Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Appointment Date & Time:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ in our \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ location.

Welcome to Joseph Eye & Laser Center. We are excited to announce Dr. Christopher Joseph has opened a new location in Hermitage as of January 2022. Our goal is to make your experience here as pleasant as possible. Everything we do here is geared towards providing you, our patient, with the highest quality medical and surgical care possible.

You should plan to be here 1.5 to 2.5 hours depending on the extent of your examination and any additional tests, studies, or procedures that might be required.

**PHYSICIAN:**

Our physician is trained in the diagnosis and treatment of all eye diseases. He has 12+ years of specialized medical and surgical experience. Dr. Joseph specializes in advanced cataract and glaucoma surgery, with interest in oculoplastic surgery.

**OFFICE WEBSITE:**

Please visit our website at: www.josepheyeandlaser.com

**PLEASE BRING WITH YOU TO THE APPOINTMENT:**

Medications- Please either bring a current list of medications you are taking or the medication bottles as received from the pharmacy.

Eye Glasses- Please bring your best or most recent eyeglasses, even if they no longer improve your vision. The glasses will provide important information about the past conditions of your eyes.

Contact Lenses- Remove soft contact lenses two weeks prior to your exam if you are planning a cataract or Lasik evaluation. Gas permeable lenses must be removed a minimum of 2 weeks or 1 week per decade of wear. (Ex: 30 years wear = 3 weeks removal)

Insurance Cards- Please bring all current insurance cards with you to the appointment. We will bill your medical insurance primary and secondary for the medical eye exam along with any additional tests, studies, or procedures performed. Any unpaid visits due to invalid insurance cards will become the patient’s (parent/guardian) responsibility.

Photo ID- We are required to obtain a copy of your photo ID. This is to protect you from someone else using your medical insurance (a type of identity theft)

**INSURANCE AND PAYMENT:** (please refer to your insurance handbook for rules)

Self-Pay- If you are not covered by medical insurance, you will be expected to pay in full at the time of service.

Medicare- We accept assignment on Medicare. If you are a Medicare beneficiary and do not have secondary coverage, you will be responsible for payment of 20% of the Medicare allowed amount.

Deductible- Be prepared to pay your medical insurance deductible if it has not been met for the year.

Copays- You are required to pay your insurance copay at the time of service. The copay amount is usually noted on your insurance cad or can be found in your insurance handbook. Your copay will be collected upon check-in.

HMO/Managed Care/OHP- If you are insured through a HMO, Managed Care, or PHP, you may need a referral authorization from your primary care physician before your appointment. It is your responsibility to check with your insurance carrier prior to your visit regarding this and request from your primary physician, if required. We will be forced to reschedule your appointment if referral is not received prior to your visit. Any unpaid visits due to invalid or non-referral will become the patient’s (parent/guardian) responsibility.

Non-Covered Services- Some services might not be covered by your insurance. Most medical insurance plans, including Medicare, do not pay for “routine eye exams.” Routine eye exams are exams which **do not** result in a medical diagnosis. For example, diagnoses such as myopia (near-sightedness), hyperopia (far-sightedness), astigmatism, presbyopia (aging eyes) would not be considered medical. Routine eye exams also include “screening for eye disease” which does not result in a medical diagnosis. In the event of service not covered by your medical insurance, you will be responsible for the charges.

Payment Options- We accept Cash, Credit, Debit, Visa, Mastercard, Discover, and CareCredit.

**REFRACTION:**

Refraction is a measurement of near-sightedness, far-sightedness, and astigmatism. Refraction is part of a complete eye exam and will be done at the initial visit. Medicare and most medical insurances do not cover refraction but it is frequently necessary to establish what a patients best corrected vision is. The refraction fee is **$30** and due at the time of service whether or not it results in a prescription for eyeglasses.

**DILATION:**

Your pupils will probably be dilated during the initial visit. Dilation lasts several hours and may blur your vision. If you have not previously driven with dilated pupils, you should bring a driver.

**GENERAL INFORMATION:**

Our office hours are Monday – Thursday 8:00 am to 5:00 pm and Friday 8:00 am to 3:00 pm (except holidays) We encourage you to call use anytime you have a question or problem with your eyes. Non-emergency calls are best handled during business hours. Emergency and after-hour calls are handled by our answering service or forwarded to the physician on call.

Brookfield Office Phone Number: (330) 619-3155 Fax: (330) 619-3175

Hermitage Office Phone Number: (724) 979-6767 Fax: (724) 979-6770

**PLEASE USE ENTRANCE AT FRONT OF BUILDING. PARKING IS ALONG THE FRONT ENTRANCES; HOWEVER, THERE IS ADDITIONAL PARKING IN REAR AND SIDES OF BUILDINGS.**

**WE HAVE PROVIDED REGISTRATION FORMS FOR YOUR COMPLETION PRIOR TO ARRIVAL. PLEASE BRING COMPLETED PAPERWORK WITH YOU TO YOUR APPOINTMENT.**

**PATIENT INFORMATION:**

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: Male/Female Age:\_\_\_\_\_\_\_ Marital Status: Single Married Divorced Widowed

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ OK to leave a voicemail? Y/N Text? Y/N

Email Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spouse Name (Parent Name if Minor):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Spouse/Parent Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer/Parent’s Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Person to notify in case of Emergency (other than spouse):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Best Contact Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: ­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Referred By?**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Family Doctor:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INSURANCE INFORMATION:**

|  |
| --- |
| **Primary Insurance Company:** |
| ID #: | Group #: | Effective Date: |
| Subscriber Name (Person who carries insurance): | Relationship to Patient: |
| Social Security #: | Date of Birth: | Employer: |
| **Secondary Insurance Company:****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Patient’s Signature****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Today’s Date** |
| ID #: | Group #: | Effective Date: |
| Subscriber Name (Person who carries insurance): | Relationship to Patient: |
| Social Security #: | Date of Birth: | Employer: |

I certify that I (or my dependent) have insurance coverage as stated above and agree to have insurance payments made directly to Joseph Eye and Laser Center or Dr. Christopher J. Joseph to be applied to my account for services rendered. I understand that I am financially responsible for all charges incurred in the event that my insurance denies payment. I am aware there may be additional collection and/or attorney’s fees if my account is referred for collection. For patients covered by Medicare the patient will be responsible for 20% of the Medicare allowable charges plus any deductibles, coinsurance, and uncovered charges that apply.

­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature Today’s Date

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I certify that I (or my dependent) have insurance coverage as stated above and agree to have insurance payments made directly to Joseph Eye and Laser Center or Dr. Christopher J. Joseph to be applied to my account for services rendered. I understand that I am financially responsible for all charges incurred in the event that my insurance denies payment. I am aware there may be additional collection and/or attorney’s fees if my account is referred for collection. For patients covered by Medicare, the patient will be responsible for 20% of the Medicare allowable charges plus any deductibles, coinsurance, and uncovered charges that apply.

Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Last Eye Exam:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any medications you currently take (RX and over-the-counter) including dose:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Do you have any allergies to any medications? YES NO If **YES**, please list the medications:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_List **ALL** major illnesses (glaucoma, diabetes, high blood pressure, heart attacks, etc.) or injuries (concussion, etc.):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List **ANY** surgeries you have had (cataract, appendectomy, etc.):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you ***currently*** have any problems in the following areas? If **YES**, please provide additional information.



Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician’s Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FAMILY HISTORY:** (Mother, Father, Grandparents, Siblings)

Has any member in your family had any of the following diseases? YES / NO / UNKNOWN

Circle all that apply: Blindness, Cataract, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis, or Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SOCIAL HISTORY:** Have you ever had a blood transfusion? YES / NO

Do you drink alcohol? YES / NO If yes, how much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you smoke? YES / NO If yes, how much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ How many years? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your vision limit any activities of daily living? Driving, reading, sports, work, etc. YES / NO

**HIPPA Compliance Patient Consent Form**

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patients’ rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPPA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

* Protected health information may be disclosed or used for treatment, payment, or healthcare operations
* The practice reserves the right to change the privacy policy as allowed by law
* The practice has the right to restrict the use of information but the practice does not have to agree to those restrictions
* The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease
* The practice may condition receipt of treatment upon execution of this consent.

**May we phone, email, or send a text to you to confirm appointments? YES NO**

**May we leave a message on your answering machine at home or on your cell phone? YES NO**

**May we discuss your medical condition with any member of your family? YES NO**

If YES, please name the members allowed:­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This consent was signed by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (PRINT NAME PLEASE)

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**AUTHORIZATION TO RECEIVE/RELEASE HEALTH INFORMATION**

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City/State/Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I Hereby Authorize the Disclosure of my Health Information From:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Person/Organization Releasing Information

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address City/State/Zip

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number / Fax Number

**To Release my Information To:**

Dr. Christopher Joseph of Joseph Eye and Laser Center

7254 Warren-Sharon Road 2151 Shenango Valley Freeway Suite C-5

Brookfield, OH 44403 Hermitage, PA 16148

P: 330-619-3155 P: 724-979-6767

F: 330-619-3175 F: 724-979-6770

**INFORMATION TO BE RELEASED:**

\_\_\_\_\_Complete Medical Record

\_\_\_\_\_Medical Records for Specific Dates of Service (please list) from\_\_\_\_\_\_\_\_\_\_to\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_Other (please list)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**This authorization remains in effect until the information has been forwarded as requested.**

**RIGHTS OF THE PATIENT:**

I understand that I have the right to revoke this authorization at any time by sending a written notification to the address below. I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. *Any information received by this office for our own use will continue to be protected by the Federal Privacy Rule (HIPPA).* I understand that I have he right to inspect or copy the protected health information to be used or disclosed as described in this document by written notification. I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ X

Printed Name of Patient or Personal Representative Signature of Patient or Personal Representative Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Description of Personal Representative’s Authority (attach necessary documentation)

\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

**Date sent:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **By:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Via:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*\*\*PLEASE SEND COMPLETE RECORDS\*\*\***