PATIENT INFORMATION

DATE: _____ **Have you been a patient in our office before? Yes No**

PATIENT:

Miss Ms. Mrs. Mr. Dr. _____
First Middle Last
I prefer to be called: _____ Male Female Birthdate: ____/____/____ Age: ____

SS#: _____/_____/_____ Drivers Lic. #:_____ State: _____

Home Address: _____ City: _____ State: ____ Zip: _____
Home Phone #: ( )_____-_____ Cell#: ( )_____-_____ Work #:( )____ -_____X_____
Employer: _____ Address: _____ Occupation: _____

FINANCIAL RESPONSIBLE PARTY: (If other than patient and/or patient is under the age of 18)

Miss Ms. Mrs. Mr. Dr. _____
First MI Last
Relationship to patient : Parent Spouse Legal guardian Other _____
Home address: _____ City:_____St:____ Zip: _____
Home Phone: ( )_____-_____ Cell #: ( )_____-_____ Wk #: ( )_____-_____ X_____
Drivers Lic. #: _____ State: _____Birthdate ___/___/___SS#: _____-_____-_____
Employer: _____ Wk Address: _____

Other Responsible Party: Miss Ms. Mrs. Mr. Dr. _____
Home address: _____City: _____ St.: _____ Zip: _____

Home Phone#: ( )_____-_____ Cell #: ( )_____-_____ Wk #:
( )_____X_____
Drivers Lic. #: _____ State: _____ SS#: _____-____-_____
Employer: _____ Wk Address: _____

DENTIST/PHYSICIAN INFORMATION:

Whom may we thank for referring you to us? _____

Name of Dentist: _____D.D.S. Address:_____
City: _____ St: ____ Zip:_____ Phone: ( )_____-_____
Orthodontist: _____ D.D.S. Address: _____
City: _____ St: ____ Zip: _____ Phone: ( )_____-_____

Name of Physician: _____ M.D. Address: _____
City: _____ St: ____ Zip: _____ Phone: ( )_____-_____

INSURANCE INFORMATION

PLEASE NOTE: *AN INSURANCE POLICY IS A CONTRACT BETWEEN THE PATIENT AND THE INSURANCE COMPANY, NOT BETWEEN THE DOCTOR AND THE INSURANCE COMPANY. WE ARE PLEASED TO COMPLETE ALL PAPERS NECESSARY FOR YOUR CLAIM. HOWEVER, PLEASE BE AWARE THAT FINANCIAL RESPONSIBILITY REMAINS WITH THE PATIENT.*

DENTAL INSURANCE

Primary Insurance Co.:_____
Billing address: _____ City: _____ St.:____ Zip: _____
Telephone: ( )_____-_____Group #: _____ Group Name: _____
Subscriber Name: _____ SS#: _____-____-_____
Subscriber date of birth: ____/___/____ Relationship to patient: self spouse parent other
Employer name: _____ Address: _____

Secondary Insurance Co.:_____
Billing address: _____ City: _____ St.:____ Zip: _____
Telephone: ( )_____-_____Group #: _____ Group Name: _____
Subscriber Name: _____ SS#: _____-____-_____
Subscriber date of birth: ____/___/____ Relationship to patient: self spouse parent other
Employer name: _____ Address: _____

MEDICAL INSURANCE

Primary Insurance Co.:_____ HMO: Yes No
Billing address: _____ City: _____ St.:____ Zip: _____
Telephone: ( )_____-_____Group #: _____ Group Name: _____
Subscriber Name: _____ SS#: _____-____-_____
Subscriber date of birth: ____/___/____ Relationship to patient: self spouse parent other
Employer name: _____ Address: _____

Secondary Insurance Co.:_____ HMO: Yes No
Billing address: _____ City: _____ St.:____ Zip: _____
Telephone: ( )_____-_____Group #: _____ Group Name: _____
Subscriber Name: _____ SS#: _____-____-_____
Subscriber date of birth: ____/___/____ Relationship to patient: self spouse parent other
Employer name: _____ Address: _____

STUDENT STATUS

Is the patient a full time student? Yes No
School attending: _____ Address: _____
Have you updated this information with your insurance company this semester? Yes No

HEALTH HISTORY RECORD

1. Are you now in good health? …… Yes No

2. Are you now or have you been under the care of a physician during the past 2 years? ……... Yes No
   Date of last physical examination: _____

3. Have you ever been a patient in a hospital? ……. Yes No
   Reason: _____ Date: _____
   _____ _____
   _____ _____
   _____ _____

4. Are you now or have you taken any drugs or medicines, including herbal medications or homopathic remedies, in the past year including medications on a daily basis ie. aspirin, birth control, Fen-Phen, Redux, etc.? … Yes No
   If so, please list : _____
   _____

5. Are you sensitive or allergic to any drugs/medications, foods or materials (i.e. penicillin, latex)? Yes No
   If so, please list: _____
   _____

6. Have you ever had any serious illnesses or conditions such as :

a) heart trouble/arrhythmia's ……	Yes No	k) venereal disease …… .	Yes No
b) high or low blood pressure …….	Yes No	l) diabetes ……	Yes No
d) tuberculosis ……	Yes No	n) hepatitis ……...	Yes No
e) kidney, liver or lung disease……	Yes No	o) heart murmur ……..	Yes No
f) arthritis ……	Yes No	p) emphysema …….	Yes No
g) rheumatic fever/scarlet fever……...	Yes No	q) severe/frequent headaches...	Yes No
h) asthma ……..…	Yes No	r) sinus trouble ……...	Yes No
i) epilepsy ……	Yes No	s) HIV/aids ……	Yes No

   j) other (please indicate) _____

7. Are you subject to any nervous disorders, fainting or dizziness?……. Yes No
8. Are you subject to excessive bleeding? ……. Yes No
9. Have you ever had psychiatric treatment?…….. Yes No
10. Do you have any difficulty in opening you mouth wide? ……. Yes No
11. Have you ever had any injury to your face or jaws? ……. Yes No
12. Do you have or have you ever been treated for TMJ (Temporomandibular Joint Disorder) …. Yes No
13. Have you ever had any difficulty with the use of local anesthetic ("Novocain") ……. Yes No
14. Do you have any numbness or tingling sensation in any part of your body? …… Yes No
15. Have you ever received radiation or surgical treatment for tumor, growth or other conditions about your head, mouth, lips?…….. Yes No
16. Women: Are you pregnant? Yes No How many months? _____
17. Do you wear contact lenses? ……. Yes No
18. Have you had anything to eat or drink in the last 6 hours? …… Yes No
    List: _____ At what time? _____ AM PM
19. Since we last saw you, has anything changed in your health history?…… Yes No
    Changes: _____
    _____

I confirm as true the above health history information.

Signature: _____ Date: _____

******Parent or guardian signature if patient is under the age of 18

Updated signature: _____ Date: _____

Patient Advisory and Acknowledgment

Receiving Dental Treatment During the COVID-19 Pandemic

Dear Patient:

You have come to our office today for a routine dental evaluation and/or treatment that will be done during the COVID-19 pandemic. Please be advised of the following:

> While our office complies with State Health Department and the Centers for Disease Control and Prevention infection control guidelines to prevent the spread of the COVID-19 virus, we cannot make any guarantees.
>
> Our staff are symptom-free and, to the best of their knowledge, have not been exposed to the virus. However, since we are a place of public accommodation, other persons (including other patients) could be infected, with or without their knowledge.

In order to reduce the risk of spreading COVID-19, we have asked you a number of "screening" questions below. For the safety of our staff, other patients, and yourself, please be truthful and candid in your answers.

PATIENT/RESPONSIBLE PARTY _____ DATE _____

PLEASE ANSWER "YES" OR "NO" WITH YOUR INITIALS, TO THE FOLLOWING QUESTIONS:

ARE YOU CURRENTLY AWAITING THE RESULTS OF A COVID-19 TEST?	_____ YES	_____ NO
DO YOU HAVE A FEVER?	_____ YES	_____ NO
DO YOU HAVE ANY SHORTNESS OF BREATH?	_____ YES	_____ NO
DO YOU HAVE A DRY COUGH?	_____ YES	_____ NO
DO YOU HAVE A RUNNY NOSE?	_____ YES	_____ NO
DO YOU HAVE A SORE THROAT?	_____ YES	_____ NO
DO YOU HAVE SNEEZING, WATERY EYES, AND/OR SINUS PAIN/PRESSURE THAT IS UNUSUAL AND NOT RELATED TO SEASONAL ALLERGIES?	_____ YES	_____ NO
HAVE YOU EXPERIENCED HEADACHES, FATIGUE, OR WEAKNESS?	_____ YES	_____ NO
HAVE YOU LOST YOUR SENSE OF TASTE AND/OR SMELL?	_____ YES	_____ NO
WITHIN THE LAST 14 DAYS, HAVE YOU TRAVELLED TO ANY FOREIGN COUNTRY?	_____ YES	_____ NO
WITHIN THE LAST 14 DAYS, HAVE YOU TRAVELLED WITHIN THE UNITED STATES?	_____ YES	_____ NO

IF SO, WHERE? _____

California Dental Association
1201 K Street, Sacramento, CA 95814
800.232.7645 cda.org

OC Max Surgery Notice of Privacy Practices

This notice describes how your health information may be used and disclosed and how you can get access to this information. Please review it carefully. The privacy of your health information is important to us.

Our Legal Duty

Federal and state laws require us to maintain the privacy of your health information. We are also required to provide this notice about our office's privacy practices, our legal duties and your rights regarding your health information. We are required to follow the practices that are outlined in this notice while it is in effect. This notice takes effect 1/1/2021 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make changes in our privacy practices and the new terms of our notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request. For more information about our privacy practices or additional copies of this notice, please contact us (contact information below).

Uses and Disclosures of Health Information

We use and disclose health information about you for treatment, payment and health care operations. For example:

Treatment
We may use or disclose your health information to another dentist or other health care providers providing treatment that we do not provide. We may also share your health information with a pharmacist in order to provide you with a prescription or with a laboratory that performs tests or fabricates dental prostheses or orthodontic appliances.

Payment
We may use and disclose your health information to obtain payment for services we provide to you, unless you request that we restrict such disclosure to your health plan when you have paid out-of-pocket and in full for services rendered.

Health Care Operations
We may use and disclose your health information in connection with our health care operations, for example in sending appointment reminders. Other health care operations include but are not limited to quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities. The California Confidentiality of Medical Information Act does limit the types of health care operations in which we can use or disclose your health information without your authorization. For example, if the dental practice is sold or merged, the new owner will seek permission to use your information to continue to treat you. Your authorization also is required if a credit or collection agency seeks your health information.

We may use business associates to conduct the above transactions. We may also use and disclose your health information if required by law or for public health, benefit and safety purposes. For example:

Public Health and Safety
We may disclose your health information to a public health authority as part of lawful activities to prevent or control disease, injuries and disabilities and to the U.S. Food and Drug Administration to report safety issues with drugs and medical devices. We may disclose your health information to appropriate authorities if we reasonably believe that you are a victim of abuse, neglect or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

Government Oversight
We may disclose your health information to government regulatory agencies, such as the Dental Board of California or the U.S. Department of Health and Human Services, to carry out their legal responsibilities in investigations, inspections, audits, enforcement and licensing.

Law Enforcement, Coroners and Legal Proceedings
We may disclose your health information to a law enforcement agency, coroner or medical examiner for official purposes such as identifying an individual or reporting crimes. We may be compelled to disclose your health information in response to a subpoena, court order, discovery request or other legal process. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmates or patients under certain circumstances.

Workers' Compensation
We may disclose your health information to the extent permitted for workers' compensation.

National Security
We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence and other national security activities.

Your Authorization
You may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it is in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those permitted uses described in this notice.

We may request your authorization to use your name, image or testimonial in our social media platforms and marketing efforts.

We may request your authorization to release your insurance information to another healthcare provider.

Other Uses and Disclosures of Health Information

We may use and disclose your health information in the following circumstances:

To Family, Friends and Persons Involved in Your Care
We may use or disclose health information to notify or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition or your death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your health care. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, aligners, X-rays or other similar forms of health information.

You have the right to request restrictions on disclosure to family members, other relatives, close personal friends or any other person identified by you.

Marketing Health-Related Services
We may contact you about products or services related to your treatment, case management or care coordination or to propose other treatments or health-related benefits and services in which you may be interested. We may also encourage you to purchase a product or service when you visit our office. If you are currently an enrollee of a dental plan, we may receive payment for communications to you in relation to our provision, coordination or management of your dental care, including our coordination or management of your health care with a third party, our consultation with other health care providers relating to your care or if we refer you for health care. We will not otherwise use or disclose your health information for marketing purposes without your written authorization. We will disclose whether we receive payments for marketing activity you have authorized.

Change of Ownership
If this dental practice is sold or merged with another practice or organization, your health records will become the property of the new owner. Your information will be used to notify you of the change and the new owner

may seek to obtain your permission to use your information to continue to treat you. You may request that copies of your health information be transferred to another dental practice.

Research
Your health information may be disclosed to researchers for research purposes. In this situation, written authorization is not required if approved by an Institutional Review Board or privacy board.

Fundraising
We may use or disclose demographic information and dates of treatment in order to contact you for fundraising activities. If you no longer wish to receive these communications, notify us at the contact information provided below and we will stop sending further fundraising information.

Patient Rights

Access
You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by contacting our office. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter. If you request copies, there may be a charge for time spent. If you request an alternate format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. California law requires you be provided with access to your health information within 15 days. Contact us for a full explanation of our fee structure.

Disclosure Accounting
You have a right to receive a list of instances in which we disclosed your health information for purposes other than treatment, payment, health care operations and certain other activities for the last six years. If you request this accounting more than once in a 12-month period, we may charge you a reasonable cost-based fee for responding to these additional requests.

Restriction
You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in emergency). In the event you pay out-of-pocket and in full for services rendered, you may request that we not share your health information with your health plan. We must agree to this request.

Alternative Communication
You have the right to request that we communicate with you about your health information by alternative means or to send it to an alternative location. You must make your request in writing. Your request must specify the alternative means or location and provide satisfactory explanation of how payment for treatment will be handled under the alternative means or location you request.

Breach Notification
In the event your unsecured protected health information is breached, we will notify you as required by law. In some situations, you may be notified by our business associates.

Amendment
You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended). We may deny your request under certain circumstances.

Notice of Privacy Practices
You have the right to a paper copy of this notice at any time.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us at:

OC Max Surgery Center
13362 Newport Ave #G
Tustin, CA 92780
T: 714-838-4141
F: 714-508-9218
E: ocmaxsurgery@gmail.com

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may send a written complaint to our office or to the U.S. Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

OC Max Surgery complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.

California

English:
Our dental practice will provide language assistance services free-of-charge to individuals who do not speak English well enough to discuss the dental care we are providing.

Spanish:

Nuestro consultorio dental les proporcionará servicios de asistencia lingüística gratuitos a los individuos que no hablen inglés con suficiente fluidez para discutir la atención dental que proporcionamos.

Chinese:

我们的牙科业务将为英语不太流利的人士提供免费的语言协助服务，以方便讨论我们提供的牙齿护理服务。

Vietnamese:

Thực hành nha khoa của chúng tôi sẽ cung cấp các dịch vụ hỗ trợ ngôn ngữ miễn phí cho những người không có khả năng nói tiếng Anh đủ tốt để thảo luận việc chăm sóc răng miệng mà chúng tôi đang cung cấp.

Tagalog:

Ang aming dental na kasanayan ay magbibigay ng walang bayad na mga serbisyong tulong na wika sa mga indibidwal na hindi nakakapagsalita ng maayos na Ingles upang talakayin ang ibinibigay naming dental na pangangalaga.

Korean:

저희 치과는 저희가 제공하는 치과 치료에 대해 영어로 논의하기가 불편하신 분들을 위해 무료 언어 지원 서비스를 제공할 것입니다.

Armenian:

Մեր ատամնաբուժական պրակտիկան կտրամադրի անվճար լեզվական ծառայություններ բոլոր այն անձանց ովքեր անգլերենին բավարար չեն տիրապետում մեր կողմից տրամադրվող ատամնաբուժական խնամքի շուրջ հարցեր քննարկելու:

Persian (Farsi):

مرکز خدمات دندانپزشکی ما خدمات کمک زبانی را به صورت رایگان برای افرادی فراهم می‌آورد که انگلیسی را با تسلط صحبت نمی‌کنند تا در مورد مراقبت های دندانی که ارائه می‌کنیم گفتگو کنند.

Russian:

Наша стоматологическая клиника бесплатно предоставляет клиентам, которые не достаточно хорошо говорят на английском языке, услуги переводчика, чтобы помочь им обсудить предоставляемую нами стоматологическую помощь.

Japanese:

当社の歯科治療では提供している歯科ケアに関して話し合える程度の英語力のない方に無料で言語サポートサービスを提供していま。

Arabic:

سوف تقدم عيادة طب الأسنان مساعدة لغوية مجانية لأولئك الذين لا يجيدون الإنكليزية من أجل مناقشة خدمات العناية بالأسنان التي نقدمها.

Punjabi:

ਉਹ ਡੈਂਟਲ ਪ੍ਰੈਕਟਿਸ ਵਿਲ ਪ੍ਰੋਵੀਦੇ ਲੈਂਗੁਏਜ ਅੱਸੀਸਟੈਂਸ ਸਰਵਿਸਜ਼ ਫ੍ਰੀ-ਓਫ-ਚਾਰਜ ਤੋਂ ਇੰਡਿਵਿਦੁਲਸ ਹੂ ਦੋ ਨ ਸਪੋੱਕ ਇੰਗਲਿਸ਼ ਵੈੱਲ ਏਨੌਘ ਤੋਂ ਡਿਸਕਸ ਥੇ ਡੈਂਟਲ ਚਾਰੇ ਵੀ ਰੇ ਪ੍ਰੋਵੀਡੀਨਗ.

Mon-Khmer:

គ្លីនិកធ្មេញយើងខ្ញុំនឹងផ្តល់នូវសេវាជំនួយផ្នែកភាសាដោយឥតគិតថ្លៃជូនដល់អតិថិជនម្នាក់ៗដែលមិនចេះនិយាយភាសាអង់គ្លេសល្អ ដើម្បីពិគ្រោះពិភាក្សាអំពីបញ្ហាសេវាគំហែទាំធ្មេញដែលយើងខ្ញុំកំពុងផ្តល់ជូន។

Hmong:

Ang aming pagsasanay ukol sa ngipin o dental practice ay magbibigay ng libreng mga serbisyong tulong sa mga indibiduwal na hindi masyadong nakakapagsalita ng Ingles upang talakayin ang pangangalaga sa ngipin na aming ibinibigay.

Hindi:
हमारे दंत चिकित्छालय के प्रभारी, जो व्यक्ती अच्छी तरह ईंग्लीश बोल नही सकते है उनको, हम जो दंत चिकित्छा देखभाल प्रदान कर रहे है उसके बारेमें बात करनेके लिये बीना कोई फ़ीस भाषा सहायता सेवाएं प्रदान करेंगे |

Thai:

แนวปฏิบัติด้านทันตกรรมของเราจะให้บริการช่วยเหลือด้านภาษาฟรีแก่บุคคลที่พูดภาษาอังกฤษไม่ชำนาญเพียงพอที่จะหารือเกี่ยวกับบริการทันตกรรมของเรา

Acknowledgement of Receipt of Notice of Privacy Practices

You May Refuse to Sign This Acknowledgement

I,_____ [full name], have received a copy of the OC Max Surgery Notice of Privacy Practices.

Print Name _____

Signature _____

Date _____

If this acknowledgement is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's name _____

Relationship to Patient _____

For Program Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ▫ Individual refused to sign
- ▫ Communications barriers prohibited obtaining the acknowledgement
- ▫ An emergency situation prevented us from obtaining acknowledgement
- ▫ Other (Please Specify)

OUR FINANCIAL POLICY

Dr. Paul D. Braun

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we ask that you read and sign prior to any treatment.

WE ACCEPT CASH, CHECKS, VISA/MASTERCARD, AND DISCOVER.
WITH PRIOR CREDIT APPROVAL, WE CAN ARRANGE AN EXTENDED PAYMENT PLAN

Regarding Insurance:

1. As a courtesy to our patients, we will accept assignment of insurance benefits, however, we do require payment of any uncovered portion, such as deductibles and co-payment, to be paid at the time of service.
2. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance company has not paid your account in full within 60 days, any unpaid balance will be due in full.
3. The balance is your responsibility whether your insurance company pays or not.
4. We cannot bill your insurance unless you bring in all insurance information.
5. Usual and customary rates: Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
6. Account balance over 60 days will be charged a service charge of 18. %
7. We are not a Medicare assignment provider. Consequently you will be responsible for all services provided in this office.
8. If you are a member of a Managed Care Insurance HMO or PPO, it is your responsibility to know your policy provisions and to inform this office.

INIT._____

Financial Responsibility

1. Adult patients are responsible for payment at the time of service.
2. The adult parent or guardian accompanying a minor is responsible for payment.
3. For unaccompanied minors, non-emergency treatment will be denied unless prior financial arrangements have been made.
4. Financial arrangements are available to our patients, but must be made prior to treatment. Such financial agreements are a commitment of your part as well as on ours.
5. A service charge of 18. % per annum, will be charged on overdue balances.

INIT_____

Missed Appointments

Unless cancelled at least 24 hours in advance, our policy is to charge for missed consultation or surgical appointments at the rate of a normal office visit. Help us serve you better by keeping scheduled appointments.

INIT_____

If it becomes necessary to utilize an outside agency to collect a past due balance, a fee of $45.00 will be added to an account before it is assistance. INIT _____

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

I have read the financial policy and understand and agree to this financial policy.

X

Signature of patient/responsible party Date sr/2010