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By signing below, you confirm information, notification of pr		_				der	stoo	d tl	ne abov
Signature of patient or Representative:									
I decline to sign			· · · · · · · · · · · · · · · · · · ·						
Printed Name:									
Date:									
Relationship to patient: Self Pare	ent 📗	Legal	guard	ian 🔲	Power of	atto	rnev		other _
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Due to HIPPA regulations - if you are over 18 years of age, please list any authorized person(s) with whom we can discuss your appointments, insurance and or/ payments with (i.e. spouse, parent, etc.)