LAKEFRONT
SURGICAL ASSOCIATES

PATIENT INFORMATION FORM

CHART #: _____

LAKEFRONT SURGICAL ASSOCIATES

PATIENT INFORMATION

Patient's Name (Last, First): | MI: | Previous Name:

Address: | City: | State: | ZIP:

Pharmacy: | Pharmacy Phone:

Home Phone: | Cell: | Work Phone: | Ext.:

Primary Care Provider (PCP): | Referring Provider:

Date of Birth: MM /DD /YYYY | Gender:

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Widowed ❑ Legally Separated ❑ Partner

Social Security Number: – – | Employer Name:

Employment Status: ❑ Full-Time ❑ Part-Time ❑ Unemployed ❑ Self-Employed ❑ Retired

Note:

Emergency Contact (Last, First): | Phone Number: | Do you have a living will? ❑ Yes ❑ No

Relationship to Patient: | ❑ Guardian

Home Phone: | Cell: | Work Phone:

RESPONSIBLE PARTY INFORMATION

Responsible Party: ❑ Self ❑ Another Patient ❑ Guarantor **Check here if information is same as patient** ❑

Responsible Party Name (Last,First): | MI:

Guarantor Account Number | Date of Birth: MM /DD /YYYY

Social Security Number - - | Telephone:

Address: | City: | State: | ZIP:

Employer: | Employer Phone Number:

PRIMARY INSURANCE INFORMATION

Insurance Company: | Phone Number:

Name of Insured: | Patient Relationship to Insured:

Subscriber ID (Policy Number): | Group ID : | Copay Amount:

Effective Date: | Termination Date: | Date of Birth: MM /DD /YYYY

Insurance Verification Completed: ❑ Y ❑ N | Verified By:

SECONDARY INSURANCE INFORMATION

Insurance Company: | Phone Number:

Name of Insured: | Patient Relationship to Insured:

Subscriber ID (Policy Number): | Group ID : | Copay Amount:

Effective Date: | Termination Date: | Date of Birth: MM /DD /YYYY

Insurance Verification Completed: ❑ Y ❑ N | Verified By:

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

_____ _____

Patient (or Responsible Party) Signature **Date**

HEALTH HISTORY

LAKEFRONT SURGICAL ASSOCIATES

CHART #: _____

DATE: _____

Name: Birth Date / / Gender:

Ethnicity: Language: Reason for your visit today:

How long have you had this problem? Your Primary Care Physician?

REVIEW OF SYSTEMS

SKIN:
- ❑ Rashes
- ❑ Itching
- ❑ Change in hair or nails

HEAD:
- ❑ Headaches
- ❑ Head Injury

EYES:
- ❑ Glasses or contacts
- ❑ Change in vision
- ❑ Eye pain
- ❑ Double vision
- ❑ Flashing lights
- ❑ Glaucoma/Cataracts
- ❑ Last Eye Exam

EARS:
- ❑ Change in hearing
- ❑ Ear pain
- ❑ Ear discharge
- ❑ Ringing
- ❑ Dizziness

NOSE/SINUSES:
- ❑ Nose Bleeds
- ❑ Nasal stuffiness
- ❑ Frequent colds

ALLERGIES:
- ❑ Hives
- ❑ Swelling of lips or tongue
- ❑ Hey fever
- ❑ Asthma
- ❑ Eczema/Sensitive skin
- ❑ Sensitivity to drugs, food, pollens, or dander

MOUTH/THROAT:
- ❑ Bleeding gums
- ❑ Sore tongue
- ❑ Sore throat
- ❑ Hoarseness

NECK:
- ❑ Lumps
- ❑ Swollen glands
- ❑ Goiter
- ❑ Stiffness

BREAST:
- ❑ Lumps
- ❑ Pain
- ❑ Nipple discharge
- ❑ BSE

RESPIRATORY/CARDIAC:
- ❑ Shortness of breath
- ❑ Cough
- ❑ Production of phlegm, color
- ❑ Wheezing
- ❑ Coughing up blood
- ❑ Chest pain
- ❑ Fever
- ❑ Night sweats
- ❑ Swelling in hands/feet
- ❑ Blue fingers/toes
- ❑ High blood pressure
- ❑ Skipping heart beats
- ❑ Heart murmur
- ❑ HX of heart medication
- ❑ Bronchitis/Emphysema
- ❑ Rheumatic heart disease

GASTROINTESTINAL:
- ❑ Change of appetite or weight
- ❑ Problems swallowing
- ❑ Nausea
- ❑ Heartburn
- ❑ Vomiting
- ❑ Vomiting blood
- ❑ Constipation
- ❑ Diarrhea
- ❑ Change in bowel habits
- ❑ Abdominal pain
- ❑ Excessive belching
- ❑ Excessive flatus
- ❑ Yellow color of skin (Jaundice/Hepatitis)
- ❑ Food intolerance
- ❑ Rectal bleeding/Hemorrhoids

URINARY:
- ❑ Difficulty in urination
- ❑ Pain or burning on urination
- ❑ Frequent urination at night
- ❑ Urgent need to urinate
- ❑ Incontinence of urine
- ❑ Dribbling
- ❑ Decreased urine stream
- ❑ Blood in urine
- ❑ UTI/Stones/Prostate infection

PERIPHERAL VASCULAR:
- ❑ Leg cramps
- ❑ Varicose veins
- ❑ Clots in veins

MUSCULOSKELETAL:
- ❑ Pain
- ❑ Swelling
- ❑ Stiffness
- ❑ Decreased joint motion
- ❑ Broken bone
- ❑ Serious sprains
- ❑ Gout

NEUROLOGIC:
- ❑ Headaches
- ❑ Seizures
- ❑ Loss of consciousness/Fainting
- ❑ Paralysis
- ❑ Weakness
- ❑ Loss of muscle size
- ❑ Muscle spasm
- ❑ Tremor
- ❑ Involuntary movement
- ❑ Incoordination
- ❑ Numbness
- ❑ Feeling of “pins and needles/tingles”

HEMATOLOGIC:
- ❑ Anemia
- ❑ Easy bruising/bleeding
- ❑ Past Transfusions

ENDOCRINE:
- ❑ Abnormal growth
- ❑ Increased appetite
- ❑ Increased thirst
- ❑ Increased urine production
- ❑ Thyroid trouble
- ❑ Heat/cold intolerance
- ❑ Excessive sweating
- ❑ Diabetes

PSYCHIATRIC:
- ❑ Tension/Anxiety
- ❑ Depression/suicide ideation
- ❑ Memory problems
- ❑ Unusual problems
- ❑ Sleep problems
- ❑ Past treatment with psychiatrist
- ❑ Change in mood/change in attitude towards family/ friends

Patient Signature **Date**

NEW PATIENT PAST MEDICAL HISTORY

CONSTITUTIONAL:
- ❑ Weight loss
- ❑ Loss of appetite
- ❑ Fevers
- ❑ Chills
- ❑ Sense of ill feeling
- ❑ Fatigue/tired

EYES:
- ❑ Blurred vision
- ❑ Double vision
- ❑ Changes in vision

EARS/NOSE/THROAT:
- ❑ Hearing loss
- ❑ Ringing in ears
- ❑ Nosebleeds
- ❑ Difficulty swallowing
- ❑ Pain with swallowing

CARDIOVASCULAR:
- ❑ Chest pain
- ❑ Chest tightness
- ❑ Abnormal beats
- ❑ Lightheadedness
- ❑ Fluid retention

RESPIRATORY:
- ❑ Shortness of breath
- ❑ Shortness of breath with exertion
- ❑ Shortness of breath lying down
- ❑ Shortness of breath at night

GASTROINTESTINAL:
- ❑ Abdominal pain
- ❑ Nausea
- ❑ Vomiting
- ❑ Vomiting blood
- ❑ Black/tarry stools
- ❑ Bright red blood from rectum
- ❑ Constipation
- ❑ Diarrhea

ENDOCRINE:
- ❑ Heat or cold intolerance
- ❑ Unexplained weight gain/loss
- ❑ Hair loss

MEDICATION ALLERGIES:

❑ Yes ❑ No

Please list below and reaction:

_____

_____

_____

_____

_____

GENITOURINARY:
- ❑ Urinary frequency
- ❑ Burning with urination
- ❑ Blood in urine
- ❑ Leaking of urine
- ❑ Urgency

MUSCULOSKELETAL:
- ❑ Joint pain
- ❑ Swelling in arms/legs
- ❑ Weakness

SKIN:
- ❑ Suspicious or changing moles
- ❑ Dryness/itching

NEUROLOGIC:
- ❑ Headaches
- ❑ Numbness
- ❑ Tingling
- ❑ Difficulty with walking

PSYCHIATRIC:
- ❑ Depression
- ❑ Anxiety

HEMATOLOGIC/LYMPHATIC:
- ❑ Lymphadenopathy
- ❑ Excessive bruising/bleeding
- ❑ Anemia

ALLERGIC/IMMUNOLOGIC:
- ❑ Environmental allergies
- ❑ Frequent infections

BREAST (If applicable)
- ❑ Skin changes
- ❑ Dimpling
- ❑ Masses
- ❑ Pain
- ❑ Nipple discharge
- ❑ Last mammogram: _____

CURRENT MEDICATIONS (Dose, frequency):

_____

_____

_____

_____

_____

NOTICE OF PRIVACY PRACTICES OF LAKEFRONT SURGICAL ASSOCIATES

an Envision Physician Services entity

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.

Your health information is personal, and we are committed to protecting it. Your health information is also very important to our ability to provide you with quality care, and to comply with certain laws. This Notice applies to all records about care provided to you by Lakefront Surgical Associates, an Envision Physician Services entity's subsidiaries. (Your physician may have different policies and a different notice regarding your health information that is created in the physician's office.) Your information may be stored electronically and if so is subject to electronic disclosure.

I. We Are Legally Required to Safeguard Your Protected Health Information.

We are required by law to:

A. maintain the privacy of your health information, also known as "protected health information" or "PHI;"
B. notify you following a breach of unsecured PHI, under certain circumstances;
C. provide you with this Notice, and
D. comply with this Notice.

II. Future Changes to Our Practices and This Notice.

We reserve the right to change our privacy practices and to make any such change applicable to the PHI we obtained about you previously. If a change in our practices is material, we will revise this Notice to reflect the change. You may obtain a copy of any revised Notice by contacting the Ethics & Compliance Department at 877-835-5267. We will also make any revised Notice available on our website at www.evhc.net.

III. How We May Use and Disclose Your Protected Health Information.

The law requires us to have your authorization for some uses and disclosures. In other circumstances, the law allows us to use or disclose PHI without your authorization. This section gives examples of each of these circumstances

Uses and Disclosures That Require Us to Give You the Opportunity to Object. Unless you object, we may provide relevant portions of your PHI *to a family member, friend or other person you indicate* is involved in your health care or in helping you get payment for your health care. We may use or disclosure your PHI to notify your family or personal representative of your location or condition. In an emergency or when you are not capable of agreeing or objecting to these disclosures, we will disclose PHI as we determine is in your best interest, but will tell you about it later, after the emergency, and give you the opportunity to object to future disclosures to family and friends. Unless you object, we may also disclose your PHI to persons performing disaster relief activities.

A. Certain Uses and Disclosures Do Not Require Your Authorization The law allows us to disclose PHI without your authorization in the following circumstances:

1. When Required by Law.
2. For Public Health Activities.
3. For Reports About Victims of Abuse, Neglect or Domestic Violence.
4. To Health Oversight Agencies.
5. For Lawsuits and Disputes.
6. To Law Enforcement. We may release PHI if asked to do so by a law enforcement official, in the following circumstances: (a) in response to a court order, subpoena, warrant, summons or similar process; (b) to identify or locate a suspect, fugitive, material witness or missing person; (c) about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement; (d) about a death we believe may be due to criminal conduct; (e) about criminal conduct at our facility; and (f) in emergency circumstances, to report a crime, its location or victims, or the identity, description or location of the person who committed the crime.
7. To Coroners, Medical Examiners and Funeral Directors.
8. To Organ Procurement Organizations.
9. For Medical Research. We may disclose your PHI without your authorization to medical researchers who request it for approved medical research projects
10. To Avert a Serious Threat to Health or Safety.
11. For Specialized Government Functions.
12. To Workers' Compensation or Similar Programs.

IV. Other Uses and Disclosures of Your Protected Health Information.

Other uses and disclosures of your PHI that are not covered by this Notice or the laws that apply to us will be made only with your written authorization. The law also requires your written authorization before we may use or disclose: (i) psychotherapy notes, other than for the purpose of carrying out our treatment, payment or health care operations purposes, (ii) any PHI for our marketing purposes or (iii) any PHI as part of a sale of PHI. If you give us written authorization for a use or disclosure of your PHI, you may revoke that authorization, in writing, at any time. If you revoke your authorization we will no longer use or disclosure your PHI for the purposes specified in the written authorization, except that we are unable to retract any disclosures we have already made with your permission. In addition, we can use or disclose your PHI after you have revoked your authorization for actions we have already taken in reliance on your authorization. We are also required to retain certain records of the uses and disclosures made when the authorization was in effect.

V. Your Rights Related to Your Protected Health Information.

Other uses and disclosures of your PHI that are not covered by this Notice or the laws that apply to us will be made only with your written authorization. The law also requires your written authorization before we may use or disclose: (i) psychotherapy notes, other than for the purpose of carrying out our treatment, payment or health care operations purposes, (ii) any PHI for our marketing purposes or (iii) any PHI as part of a sale of PHI. If you give us written authorization for a use or disclosure of your PHI, you may revoke that authorization, in writing, at any time. If you revoke your authorization we will no longer use or disclosure your PHI for the purposes specified in the written authorization, except that we are unable to retract any disclosures we have already made with your permission. In addition, we can use or disclose your PHI after you have revoked your authorization for actions we have already taken in reliance on your authorization. We are also required to retain certain records of the uses and disclosures made when the authorization was in effect.

You have the following rights:

A. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask us to limit how we use and disclose your PHI. Any such request must be submitted in writing to our Privacy Officer. We are not required to agree to your request. If we do agree, we will put it in writing and will abide by the agreement except when you require emergency treatment. Notwithstanding the foregoing, we must agree to a restriction on the use or disclosure of your PHI if: (i) the disclosure is for our payment or health care operations purposes and is not otherwise required by law and (ii) you or another person acting on your behalf has paid for our services in full.

B. The Right to Choose How We Communicate With You. You have the right to ask that we send information to you at a specific address (for example, at work rather than at home) or in a specific manner (for example, by e-mail rather than by regular mail, or never by telephone). We must agree to your request as long as it would not be disruptive to our operations to do so. You must make any such request in writing, addressed to our Privacy Officer.

C. The Right to See and Copy Your PHI. Except for limited circumstances, you may look at and copy your PHI if you ask in writing to do so. Any such request must be addressed to our Patient Billing Service Center, which will respond to your request within 10 days (or 30 days if the extra time is needed). In certain situations we may deny your request, but if we do, we will tell you in writing of the reasons for the denial and explain your rights with regard to having the denial reviewed. If we keep your information in an electronic format, you may request that we provide it to you in that format and we will do so if it would be feasible.

D. The Right to Correct or Update Your PHI. If you believe that the PHI we have about you is incomplete or incorrect, you may ask us to amend it. Any such request must be made in writing and must be addressed to our Patient Billing Service Center, and must tell us why you think the amendment is appropriate. We will not process your request if it is not in writing or does not tell us why you think the amendment is appropriate. We will act on your request within 30 days or less if state law requires (or 60 days if the extra time is needed), and will inform you in writing as to whether the amendment will be made or denied. If we agree to make the amendment, we will ask you who else you would like us to notify of the amendment.

   We may deny your request if you ask us to amend information that:

   1. was not created by us, unless the person who created the information is no longer available to make the amendment;
   2. is not part of the PHI we keep about you;
   3. is not part of the PHI that you would be allowed to see or copy; or
   4. is determined by us to be accurate and complete.
   5. If we deny the requested amendment, we will tell you in writing how to submit a statement of disagreement or complaint, or to request inclusion of your original amendment request in your PHI.

E. The Right to Get a List of the Disclosures We Have Made. You have the right to get a list of instances in which we have disclosed your PHI going back six years from the date of your request. The list will not include disclosures we have made for our treatment, payment and health care operations purposes, those made directly to you or your family or friends or through our facility directory, or for disaster relief purposes. Neither will the list include disclosures we have made for national security purposes or to law enforcement personnel.

   Your request for a list of disclosures must be made in writing and be addressed to the Billing Center address that is listed on your invoice. We will respond to your request within 30 days, or less if state law requires (or 60 days if the extra time is needed). The list we provide will include disclosures made within the last six years unless you specify a shorter period. The first list you request within a 12-month period will be free. You will be charged our costs for providing any additional lists within the 12-month period.

F. F. The Right to Get a Paper Copy of This Notice. Even if you have agreed to receive the Notice by e-mail, you have the right to request a paper copy as well. You may obtain a paper copy

VI. Complaints.

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the federal Department of Health and Human Services. To file a compliant with the DHHS put your complaint in writing and address it to the U S Department of Health & Human Services, 200 Independence Ave. S.W., Washington DC, 20201. Or call them at 877-696-6775. To file a complaint with us, put your complaint in writing and address it to our Envision Healthcare Corporation HIPAA Privacy Officer at Envision Healthcare Corporation 1A Burton Hills Blvd, Nashville, TN 37215. You may also contact our Privacy Officer at 877-835-5267 to file a complaint, or if you have questions or comments about our privacy practices. We will not retaliate against you for filing a complaint.

Effective Date: April 14, 2003
Revision Date: September 4, 2019

CONSENT FOR TREATMENT AND PAYMENT AGREEMENT

LAKEFRONT SURGICAL ASSOCIATES

I hereby authorize **Lakefront Surgical Associates, an Envision Physician Services entity** to use and/or disclose my health information which specifically identifies me or which can reasonable be used to identify me to carry out my treatment, payment and healthcare operations.

Treatment includes but is not limited to: the administration and performance of all treatments, the administration of any needed anesthetics, the use of prescribed medication, the performance of such procedures as may be deemed necessary or advisable in the treatment of this patient such as diagnostic procedures, the taking and utilization of cultures and of other medically accepted laboratory tests, all of which in the judgment of the attending physician or their assigned designees may be considered medically necessary or advisable.

Payment includes but is not limited to: the authorization of payment directly to **Lakefront Surgical Associates, an Envision Physician Services entity** of benefits otherwise payable to me. I hereby acknowledge the release of my medical records to third party insurers or authorized persons to whom disclosure is necessary to establish or collect a fee for the services provided, such as billing and collection services, insurance payers, auto accident insurers, or for work related injury to my employer or designee understand that I am financially responsible for charges not covered. I acknowledge that patient records may be stored electronically and made available through computer networks.

Healthcare Operations include but are not limited to: release of my medical information to any of my physicians and their offices or insurance companies participating in my care or treatment and the quality of that care.

I understand that this is given in advance of any specific diagnosis or treatment and that these services are voluntary and that I have the right to refuse these services. I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. This consent will remain in full force unless revoked in writing and will not affect any actions that were taken prior to receiving my revocation. A photocopy of this consent shall be considered as valid as the original.

Patient and/or guarantor are responsible for charges incurred. It is a courtesy for our office to file with your insurance; however, you are responsible for your co-pay and or percentage which the insurance is not responsible for on the day of your visit. It is the patient's responsibility to obtain any necessary referral forms from your primary care physician when required. If the referral is not obtained before the visit, the patient is liable for payment in full on the date of service. Our office will contact your insurance company to precertify any procedure/surgery that may be ordered or performed by our surgeons. Precertification is NOT a guarantee of payment. If we are unable to obtain payment within a reasonable amount of time from the patient/guarantor we will place your account with a collection agency which will leave you liable for any additional charges incurred.

I agree to forward to Lakefront Surgical Associates, an Envision Physician Services entity, all insurance or third-party payments that I receive for services rendered to me immediately upon receipt.

MEDICARE LIFETIME AUTHORIZATION

I certify that the information given to me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical information about me to release to the Social Security Administration of its intermediaries or carriers any information needed for this or a related Medicare claim. I request that the payments of authorized benefits be paid on my behalf. I assign the benefits payable for services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment.

I assign the benefits payable for services to Lakefront Surgical Associates, an Envision Physician Services entity for any and all insurance.

I acknowledge that I have been given Lakefront Surgical Associates, an Envision Physician Services entity Notice of Privacy Practices. I understand that if I have questions or complaints that I should contact the Facility Privacy Official.

RELEASE OF MEDICAL INFORMATION

I give permission for my protected health information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below. I understand that I may request individuals to leave the exam room at any time.

Name of Person who is authorized to receive information:	Please circle: Release info	Allowed in exam room
_____	Y / N	Y / N
_____	Y / N	Y / N

***If the requestor of information is not a healthcare provider, the released information may no longer be protected from re- disclosure**

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____

Patient Signature

_____ _____

Patient Date of Birth **Date**

CONTROLLED SUBSTANCE POLICY

LAKEFRONT
SURGICAL ASSOCIATES

Controlled substances include opioid pain relievers, Codeine, Vicodin, Lortab, Norco and others, as well as anxiety medications such as Klonopin and Xanax. Controlled substances are controlled for good reason. Abuse of these mediations is widespread. Taking narcotics for more than a few weeks may lead to addiction, which can be a severe problem. Prescriptions of these medications are strictly supervised by the Drug Enforcement Agency (DEA), and our licenses are at risk if we prescribe them without compelling reasons. For this reason, we have enforced the following policy:

1. We make every effort to appropriately treat your immediate post-injury or post-surgical pain with the appropriate pain medication.
2. We prescribe narcotics for short-term use only and only if non-narcotic medications unsuccessfully treat your pain.
3. We do not refill or replace any lost, forgotten, stolen or any other prescriptions that have become unavailable in any other way.
4. We have a strict policy not to prescribe controlled substances on night and weekends. Should you have severe pain at night or during the weekend, you should go to the nearest emergency room to seek treatment.
5. Should you need long-term narcotic pain medication, you will be referred to your primary care physician or a pain management clinic.
6. We generally do not prescribe medications for anxiety. We do not refill such prescriptions written by other physicians. This is the responsibility of your primary care physician, psychiatrist, etc.

I, _____, understand that by signing below, I have read and agree with the rules and regulations of **Lakefront Surgical Associates, an Envision Physician Services entity** and agree to abide by such rules and regulations.

_____ _____

Patient Signature **Date**

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

LAKEFRONT SURGICAL ASSOCIATES

Patient's Full Name: Date of Birth: MM /DD /YYYY

Address: City: State: ZIP:

Phone:

At the request of the Individual, I _____ do hereby authorize Lakefront Surgical Associates,
Patient Name
an Envision Physician Services entity to release:

Dates of _____

❑ ALL ❑ Discharge Summary ❑ History & Physical ❑ Progress Notes ❑ Operative Notes

❑ Pathology Reports ❑ Lab Reports ❑ Radiology Reports ❑ Emergency Reports ❑ Other

❑ I DO ❑ I DO NOT authorize the release of information related to AIDS or HIV infection, psychiatric care, and/or psychological assessment, and treatment for alcohol and/or drug use.

Information Release to:

Name of Company/Agency/Facility/Person

Address: City: State: ZIP:

Purpose of Disclosure:

❑ Referral to Specialist ❑ Insurance ❑ Workers' Comp ❑ Physician Change ❑ Legal Investigation

❑ Disability Determination ❑ Personal ❑ Continuing Care

I hereby authorize disclosure of health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification, but that it will not affect any information released prior to the notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and it would then no longer be protected by federal regulations. I understand that **Lakefront Surgical Associates, an Envision Physician Services entity** will not condition its treatment of me on whether or not I sign this Authorization.

Patient Signature **Date**