlakesclinic.org**

# CHILD HEALTH HISTORY

Today's Date _____

**PATIENT.** First Name _____ Last Name_____ Date of Birth _____

Your Name_____ Relationship to Patient _____

What brings you to NorthLakes Community Clinic today? _____

Has patient had any trouble associated with previous dental treatments? _____

_____

Is the child currently experiencing dental pain or discomfort? ☐ Yes ☐ No

Does the child frequently have bad breath? ☐ Yes ☐ No _____ _____

**HEALTH CONDITIONS.** Please check ✓ ALL that apply: **Height:** **Weight:**

- ☐ ADD/ADHD
- ☐ AIDS/HIV
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial or Damaged Heart Valve
- ☐ Asthma
- ☐ Autism/Autism Spectrum
- ☐ Autoimmune Disease
- ☐ Bacterial Endocarditis
- ☐ Bleeding Disorders
- ☐ Blood Transfusion
- ☐ Bone/Muscle Problems
- ☐ Bronchitis
- ☐ Cancer- Type:_____
- ☐ Congenital Heart Disease
- ☐ Diabetes: Type I or II
- ☐ Eating Disorders
- ☐ Epilepsy
- ☐ Excessive Urination
- ☐ Fainting Spells
- ☐ G.E.Reflux/Persistant Heartburn
- ☐ Hearing Loss
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hemophilia
- ☐ Hepatits- Type:_____
- ☐ High / Low Blood Pressure
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Malnutrition
- ☐ Mental Health Disorders
  Specify: _____
- ☐ Neurological Disorders
- ☐ Organ Transplant
- ☐ Recurrent Infections
  Type of Infection:_____
- ☐ Rheumatic Fever
- ☐ Seizures
- ☐ Severe Headaches/Migraines
- ☐ Recent Weight Loss
- ☐ Sleep Disorder
- ☐ Sinus Trouble
- ☐ Stomach Ulcers
- ☐ Systemic Lupus Erythematosus
- ☐ Thyroid Disorders
- ☐ Tuberculosis
- ☐ Other medical conditions or illnesses:

  _____

  _____

Does the patient have any allergies? ☐ Yes ☐ No If yes, please list_____

_____

Has patient had any serious illness, hospitalization or an operation in the past 5 years? ☐ Yes ☐ No

If yes, please explain:_____

Has the patient had an artificial joint replacement? ☐ Yes ☐ No If yes, please list _____

Does the child have any inherited problems? ☐ Yes ☐ No If yes, please list _____

DENTAL

# CHILD HEALTH HISTORY

Has a physician or dentist recommended that the patient take antibiotics prior to dental treatment? ☐ Yes ☐ No
Reason: _____

Is there anything else you would like us to know about this child's health? ☐ Yes ☐ No List: _____

Is the child in good health? ☐ Yes ☐ No Date of last physical: _____

Physician: _____ Clinic _____

Mental Health Counselor: _____ Clinic _____

Preferred Pharmacy (include city): _____

Has the child been a victim of abuse? ☐ Yes ☐ No

Is the child safe now? ☐ Yes ☐ No Is the home safe? ☐ Yes ☐ No

List all medications, including vitamins, herbals and over-the-counter (indicate if there are more than you can list here)
**You may give your medication list to the dental staff to make a copy.*

| Medication/Supplement Name | Amount | Reason for Taking |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

What does the child drink in a day? Please list: _____

How many juice/soda/energy drink/carbonated drinks in a day? _____

How would you describe the child's snacking habits. _____

What type of water does your child drink? ☐ City ☐ Well ☐ Bottled ☐ Filtered

Does your child take fluoride supplements or vitamins? ☐ Yes ☐ No

Does your child use fluoride toothpaste? ☐ Yes ☐ No

How would you describe the child's brushing habits? _____

**DENTAL PROBLEMS** (history of, conditions related to). Please check ✓ ALL that apply:

- ☐ Bleeding Gums when brushing/flossing
- ☐ Bruxing/Grinding of your teeth
- ☐ Clicking/popping/discomfort in the jaw
- ☐ Dry Mouth
- ☐ Earaches or neck pains/headaches
- ☐ Food or Floss catching in between teeth
- ☐ Injury to the head or mouth
- ☐ Orthodontics (Braces)
- ☐ Sores/Ulcers in your mouth/Cold Sores
- ☐ Tooth Sensitivity to cold/hot/sweets/pressure
- ☐ Other dental conditions we should know about (please explain):

Note: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment. I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of truthful health history and that my dentist and their staff will rely on this information for treating this child.

X _____ _____
Signature of Patient/Legal Guardian Date

_____ _____
Signature of Dentist Date

northlakes COMMUNITY CLINIC

Ashland - Iron River - Washburn
Hayward - Minong
Turtle Lake - Balsam Lake

ph. (888) 834-4551 northlakesclinic.org

# PATIENT INFORMATION

*Please complete this form and return it to the receptionist. If you would like assistance, please ask.*

**Patient Personal Information** **Today's Date:** _____

Legal Name _____ Middle Initial _____

Maiden or Previous Name _____ Date of Birth (DOB) _____

Name you prefer to be called (if different) _____ Social Security Number (SSN) _____

Mailing Address _____

City _____ State, Zip _____

Home Phone _____ Cell _____ **OK to leave message?** ☐ Yes ☐ No

Email _____ Preferred Pronoun: ☐ He ☐ She

Gender (check ✓ ALL that apply): ☐ Male ☐ Female ☐ Transgender / Female-to-Male ☐ Transgender / Male-to-Female ☐ Other ☐ Choose not to disclose

Sexual Orientation Identity: ☐ Heterosexual/Straight ☐ Lesbian or gay ☐ Bisexual ☐ Queer ☐ Something Else ☐ Not Sure ☐ Choose not to disclose

Family of Residence: ☐ Both Parents ☐ Foster Family ☐ Father Only ☐ Mother Only ☐ Other Family Member ☐ Independent ☐ Blended Family ☐ Other
*(18 years and under)*

Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Other _____

Race (check ✓ ALL that apply): ☐ American Indian/Native Alaskan ☐ Asian ☐ Black/African American ☐ Native Hawaiian ☐ Other Pacific Islander ☐ White

Ethnic Category (select one): ☐ Hispanic/Latino ☐ Non-Hispanic/Latino

Preferred Language _____

Primary Physician: _____ Clinic or Hospital Name/Location/State: _____

Emergency Contact _____ Phone _____ Relationship _____

If patient is under 18 years of age, who is the parent or legal guardian?

Name _____ Phone _____ Relationship _____

How did you hear about us? ☐ Newspaper ☐ Radio-TV-Movie ☐ Website/Social Media ☐ Relative-Friend ☐ Referral ☐ SAS/Outreach ☐ Other _____

Would you like to sign up for our Patient Portal? ☐ Yes ☐ No

## INSURANCE INFORMATION

**PRIMARY <u>Medical</u> Insurance Company (if uninsured, write "NONE")** _____

Name of policy holder _____ Relationship to patient: ☐ Self ☐ Parent ☐ Spouse ☐ Other

Policy holder's address (if different than above) _____

DOB _____ Social Security # _____

Insurance ID/Policy # _____ Group # _____

**SECONDARY or <u>Dental</u> Insurance Company (if applicable)** _____

Name of policy holder _____ Relationship to patient: ☐ Self ☐ Parent ☐ Spouse ☐ Other

Policy holder's address (if different than above) _____ DOB _____

Insurance ID/Policy # _____ Group # _____

**CONSENT FOR GENERAL CARE**

I present myself for health care services at NorthLakes Community Clinic (NorthLakes) to be provided by authorized employees of the Clinic and clinical staff as may, in their professional judgment, be deemed necessary or beneficial. I realize that among those who attend to patients are NorthLakes health care staff and other health care personnel in training who, unless requested otherwise, may be present during patient care as part of their education. I acknowledge that no guarantees have been made to me as to the effect of such examinations or treatments on my condition.

If a health care worker is exposed to my blood or other potentially infectious materials through any eye, mouth or other mucous membrane, non-intact skin or parenteral contact, I consent to a test of my blood to screen for the presence of Hepatitis B, Hepatitis C, Human Immunodeficiency Virus (HIV) or any antibody to the HIV virus, the cause of Acquired Immunodeficiency Syndrome (AIDS). I also consent to the release of reasonable, necessary portions of my medical record to assist NorthLakes in assessing potential risk related to such exposure. I authorize NorthLakes to release the test results to the exposed health care worker and any health care professional responsible for evaluating the exposed health care worker. I understand that I may have the right to consent to release of my test results to myself and/or my primary care physician.

**AUTHORIZATION TO RELEASE INFORMATION**

I authorize NorthLakes to disclose information from my medical/dental records (including transfer records) and/or my business office records to whom NorthLakes believes is responsible for the payment of my bill or is involved in my care and treatment. Should any portion of my records contain information regarding drug or alcohol abuse, consent is given to release such information necessary to obtain payment of my bill from insurance companies or other funding sources as named on the Requisition Records. I may revoke this consent at any future date upon written notification to NorthLakes; however, I understand NorthLakes may release information in good faith from the date I sign this consent until the date I may choose to revoke it. I authorize use of my medical/dental records and information for legitimate medical or scientific research purposes. Research procedures to not identify individuals by name or personal indentifying characteristics.

**OCCUPATIONAL HEALTH SERVICES**

I consent to a physical examination/evaluation or testing to be performed by the staff of NorthLakes occupational health and any affiliated sites. I understand that I can expect an explanation of findings of the physical examination and any tests performed. No treatment is expected in connection with this exam/testing as it is for evaluation purposes only. I understand that my employer or insurer who is requesting this examination may be responsible for reimbursing NorthLakes or affiliated sites per company policy. Access to information from this evaluation/testing shall follow applicable statutes and regulations.

**MEDICARE/MEDICAID PATIENTS**

I certify the information I gave in applying for payment under Title XVIII or XIX of the Social Security Act is correct. I request payment of authorized benefits on my behalf for any services furnished me by NorthLakes, including physician services, and assign such benefits to NorthLakes. I authorize NorthLakes to release to Medicare/Medicaid and its agents any information needed to determine these benefits or related services. I understand I am responsible for the costs of non-covered services and for the deductible, co-insurance and co-payment charges allowed under federal regulations.

**FINANCIAL AGREEMENT**

I agree to pay NorthLakes for all services provided to me by NorthLakes and others for whom NorthLakes collects bills at the regular rates. This includes services which, for any reason, are not paid by insurance, government programs or other third party sources. I understand that any self-pay portion of my clinic bill is due upon notification.

I authorize payments be made directly to NorthLakes of insurance, Medicare/Medicaid benefits or other funding sources I am entitled to as payment for services provided me. I understand professional (physician) services for radiology, lab and pathology are charged separately from my clinic bill and that I am financially responsible to those physicians for any charges for their professional services. If assignment of insurance benefits is accepted by such physicians, I authorize insurance payments be made directly to those physicians.

X _____ _____

Signature of Patient or Authorized Representative Date

X I acknowledge being offered the NorthLakes Notice of Privacy Practices _____(Initials)

northlakes COMMUNITY CLINIC

Ashland - Balsam Lake - Birchwood - Hayward
Iron River - Minong - Park Falls - Turtle Lake - Washburn

ph. (888) 834-4551 northlakesclinic.org

# REQUIRED INFORMATION ABOUT YOUR HOUSEHOLD INCOME

This site is a Federally Qualified Health Center (FQHC) which means we receive a federal grant that allows us to provide a discounted fee on services to our patients who qualify. We are required to provide certain information to the Bureau of Primary Health Care each year regarding all of our patients. The *only* reason this information is collected is for reporting purposes and we respect that this is personal and confidential information. Your help is very much appreciated.

**Today's Date** _____

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

## How many people are in your household? _____

*(Please include yourself and anyone related by blood, marriage or adoption, and are financially responsible for each other)*

## Total Annual Household Income ☐ No Income

Using the table below, please indicate which column represents your TOTAL family/household gross income level (before anything is deducted) based on the number of persons included in your household. This includes any wages, child support, alimony, disability, social security, retirement, unemployment, etc. **Check Below.**

| Household/ Family Size | ☐ <100% | ☐ 101-150% | ☐ 151-200% | ☐ >200% |
|---|---|---|---|---|
| | Less than or equal to | Between | Between | Greater than or equal to |
| 1 | $ 12,140 | 12,141 - 18,210 | 18,211 - 24,280 | $ 24,281 |
| 2 | $ 16,460 | 16,461 - 24,690 | 24,691 - 32,920 | $ 32,921 |
| 3 | $ 20,780 | 20,781 - 31,170 | 31,171 - 41,560 | $ 41,561 |
| 4 | $ 25,100 | 25,101 - 37,650 | 37,651 - 50,200 | $ 50,201 |
| 5 | $ 29,420 | 29,421 - 44,130 | 44,131 - 58,840 | $ 58,841 |
| 6 | $ 33,740 | 33,741 - 50,610 | 50,611 - 67,480 | $ 67,481 |
| 7 | $ 38,060 | 38,061 - 57,090 | 57,091 - 76,120 | $ 76,121 |
| 8 | $ 42,380 | 42,381 - 63,570 | 63,571 - 87,760 | $ 84,761 |
| 9 | $ 46,700 | 46,701 - 70,050 | 70,051 - 93,400 | $ 93,401 |
| 10 | $ 51,020 | 51,021 - 76,530 | 76,531 - 102,040 | $102,041 |

*If your household size is larger than 10, please see our Patient Services Representative for assistance in calculating your federal poverty level.*

**U.S. Veteran?** ☐ Yes ☐ No **Agricultural Status?** ☐ Migratory ☐ Seasonal ☐ Employed year round ☐ Non-Agricultural

# SLIDING FEE INFORMATION

We are able to offer a sliding fee scale on eligible services at NorthLakes to individuals or families with no income, low-income, or underinsured. Sliding fee calculations are based on the family/household size and annual gross income. Eligibility is based on your ability to pay according to Health Resource and Service Administration (HRSA) guidelines. Our Resource Coordinators are available to help if you need assistance applying for the sliding fee scale.

☐ **YES! I want to apply for the sliding fee scale.**

☐ **NO THANKS. I do not want to apply for the sliding fee scale.**

# YOU MAY BE ELIGIBLE!

1. Even if you have insurance
2. Even if you don't have insurance
3. Even if you live out of state or live in WI seasonally
4. Even if you don't have many appointments
5. Even if you applied but were previously denied
6. Even if you do not have any income or POI
7. Even if you and your children have Medicaid/ MA/Badgercare

northlakes COMMUNITY CLINIC

northlakesclinic.org

# PERMISSION TO DISCUSS

Today's Date: _____

**Patient Name:** LAST _____ FIRST _____ MI _____ Date of Birth _____

The staff at NorthLakes Community Clinic may discuss my health information with individuals that I have designated below. A staff member has fully explained what this consent means.

**PLEASE PRINT**

I hereby authorize: *(Name and Relationship to patient)*

| Name | Relationship |
|---|---|
| Positive Alternatives | Placement Provider |
| | |
| | |
| | |

Services: *(Check all that apply)*

- ❑ Medical
- ❑ Chiropractic
- ❑ Dental
- ❑ Mental Health Counseling
- ❑ Substance Use Disorder & Recovery Counseling
- ❑ Pharmacy/Prescription Services
- ❑ Occupational Therapy
- ❑ Speech Therapy
- ❑ Financial/Billing Information

☐ **DO NOT** share my health information and/or medical records. _____ Patient Initials

**YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:**

**Right to Inspect or Copy the Health Information to Be Used or Disclosed** – I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting the Medical Records Dept. **Right to Receive Copy of This Authorization** – I understand that if I agree to sign this authorization, I will be provided with a copy of it. **Right to Refuse to Sign This Authorization** – I understand I am under no obligation to sign this form and that the person(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. (Exception: To provide care that is done solely for the purpose of creating information to release to another party, in which case care cannot be provided without authorization disclosure. Authorization is needed to release information to payers for certain mental health services and HIV testing. If I refuse to sign the authorization form for this purpose, I understand I may be responsible for paying the entire bill for these services.) **Right to Revoke This Authorization** – I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the medical records department. I understand that the revocation will not apply to information that has already been released in response to this or any other previously received authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest claim under my policy. Unless otherwise revoked, this consent is effective for one year from the date of signature. This authorization expressly waives any requirement that it must be used within a certain number of days after the date of signing, or that it must be dated within any time period before the date it is used. This authorization shall also extend to records of future treatment, after the date of signing of this authorization, as long as such treatment occurs while this authorization is still in effect.

I have had an opportunity to review and understand the content of this authorization. By signing this authorization, I am confirming that it accurately reflects my wishes.

**If I am signing as Authorized Representative of the patient, I am:**

☐ Parent of minor ☐ Court appointed guardian/conservator ☐ POA for HealthCare ☐ Spouse/Adult Family Member of deceased patient

Patient Signature/Legal Rep: _____ Date _____

Signature of Witness _____ Title _____

Form 044

NL-CL.CONSDiscuss-release, 0217 -NGm

northlakes COMMUNITY CLINIC

DENTAL

- ☐ Hayward
- ☐ Turtle Lake
- ☐ Balsam Lake
- ☐ Iron River
- ☐ Ashland

# CONSENT TO TREATMENT

**Patient Name:** _____ **Birth date:** _____

I give consent for my child or dependent adult of whom I am the guardian to receive dental treatment as deemed necessary by the providers at NorthLakes Community Clinic. These procedures include, but are not limited to: examinations, oral prophylaxes (cleaning), fluoride treatments, sealants, restorations (amalgam or resin fillings and crowns), periodontal (gum) treatments, endodontic (root canal) treatments, extractions, and the use of local anesthetics. I understand that the use of local anesthetics carries a small risk of adverse effects including swelling, bruising, allergic reaction, changes in pain perception, or prolonged anesthesia. **This consent shall be considered in effect until rescinded or amended.**

_____ _____

(Print your name) (Relationship) (Date)

_____

(Your signature)

_____ _____

(Witness) (Date)

## This section needs to be completed for children under the age of 18 and dependent adults by a parent or legal guardian ONLY.

I affirm that I am the parent or legal guardian for the above named patient. If I am unable to accompany the patient, I give permission for the individuals named below to escort the patient and authorize treatment. The responsible adult bringing the patient must remain at the office for the duration of the appointment. All escorts must be over the age of 18.

**Name:** Positive Alternatives **Relationship:** Placement Provider

**Name:** _____ **Relationship:** _____

***If child / dependent adult is 16 years or older, please check one:**

☐ Since my child / dependent adult is age 16 or older, I also give permission for him/her to present for treatment unaccompanied.

☐ Although my child / dependent adult is age 16 or older, I wish to be present for all treatments performed.

**Name:** _____ **Relationship:** _____

_____ _____

(Signature of parent or legal guardian) (Date)

**This consent shall be considered in effect until rescinded or amended.**

northlakes COMMUNITY CLINIC

DENTAL

☐ Hayward ☐ Iron River

☐ Ashland ☐ Turtle Lake

# MISSED DENTAL APPOINTMENT POLICY

## *Patient Acknowledgement of Missed Dental Appointment Policy*

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

Because there are so many patients waiting to receive dental care at our clinic, we enforce a Missed Appointment Policy.

*We value your time and dental health, so if scheduling appointments is difficult, same day appointments may be available to you. Same day appointments may accommodate busy families or your changing schedule. Please ask the front desk for more details.*

**Missed Appointment Policy** **Pt. Initials** _____

If a patient misses or cancels an appointment with less than 24 hours notice, they may be rescheduled one time. If a patient misses a second appointment, regardless of the reason for the missed appointment, he/she will be asked to utilize same day appointments. A patient/parent may contact a Resource Coordinator to appeal the restriction.

**Late for an Appointment** **Pt. Initials** _____

Patients who arrive more than 10 minutes late for an appointment may not be seen that day. Patients who arrive late may be re-scheduled one time. If a patient arrives late to a second appointment, he/she may be asked to utilize same day appointments.

"Same day" appointments may be available for a patient who arrives late. Please ask the front desk staff for more details.

**Continuation of Care**

Preventative maintenance is important. If you do not return for scheduled appointments for a dental treatment plan, or have missed your recommended routine dental check-up for more than 3 years, you will be considered a "new patient" and may not be able to reschedule your regular dental care.

**Appointment Reminders**

It is the patient's responsibility to remember appointments. We try to verify appointments by phone one to two business days before the appointment. Please be sure we have your current contact information so we can call you.

For children under the age of 19, we try to send a reminder postcard or make a reminder phone call for regular check ups. However, we may not be able to reach every patient due for a check up. It is helpful to mark 6 months on the calendar to schedule your next visit.

**ALL CHANGES IN APPOINTMENTS REQUIRE 24-HOUR NOTICE.**

I acknowledge that I have read, understand and will adhere to the dental appointment policies listed above.

X _____

Signature of Patient/Legal Guardian Date

Printed Name _____

NorthLakes Representative Signature _____

northlakes COMMUNITY CLINIC

**INTERNAL CARE**

Ashland - Balsam Lake - Birchwood - Hayward
Iron River - Minong - Turtle Lake - Washburn

**ph.** (888) 834-4551 **northlakesclinic.org**

# NORTHLAKES HEALTH INFORMATION RELEASE

Today's Date _____

Patient Name: _____ Maiden Name: _____

Date of Birth: _____

**Please Note:** As a patient of NorthLakes Community Clinic, which offers many services (listed below):

| | | | |
|---|---|---|---|
| Medical | Psychiatric Medication Management | Mental Health Counseling | Prescription Services |
| Dental | Chiropractic | Recovery Services | NorthLakes Billing |
| Pediatric Occupational Therapy | | Pediatric Speech Therapy | Wellness |
| Resource Coordination | | School Based Mental Health Counseling | |

All services and care team members that are a part of your health care plan will have access to your Protected Health Information in order for the team to better serve your health care needs. You have the right to have any area of your services excluded please list: _____

As a patient of NorthLakes Community Clinic, if you are seen in an Emergency Room or Urgent Care, for continuity and coordination of care these outside medical facilities will have access to your electronic records.

Please initial: _____

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosures. I understand that the information in my medical records may include information relating to sexually transmitted disease (STD), acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), psychiatric management, behavioral and mental health services, and treatment for alcohol and drug use through NorthLakes general provision of health care. NorthLakes employs certain staff members who provide substance use disorder diagnoses, treatment, or referral for treatment through NorthLakes Recovery Program. I understand records created as part of this program are protected under the Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2 and/or HIPAA 45 CFR, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. In addition, I understand that this consent form does not apply to my records that do not identify me, directly or indirectly, as an individual participating in a program for substance use disorders. I understant that I have the right to receive a copy of the health information I have authorized to be used or disclosed by this authorized form as required ss. DHS 92.05,92.06, and 94.05. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I can do so in writing or verbally. However, it is highly recommended to send a written revocation to the Medical Records Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Date Signature of ☐ Patient ☐ Parent ☐ Legal Guardian ☐ Authorized Legal Representative

Date Signature of ☐ Patient ☐ Parent/Guardian (*If patient is 14+years of age, both patient and parent/guardian must sign)*

This authorization will expire one year from the above date, unless listed here: _____

OFFICE USE ONLY: ☐ A ☐ BL ☐ BW ☐ H ☐ IR ☐ M ☐ TL ☐ W ☐ OUTREACH