RESTORE
MEDICAL PARTNERS

WELCOME TO THE OFFICES OF RESTORE MEDICAL PARTNERS

We thank you for choosing Restore Medical Partners for your healthcare needs. We are honored to be your physicians and we're committed to providing you with the best healthcare possible. By working closely with our providers, our hope is that we form a partnership to reduce your pain and keep you as healthy and functional as possible.

We strive to offer a very welcoming environment and ensure our staff is committed to making your experience as pleasant as possible. Our goal is to provide excellent customer service, prompt phone call return within 24 hours, prompt scheduling within 24 hours, and consistently show the highest level of compassion for our patients.

We value your feedback and welcome you to leave comments on patient feedback surveys throughout your experience with us. Finally, we look forward to your upcoming office visit and to helping you relieve you pain and get back to living a wholesome and active lifestyle.

Sincerely,

Michael Katz, DPM

333 S. Sunset Lake Blvd., Suite 365
Venice, FL 34285
Phone: (941) 441-9171
Fax: (941) 218-4825
www.restoremedicalpartners.com

RESTORE
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NEW PATIENT INTAKE FORM

Completed intake paperwork helps our physicians and other providers get to know you and your medical history better. We depend on its accuracy and completeness to provide you with the best possible care. Please contact our front desk at (941) 375-3006 if you need assistance with any of the sections on this form.

Patient Information

NAME:_____ TODAY'S DATE: _____

DATE OF BIRTH:___/___/_____ REFERRING PHYSICIAN: _____

AGE:_____ PRIMARY CARE PHYSICIAN: _____

HEIGHT:_____ PREFERRED PHARMACY: _____

WEIGHT:_____ PREFERRED IMAGING FACILITY:_____

HOW DID YOU HEAR ABOUT US:

☐ Physician ☐ Friend/Family ☐ Google/Internet ☐ Social Media ☐ Billboard ☐ TV Commercial

Other: _____

ALLERGIES

Do you have any drug/medication allergies? YES ☐ NO

If so, please list all medications you are allergic to:

	Medication Name	Allergic Reaction
1)		
2)		
3)		
4)		
5)		

FAMILY HISTORY

Mark all appropriate diagnoses as they pertain to your first degree relatives:

☐ Arthritis
☐ Asthma
☐ Back Problem
☐ Blood Coagulation Disorder
☐ Cerebrovascular Accident
☐ Chronic Obstructive Lung Disease
☐ Coronary Arteriosclerosis
☐ Depression
☐ Diabetes
☐ Disorder of Thyroid Gland
☐ Heart Disease
☐ Hypercholesterolemia

☐ Other Medical Problems: _____

☐ I have no significant family medical history

PAST SURGICAL HISTORY

Please list any surgical procedures you have had done in the past:

☐ Appendectomy
☐ Back Surgery
☐ Caesarean Section
☐ Carpal Tunnel Surgery
☐ Cholecystectomy
☐ General Surgery
☐ Hernia Repair
☐ Hysterectomy
☐ Joint Replacement
☐ Knee Surgery
☐ Neck Surgery
☐ Orthopedic Surgery
☐ Plastic Surgery
☐ Shoulder Surgery
☐ Sinus Surgery
☐ Tonsillectomy/ Adenoids
☐ Foot Surgery
☐ Other:_____

Date of Procedure: _____

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NEW PATIENT INTAKE FORM
CONTINUED

SOCIAL HISTORY

Tobacco Use:

☐ Never Used ☐ Former user ☐ Current Every Day Smoker ☐ Current Some Day Smoker

Packs per day _____ How many years? _____ Quit Date: _____

Alcohol Use: ☐ Social Use ☐ Daily Use ☐ History of alcoholism ☐ None

Caffeine Intake: ☐ None ☐ Occasional ☐ Moderate ☐ Heavy

Illegal Drug Use:

☐ Denies any use ☐ Currently user ☐ Former User ☐ Abuse of narcotic or prescription medication

Occupation: _____ When was the last time you worked? _____

Who is in your current household? _____

Are there any stairs in your current home? ☐ Yes ☐ No If Yes, How many? _____

Disability:

☐ Temporary Disability ☐ Permanent Disability ☐ Retired ☐ Unemployed

Are you currently under worker's compensation? ☐ Yes ☐ No

Is there an ongoing lawsuit related to your visit today? ☐ Yes ☐ No

PAST MEDICAL HISTORY

Do you have ANY history of Cancer? ☐ Yes ☐ No

Have you ever had an appendectomy? ☐ Yes ☐ No **Date:** _____

Mark the following conditions/diseases that you have been treated for in the past:

	YES	NO		YES	NO		YES	NO
Acid Reflux (GERD)	☐	☐	Headaches	☐	☐	Insomnia	☐	☐
Anemia	☐	☐	Heart Attack	☐	☐	Night Sweats	☐	☐
Anxiety	☐	☐	Heart Valve Disorders	☐	☐	Unexplained Weight Gain	☐	☐
Asthma	☐	☐	High Blood Pressure	☐	☐	Unexplained Weight Loss	☐	☐
Bipolar Disorder	☐	☐	Hyperthyroidism	☐	☐			
Bronchitis/Pneumonia	☐	☐	Hypothyroidism	☐	☐			
Bursitis	☐	☐	Glaucoma	☐	☐			
Cancer	☐	☐	Kidney Stones	☐	☐			
Carpal Tunnel	☐	☐	Low Sex Drive	☐	☐			
Chronic Joint Pains	☐	☐	Migraines	☐	☐			
Chronic Kidney Disease	☐	☐	Multiple Sclerosis	☐	☐			
Constipation	☐	☐	Osteoarthritis	☐	☐			
Coronary Artery Disease	☐	☐	Osteoporosis	☐	☐			
Depression	☐	☐	Peripheral Neuropathy	☐	☐			
Diabetes	☐	☐	Peripheral Vascular	☐	☐			
Dialysis	☐	☐	Disease	☐	☐			
Difficulty Sleeping	☐	☐	Rheumatoid Arthritis	☐	☐			
Easy Bruising	☐	☐	Schizophrenia	☐	☐			
Emphysema/COPD	☐	☐	Seizures	☐	☐			
Fatigue	☐	☐	Stroke/TIA	☐	☐			
Fibromyalgia	☐	☐	Thyroid Problem	☐	☐			
Gastrointestinal Bleeding	☐	☐	Urinary Incontinence	☐	☐			
Head Injury	☐	☐	Chills	☐	☐			

Other Diagnosed Conditions

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NEW PATIENT INTAKE FORM
CONTINUED

DIAGNOSTIC TESTS AND IMAGING

Mark all of the following tests that you have related to your current pain complaints:

☐ MRI of the:_____ Date:_____

☐ X-Ray of the:_____ Date:_____

☐ CT Scan of the:_____ Date:_____

☐ EMG/NCV study of the:_____ Date:_____

☐ Other Diagnostic Testing:_____ Date:_____

☐ I have not had ANY diagnostic tests for my current pain complaint

Mark the following physicians or specialists you have consulted for your current pain problem(s):

☐ Acupuncturist	☐ Neurosurgeon	☐ Psychiatrist/Psychologist
☐ Chiropractor	☐ Orthopedic Surgeon	☐ Rheumatologist
☐ Internist	☐ Physical Therapist	☐ Neurologist
☐ Podiatrist	☐ Other:_____	

PAIN HISTORY

Chief Complaint (Reason for your visit today)? _____

Does this pain radiate? If so, where? ☐ No ☐ Yes

Lower Extremity ☐ Left ☐ Right ☐ Bilateral
Groin ☐ Left ☐ Right
Buttock ☐ Left ☐ Right
Hip ☐ Left ☐ Right

Please list any additional areas of pain: _____

Previous medication(s) used for this condition and efficacy: _____

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NEW PATIENT INTAKE FORM
CONTINUED

PAIN DESCRIPTION

Check all of the following that describe your pain:

☐ Dull/Aching ☐ Hot/Burning ☐ Tightness ☐ Stabbing/Sharp ☐ Cramping

☐ Numbness ☐ Throbbing ☐ Tingling/Pins and Needles

How often does the pain occur? ☐ Constant ☐ Intermittent (comes and goes) ☐ Pain at Night

Severity: ☐ Worsening ☐ Interferes with Sleep ☐ Interferes with Work ☐ Middle of the night

If "0" is no pain and "10" is the worst pain you can imagine, how would you rate your pain?

Right Now_____ The Best It Gets_____ The Worst It Gets_____

ONSET OF SYMPTOMS

Approximately when did this pain begin? _____

What Caused your current pain episode? _____

_____

How did your current pain episode begin? ☐ Sudden ☐ Gradual ☐ Chronic

Intermittent episodes lasting:_____Days _____Months _____Weeks _____Years

Since your pain began how was it changed? ☐ Improved ☐ Worsened ☐ Stayed the same

ALLEVIATING FACTORS

Please circle any and all that apply for pain alleviation:

☐ Nothing ☐ Heat ☐ Ice ☐ Medications ☐ Sitting

☐ Standing ☐ Stretching ☐ Lying Down ☐ Position Change ☐ Rest

☐ Physical Therapy ☐ Epidural Injections ☐ Other: _____

AGGRAVATING FACTORS

Please circle any and all that apply for pain aggravation:

☐ Cannot Identify ☐ Getting out of Bed ☐ Transitioning from Sitting to Standing

☐ Transitioning from Standing to Sitting ☐ Walking Up/Downstairs

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NEW PATIENT INTAKE FORM
CONTINUED

REVIEW OF SYSTEMS

Mark the following symptoms that you currently suffer from:

Constitutional:	☐ Chills ☐ Night Sweats ☐ Insomnia ☐ Unexplained Weight Gain	☐ Difficulty sleeping ☐ Fatigue ☐ Weakness ☐ Unexplained Weight Loss	☐ Easy bruising ☐ Fevers ☐ Tremors
Eyes:	☐ Recent Visual changes	☐ Dry Eyes	☐ Irritation
Ears:	☐ Difficulty Hearing	☐ Ear Pain	☐ Ear Discharge
Nose:	☐ Frequent Nose Bleeds	☐ Nose Problems	☐ Sinus Problems
Mouth/Throat:	☐ Sore Throat ☐ Dry Mouth ☐ Teeth Abnormalities	☐ Bleeding Gums ☐ Oral Abnormalities ☐ Mouth Breathing	☐ Snoring ☐ Mouth Ulcers
Cardiovascular:	☐ Chest Pain ☐ Arm Pain ☐ Shortness of Breath When Walking	☐ Heart Murmur ☐ Palpitations ☐ Shortness of Breath When Lying Down	☐ Blood Clots ☐ Swelling in feet
Respiratory:	☐ Cough	☐ Wheezing	☐ Shortness of breath
Gastrointestinal:	☐ Constipation ☐ Diarrhea	☐ Acid Reflux ☐ Nausea/Vomiting	☐ Abdominal Pain ☐ Change in Appetite
Genitourinary/ Nephrology:	☐ Urinary Loss of Control ☐ Pain When Urination ☐ Decreased Urine Flow/Frequency	☐ Difficulty Urinating ☐ Vaginal Discharge	☐ Hematuria
Musculoskeletal:	☐ Back Pain ☐ Joint Swelling ☐ Limited Motion	☐ Joint Pains ☐ Muscle Aches/Weakness ☐ Previous Injury	☐ Joint Stiffness ☐ Neck Pain ☐ Trauma
Skin:	☐ Abnormal Mole ☐ Itching ☐ Laceration ☐ Bruising	☐ Jaundice ☐ Dry Skin ☐ Growths/Lesions ☐ Insect Bites	☐ Rash ☐ Skin Lumps ☐ Redness ☐ Flaking
Neurological:	☐ Dizziness ☐ Numbness/Tingling ☐ Loss of Consciousness	☐ Headaches ☐ Restless Legs ☐ Shooting Pain	☐ Tremors ☐ Seizures
Psychiatric:	☐ Depressed Mood ☐ Suicidal Thoughts ☐ Hallucination	☐ Anxiety ☐ Insomnia ☐ Alcohol Abuse	☐ Stress Problems ☐ Restlessness
Endocrine:	☐ Fatigue	☐ Temperature Intolerance	☐ Increased Thirst
Hematologic/Lymphatic:	☐ Swollen Glands	☐ Easy Bruising	☐ Excessive Bleeding
Allergic/Immunologic:	☐ Runny Nose ☐ Hives	☐ Sinus Pressure ☐ Frequent Sneezing	☐ Itching
Chest/Breasts:	☐ Lumps	☐ Tenderness	☐ Discharge

☐ All other review of systems negative

☐ Reviewer _____

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333 S Tamiami Trl, Suite 101
Venice, FL 34285
Ph: (941) 375-3006
F: (941) 218-4825

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

I authorize Restore Medical Partners and any affiliates or subsidiaries to obtain/release a copy of all pertinent health and medical information described below (please make sure both circles are selected/approved) :

◯ Restore Medical Partners is authorized to send my records to my care team or any medical facility associated with my care
- This includes but is not limited to initial evaluation, most recent office visit, surgical/injection reports, allergies and medications, imaging, lab reports, follow up encounters, and all medical records

◯ Restore Medical Partners is authorized to obtain my records from my care team or any medical facility associated with my care
- This includes but is not limited to my entire medica record, initial evaluation, most recent office visit, surgical/injection reports, allergies and medications, imaging, lab reports, and follow up encounters

If we are requesting this Authorization from you for our own use and disclosure or to allow another health care provider or health plan to disclose information to us:

1. We cannot condition our provision of services or treatment to you on the receipt of this signed Authorization;
2. You may inspect a copy of the protected health information to be used or disclosed;
3. You may refuse to sign this Authorization; and
4. We must provide you with a copy of this signed Authorization.
5. You have the right to revoke this Authorization at any time, provided that you do so in writing and except to the extent that we have already used or disclosed the information in reliance on this Authorization.
6. Unless revoked earlier or otherwise indicated, this authorization will auto renew ever 180 day from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

By signing below, I authorize Restore Medical Partners to release or obtain copies of my medical records. I understand that my record may contain information about alcohol and/or drug treatment, mental health, or psychiatric treatment, and/or HIV/AIDS information. I do herein expressly and voluntarily consent to the disclosure of my health information, as specified, for the purpose or need as indicated above. I have reviewed and I understand this Authorization. I also understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer be protected under Federal law. I understand that Restore Medical Partners may utilize a medical record correspondence service and there may be a fee assessed for this service. PLEASE ALLOW 7 TO 10 BUSINESS DAYS FOR RECORDS TO BE COPIED.

* / /

SIGNATURE OF PATIENT/LEGAL REPRESENTATIVE ***RELATIONSHIP TO PATIENT*** ***DATE (mm/dd/yyyy)***

64B8-10.003 Costs of Reproducing Medical Records:
Specific Authority 456.057(18), 458.309 FS. Law Implemented 456.057(18) FS. History–New 11-17-87, Amended 5-12-88, Formerly 21M-26.003, 61F6-26.003, 59R-10.003, Amended 3-9-09.

1. Any person licensed pursuant to Chapter 458, F.S., required to release copies of patient medical records may condition such release upon payment by the requesting party of the reasonable costs of reproducing the records.
2. Reasonable costs of reproducing copies of written or typed documents or reports shall not be more than the following:
a. For the first 25 pages, the cost shall be $1.00 per page b. For each page in excess of 25 pages, the cost shall be 25 cents per additional page
3. Reasonable costs of reproducing x-rays, and such other special kinds of records shall be the actual costs. The phrase "actual costs" means the cost of the material and supplies used to duplicate the record as well as the labor cost and overhead costs associated with such duplication.

Specific Authority 456.057(18), 458.309 FS. Law Implemented 456.057(18) FS. History–New 11-17-87, Amended 5-12-88, Formerly 21M-26.003, 61F6-26.003, 59R-10.003, Amended 3-9-09

RESTORE
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COMPREHENSIVE PATIENT AGREEMENT FORM

As your providers, we are committed to providing you, the patient, with the best possible medical care. In order to achieve this goal, we need your assistance and understanding of our practice policy and procedures that effect all providers and patients.

OFFICE HOURS:
8:00am-5:00pm Monday through Friday.

Please notify our office at least 24 hours in advance if you are unable to keep your scheduled appointment by phone or the online patient portal. **Missed appointments and/or last-minute cancellations may incur a $50 charge for office visits, and $100.00 for procedures.** You may call our office at (941) 375-3006 for any appointment change notifications.

PRESCRIPTIONS AND REFILLS:

You are responsible for your medication and their refills. Please call the pharmacy for all refill requests. The office has a 24 hour and a 48-hour turnaround policy regarding digital and written prescriptions accordingly. The pharmacy will notify our office of your request. ***This process is much faster as we will have all the information that the pharmacy needs to process your refill.*** In order to comply with the Drug Enforcement Agency there will be NO prescriptions called in after hours or on weekends by any on-call Provider. Controlled medications will not be "called in" under any circumstances.

AUTHORIZATION TO RELEASE OR RECEIVE MEDICAL INFORMATION & AUTHORIZATION OF ASSIGNMENT OF BENEFITS

We strongly feel that all patients deserve from us the best medical care that we can provide. Further, we feel that everyone benefits when definitive financial arrangements are agreed upon. Accordingly, we have prepared this material to acquaint you with our policy. *Our professional services are rendered to you, not the insurance company. Therefore, payment for treatment is your responsibility.* Please read the following:

- I authorize Restore Medical Partners to release or receive any information necessary to expedite insurance claims.
- I hereby authorize Restore Medical Partners to bill my insurance company directly for their services.
- I authorize payment directly to my Physician of any insurance benefits otherwise payable to me.
- In the event I receive payment from my insurance carrier, I agree and endorse any payment I receive over to my Physician for which these fees are payable.

I understand that I am directly and fully financially responsible to my Physician for charges not covered by my insurance. I further understand that such payment is not contingent on any settlement, judgement or insurance payment by which I eventually recover said fee. I realize that if my insurance company fails to pay by balance in full, or there is no payment made within 60 days, it is my responsibility to pay my bill directly. I further understand and agree, that if I fail to make timely payments on my account, I will be responsible for any and all reasonable costs of collection, including filing fees as well as reasonable attorney's fee. I have read and understand what is expected of me, the patient, in relation to any care, my insurance carriers and my financial responsibilities.

FINANCIAL POLICY:

We adhere to a clear and comprehensive financial policy. As a courtesy to all of our patients, it is our normal practice to:

- Verify eligibility and benefits prior to your appointment.
- File your claim with Medicare and/or commercial healthcare insurance providers.

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For All Patients:

- Payment is required at the time of service unless prior arrangements have been made.
- I am responsible for knowing the terms of my policy, including deductibles, copayments, coinsurances, and any applicable referral procedures.
- I am financially responsible for all charges, whether or not covered by insurance. This includes, but is not limited to, out-of-network, laboratory, and anesthesia service charges.
- All anesthesia fees are billed independently of Restore Medical Partners and are ultimately my responsibility. This means I MAY RECEIVE A SEPARATE BILL FOR ANESTHESIA following a procedure. It is necessary to contact Spartan Anesthesia directly to resolve any billing concerns.
- All Laboratory fees are billed by Restore Medical Partners unless otherwise required by insurance, or specifically requested, and are ultimately my responsibility. I MAY RECEIVE A SEPARATE LAB BILL IF THE TEST IS SENT TO LABCORP OR QUEST. It is necessary to contact the lab directly to resolve any billing concerns if performed at an outside lab.
- Patients with overdue accounts will be sent a statement from Restore Medical Partners to the address on file. It is my responsibility to keep my address current. Every effort is made to help our patients satisfy their obligations in a reasonable manner and avoid our collections process.
- I understand and agree additional services such as labs, or in-office injections may be performed as a course of treatment. I am responsible for any additional costs these services may result in.
- In the event we are unable to verify your benefits, you cannot provide proof of coverage at the time of visit, or no authorization is on file, I can either: Reschedule my appointment, or Make payment in full. We will provide financial statements to help you pursue reimbursement of the claim (upon request). However, we will not file reimbursement for you.

ONLINE COMMUNICATION & HIPAA

Upon signing the HIPAA consent form, you agree to be solely responsible for your username and password. It is not to be shared. If you choose to share this information you are allowing that person to see your PHI (Private Health Information). By signing this form you acknowledge and accept all of the following:

- I have been explained the details of the online patient portal. I understand them, and my questions have been answered.
- Alternative methods are available to me via (in person, mail, telephone).
- I am aware that my private health information (PHI) carries a risk to my privacy should it be compromised.
- I agree to take precautions to keep my online communication safe, including but not limited to:
  - Keeping passwords confidential.
  - Closing my computer or screen when not in use.
  - Refraining from storing PHI on employer-owned computers or phones, etc.

I agree to indemnify and hold harmless, Restore Medical Partners, of and from any claims, losses, causes of action, damage, lawsuits, judgements, including attorney's fee and cost.

HIPAA 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.

RESTORE MEDICAL PARTNERS adheres strictly to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) at all times. The following method of operations will be used to insure privacy of a patient's Protected Health Information (PHI).

- Based on HIPAA guidelines your medical records may be transferred to another care provider upon your signed authorization. Records will not be transferred without you or your legal designee's signed authorization.
- You may review your records by scheduling a time with the office.
- After review of your records if you disagree with any of the documentation in the records you have the option of writing your own documentation to be placed in the chart.
- If an appointment with another medical provider is required, only the necessary information to schedule an appointment will be provided.
- If you elect to not allow any other member of your family access to your records you have the right to notify our office. That notice must be in writing. If you wish to provide access to your records to a designated individual you may also provide that notice in writing.
- Our office will not provide any information about you or your medical condition to any other party other than other medical providers to whom you have been referred for treatment without your specific authorization.
- If you are chosen to be part of any research program you will be required to sign additional authorizations and releases so that your PHI may be used in the program.

- Under the HIPAA rules, we may use the necessary PHI from your medical records to file insurance claims on your behalf. Your authorization and insurance assignment allows the practice to file insurance on your behalf.
- There will be certain circumstances where public health authorities and health oversight agencies may require a copy of your records. They are authorized under law to collect that information and we are required to furnish a copy of your PHI.
- We are required by law to protect and privacy of all of our patients, preventing any and all disclosure of PHI to unauthorized parties.
- We are required by law to maintain the privacy of, and to provide individuals with, this notice of our legal duties and privacy practices with regard to PHI.
- If you are on active duty military or are called to active duty military, under federal law we are required to supply a copy of your record.

PATIENT RIGHTS

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party. I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards. I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

LATE CANCELLATION/ "NO CALL, NO SHOW" POLICY

Restore Medical Partners is committed to providing high quality, efficient, and timely care to all of our patients. If an appointment is canceled or rescheduled within 24 hours of your scheduled time, a $50 fee may be applied. There will also be a $50 charge for all "No call, No Show" appointments. Please make note of the person's name that you spoke with when cancelling or rescheduling your appointment. We understand that there may be extenuating circumstances that cannot be controlled, so we will do our best to accommodate.

I hereby acknowledge receipt, understanding, and agreement with all information listed within this Comprehensive Patient Agreement. I also acknowledge that these policies have been put in place for the benefit of patients, including myself, and that I commit to abiding by these guidelines whilst I am a patient of Restore Medical Partners.

PATIENT SIGNATURE		DATE	

RESTORE
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CONSENT FOR COMMUNICATION AND/OR DISCLOSURE

I request the following alternatives or limitations relating to communications directed to me by my healthcare provider or employee of Restore Medical Partners. I understand that this HIPAA consent applies to ALL providers of Restore Medical Partners. It is my responsibility to notify Restore Medical Partners of any changes.

Please Print (Last Name) **(First Name)** **(Middle Initial)** **(Date of Birth)**

I give permission to share the following information with the person(s) listed below. Please mark yes (Y) or no (N) in the columns to the right.

Name:_____ **Relationship:**_____ **Appointment:**_____
Billing:_____
Medical: _____

Name:_____ **Relationship:**_____ **Appointment:**_____
Billing:_____
Medical: _____

Name:_____ **Relationship:**_____ **Appointment:**_____
Billing:_____
Medical: _____

Please note that if a person is not listed on this form, Restore Medical Partners will not share information with him/her. Signature below will also constitute your unrestricted agreement that medically relevant information may be left on a voicemail or other answering device that you provide to us.

PATIENT SIGNATURE		DATE	
WITNESS SIGNATURE		DATE	