BARNHILL SPORTS MEDICINE

7000 W. 9th Ave. • Amarillo, TX 79106 • (806) 350-3500
www.barnhillsportsmed.com

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE

I _____ acknowledgement that I have received a copy of Barnhill Sports Medicine Institute's Notice of Privacy Practices. This Notice describes how Barnhill Sports Medicine Institute may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and my healthcare information, and my rights regarding my protected health information.

_____ _____

Patient/Parent-Guardian Signature Date
Signature

If Parent-Guardian's Signature appears above, please describe Parent-Guardian's relationship to the patient: _____

STUDENT-ATHLETE AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize any medical provider of the Student-athlete listed below, associated with his/her school/ organization/team, including Barnhill Sports Medicine Institute, Dr. Bill Barnhill, Dr. Clay Stewart, and other Barnhill Sports Medicine Institute Medical Providers, to release the Student-athlete's protected health information and related information regarding the Student-athlete's medical status, medical condition, injuries, illness, prognosis, diagnosis, injury rehabilitation, athletic participation status, related personally unidentifiable health information, and to provide emergency medical treatment. This protected health information may be released to the Student-athlete's parents/legal guardians, other health care providers, hospital and/or medical clinics and laboratories, physical therapists, athletic trainers, athletic coaches, athletic directors, and other medical personnel of the Student-athlete's school/organization/team.

I understand that my refusal to sign this authorization/consent for the disclosure of the Student-athlete's protected health information authorization may affect the Student-athlete's ability to participate in athletics at his/her school/ organization/team.

I understand that my protected health information is protected by the federal regulations under the Health Information Portability and Accountability Act (HIPAA) and may not be disclosed without my authorization. I understand that once information is disclosed per authorization or consent, the information is subject to re-disclosure and may no longer to re-disclosure and may no longer be protected by HIPAA. I understand that I may revoke this authorization/consent at any time by notification in writing.

This authorization/consent for the disclosure of the Student-athlete's protected health information expires one year from the date it is signed.

REQUIRED SIGNATURE FOR PARTICIPATION

_____ _____

Patient/Parent-Guardian Signature Date
Signature

NOTICE OF PRIVACY PRACTICES

Barnhill Sports Medicine is committed to maintaining the privacy of our clients' Protected Health Information (PHI), while providing the highest quality service. In accordance with HIPAA regulations, all patients will receive a full written notice of our clients' privacy practices at their first office visit after April 14, 2003. This notice will explain your privacy rights regarding your PHI and our obligations concerning the use and disclosure of your PHI.

Barnhill Sports Medicine may use and disclose our PHI for treatment, payment, and health care operations as well as other times in order to provide you with quality service.

You have the right to inspect, copy, and amend your PHI. You have the right to request restrictions on the use of your PHI. You have the right to an accounting of the disclosures of your PHI.

You have the right to complain about alleged violation to our practice privacy officer and the U.S. Department of Health and Human Services.

Barnhill Sports Medicine will provide you with a full Notice of Privacy Practices (NPP). Please read it, and if you have questions, please contact our privacy officer for clarification or assistance.

Indicate any persons authorized to discuss your PHI with our office or those who are authorized to receive copies of your medical records. Include the persons name and relationship to yourself. Include a start date and an end date to set restrictions of any individual(s).

NAME	RELATIONSHIP	START DATE	END DATE

FINANCIAL POLICIES

Payment of Benefits: I understand that Barnhill Sports Medicine will bill my insurance company if I have provided adequate information (full insurance information - ID#, group #, insurance cards). I authorize payment of benefits by my insurance company directly to Barnhill Sports Medicine. I agree that after 60 days, all balances due to Barnhill Sports Medicine become my responsibility. I acknowledge I am responsible for all charges incurred. Barnhill Sports Medicine will accept partial payments whether or not marked 'Paid in full' without losing our rights under this agreement.

Authorization for Release of Medical Records: I authorize my insurance company, organization, employer, hospital or health care provider to release any information requested with regards to the processing of my claim. I certify that the information which I furnished on this registration form is true and correct. I understand that it is a crime to fill out the form with facts which I know are false or leave out facts which I know to be important.

Terms: Deductibles and insurance co-payments are due from patients at the time of service. If there is no insurance coverage, full payment is required at the time of service. In the event that there is no insurance coverage and surgery is deemed necessary Barnhill Sports Medicine will require a $1000.00 deposit for surgical fees prior to the surgery being performed. Barnhill Sports Medicine does not accept third-party liability claims. I understand and agree to the above financial policies of Barnhill Sports Medicine.

Patient/Parent-Guardian Signature:_____ **Date:**_____

Witness Signature: _____ **Date:**_____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW BARNHILL SPORTS MEDICINE MAY USE DISCLOSE YOUR HEALTHCARE INFORMATION AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION, PLEASE REVIEW CAREFULLY.

Barnhill Sports Medicine is required to maintain the privacy of your protected health information. This information consists of all records related to your health, including demographic information, either created by Barnhill Sports Medicine or received by Barnhill Sports Medicine from other healthcare providers.

We are required to provide you with notice of our legal duties and privacy practices with respect to your protected health information. These legal duties and privacy practices are described in this Notice. Barnhill Sports Medicine will abide by the terms of this Notice, or the Notice currently in effect at the time of the use or disclosure of your protected health information.[1]

Barnhill Sports Medicine reserves the right to change the terms of this Notice and to make any new provisions effective for all protected health information that we maintain. Patients will be provided a copy of any revised Notices upon request. An individual may obtain a copy of the current Notice from our office at any time.

Uses and Disclosures of Your Protected Health Information not Requiring Your Consent

Barnhill Sports Medicine may use and disclose your protected health information. without your written consent or authorization, for certain treatment, payment healthcare operations. There are certain restrictions on uses and disclosures of treatment records, which include registration and all other records concerning individuals who are receiving, or who at any time have received services for mental illness, developmental disabilities, alcoholism, or drug dependence. There are also restrictions on disclosing HIV test results.

Treatment may include:
- Providing, coordinating, or managing healthcare and related services by one or more healthcare providers;
- Consultations between healthcare providers concerning a patient;
- Referrals to other providers for treatment;
- Referrals to nursing homes foster care homes, or home health agencies.

For example, Barnhill Sports Medicine may determine that you require the services of a specialist. In referring you to another doctor, Barnhill Sports Medicine may share or transfer your healthcare information to that doctor.

Payment activities may include:
- Activities undertaken by Barnhill Sports Medicine to obtain reimbursement for services provided to you;
- Determining your eligibility for benefits or health insurance coverage;
- Managing claims and contacting your insurance company regarding payment;
- Collection activities to obtain payment for services provided to you;
- Reviewing healthcare services and discussing with your insurance company the medical necessity of certain services or procedures, coverage under your health plan, appropriateness of care, or justification of charges;
- Obtaining pre-certification and pre-authorization of services to be provided to you.

For example Barnhill Sports Medicine will submit claims to your insurance company on your behalf. This claim identifies you, your diagnosis and services provided to you.

Healthcare operations may include
- Contacting healthcare providers and patients with information about treatment alternatives;
- Conducting quality assessment and improvement activities;
- Conducting outcomes evaluation and development[1] of clinical guidelines;
- Protocol development, case management, or care coordination;
- Conducting or arranging for medical review, legal services. and auditing functions.

For example, Barnhill Sports Medicine may use your diagnosis, treatment, and outcome information to measure the quality of the services that we provide, or assess the effectiveness of your treatment when compared to patients in similar situations.

Barnhill Sports Medicine may contact you, by telephone or mail, to provide appointment reminders. You must notify us if you do not want to accept appointment reminders.

We may not disclose your protected health information to family members or friends who may be involved with your treatment or care without your written permission. Health information may be released without written permission to a parent, guardian, or legal custodian of a child; the guardian of an incompetent adult; the healthcare agent designated in an incapacitated patient's healthcare power of attorney; or the personal representative or spouse of a deceased patient.

There are additional situations when Barnhill Sports Medicine is permitted or required to use or disclose your protected health information without your consent or authorization. Examples include the following:

- As permitted or required by law.
  In certain circumstances we may be required to report individual health information to legal authorities, such as law enforcement officials, court officials, or government agencies. For example, we may have to report abuse, neglect, domestic violence or certain physical injuries. We are required to report gunshot wounds or any other wound to law enforcement officials if there is reasonable cause to believe that the wound occurred as a result of a crime.
  Mental health records may be disclosed to law enforcement authorities for the purpose of reporting an apparent crime on our premises.
- For public health activities.
  We may release healthcare records, with the exception of treatment records, to certain government agencies or public health authority authorized by law, upon receipt of written request from that agency. We are required to report positive HIV test results to the state epidemiologist. We may also disclose HIV test results to other providers or persons when there has been or will be risk of exposure.

[1]This Notice is prepared in accordance with the Health Insurance Portability and Accountability Act. 45 C.F.R. 164.520.

We may report to the state epidemiologist the name of any person known to have been significantly exposed to a patient who tests positive for HIV. We are required by law to report suspected child abuse and neglect and suspected abuse of an unborn child, but cannot disclose HIV test results in connection with the reporting or prosecution of alleged abuse or neglect. We may release healthcare records, including treatment records and HIV test results, to the Food and Drug Administration when required by federal law. We may disclose healthcare records, except for HIV test results, for the purpose of reporting elder abuse or neglect, provided the subject of the abuse or neglect agrees, or if necessary to prevent serious harm. Records may be released for the reporting of domestic violence if necessary to protect the patient or community from imminent and substantial danger.

- For health oversight activities.
  We may disclose healthcare records, including treatment records, in response to a written request by any federal or state governmental agency to perform legally authorized functions, such as management audits, financial audits, program monitoring and evaluation, and facility or individual licensure or certification. HIV test results may not be released to federal or state governmental agencies, without written permission, except to the state epidemiologist for surveillance, investigation, or to control communicable diseases.

- Judicial and Administrative Proceedings.
  Patient healthcare records, including treatment records and HIV test results, may be disclosed pursuant to a lawful court order. A subpoena signed by a judge is sufficient to permit disclosure of all healthcare records except for HIV test results.

- For activities related to death.
  We may disclose patient healthcare records, except for treatment records, to a coroner or medical examiner for the purpose of completing a medical certificate or investigating a death. HIV test results may be disclosed under certain circumstances.

- For research.
  Under certain circumstances, and only after a special approval process, we may use and disclose your health information to help conduct research.

- To avoid a serious threat to health or safety.
  We may report a patient's name and other relevant data to the Department of Transportation if it is believed the patient's vision or physical or mental condition affects the patient's ability to exercise reasonable or ordinary control over a motor vehicle. Healthcare information, including treatment records and HIV test results, may be disclosed where disclosure is necessary to protect the patient or community from imminent and substantial danger.

- For workers' compensation.
  We may disclose your health information to the extent such records are reasonably related to any injury for which workers compensation is claimed.

Barnhill Sports Medicine will not make any other use or disclosure of your protected health information without your written authorization. You may revoke the authorization at any time, except to the extent that Barnhill Sports Medicine has taken action in reliance thereon. Any revocation must be in writing.

Your Rights Regarding Your Protected Health Information

You are permitted to request that restrictions be placed on certain uses or disclosures of your protected health information by Barnhill Sports Medicine to carry out treatment, payment, or healthcare operations. You must request such a restriction in writing. We are not required to agree to your request, but if we do agree, we must adhere to the restriction, except when your protected health information is needed in an emergency treatment situation. In this event, information may be disclosed only to healthcare providers treating you. Also, a restriction would not apply when we are required by law to disclose certain healthcare information.

You have the right to review and/or obtain a copy of your healthcare records, with the exception of psychotherapy notes, or information compiled for use (or in anticipation for use) in a civil, criminal, or administrative action or proceeding. Barnhill Sports Medicine may deny an access under other circumstances, in which case you have the right to have such a denial reviewed. We may charge a reasonable fee for copying your records.

You may request that Barnhill Sports Medicine send protected health information, including billing information, to you by alternative means or to alternative locations. You may also request that Barnhill Sports Medicine not send information to a particular address or location or contact you at a specific location, perhaps your place of employment. This request must be submitted in writing. We will accommodate reasonable requests by you.

You have the right to request that Barnhill Sports Medicine send protected portions of your healthcare records, as long as such information is maintained by us. You must submit this request in writing, and under certain circumstances the request may be denied.

You may request to receive an accounting of the disclosures of your protected health information made by Barnhill Sports Medicine for the six years prior to the date of the request, beginning with disclosures made after April 14, 2003. We are not required, however, to record disclosures we make pursuant to a signed consent or authorization.

You may request and receive a paper copy of this Notice, if you had previously received or agreed to receive the Notice electronically.

Any person or patient may file a complaint with Barnhill Sports Medicine and/or the Secretary of Health and Human Services if they believe their privacy rights have been violated, To file a complaint with Barnhill Sports Medicine, please contact the Privacy Officer at the following:

Barnhill Sports Medicine Clinic
7000 S. W. 9th Ave.
Amarillo, Texas 79106
Phone: 806-350-3500

It is the policy of Barnhill Sports Medicine that no retaliatory action will be made against any individual who submits or conveys a complaint of suspected or actual non-compliance or violation of the privacy standards.

This Notice of Privacy Practices is effective April 14, 2003.

BARNHILL SPORTS MEDICINE

7000 W. 9th Ave, Amarillo, TX 79106, (806) 350-3500

Today's Date ___/___/___

PATIENT INFORMATION

Patient Name _____ Occupation/School _____

Age _____ Sex _____ Height _____ Weight _____

REASON FOR TODAY'S VISIT

Explain Problem or Injury _____

(circle one) *Right Left Chronic Acute* Date Of Injury/Symptom ___/___/___ Reinjury Date ___/___/___

(circle one) *Football Basketball Baseball Track Wrestling Volleyball Tennis Rodeo Gymnastics Soccer Hockey*

Other _____

HAVE YOU SOUGHT PRIOR MEDICAL ATTENTION FOR THIS PROBLEM ____YES ____NO

If YES, check all that apply: ____Has the problem ever been operated on? ____Has there ever been any therapy/rehab?
____Has there ever been any type of cast? ____Has there ever been any type of brace?

Explanation: _____

MEDICAL HISTORY

List all Prior Surgeries _____

List of Current Medications and Dosages or check: ____None

_____

List all Allergies and/or Allergies to Medication or check: ____None

_____

HABITS Tobacco Use: ____ Yes ____ No Type and Amount / Day _____

Drink Alcohol: ____ Yes ____ No How Often _____

ILLNESSES (Check all of the Medical Conditions that you have or have had)

__ Arthritis
__ Bleeding Disorders
__ Diabetes
__ Ulcers
__ Heart Failure
__ Heart Arrhythmia
__ Asthma
__ Blood Clot/Embolus
__ Liver Disease
__ Hernia
__ Peripheral Vascular Disease
__ Anemia
__ Cancer
__ Kidney Disease
__ Hepatitis
__ Gout
__ Neurological Disease
__ AIDS
__ Colitis
__ High Blood Pressure
__ Epilepsy
__ Skin Disease
__ Other

Explanation _____

_____

_____

PHARMACY OF CHOICE _____

REFERING DOCTOR, COACH, TRAINER OR OTHER _____

I certify that the information provided above is correct and true.

SIGNATURE _____ **DATE** _____

BARNHILL SPORTS MEDICINE

7000 W. 9th Ave, Amarillo, TX 79106, (806) 350-3500

Patient Information

Last Name_____ First Name_____ MI _____ Circle (if applies) Jr. Sr. III

Date of Birth ____/____/____ Age _____Home Phone _____Cell/Message Phone _____

Mailing Address_____ APT# _____City_____

State_____ Zip Code_____ Social Security #_____-_____-_____ Marital Status _____

Physical Address_____APT# _____ City_____State_____Zip_____

Employer/School_____ Employer/School City_____ Employer/School Phone #_____

Date Of Injury ____/____/____ Were You Referred To Us? (circle one) **YES NO** If YES, by whom? _____

IF MARRIED: Name of Spouse_____ Cell/Alternate Phone # _____

Spouse Employer _____ Spouse Employer Phone # _____

RESPONSIBLE PARTY INFORMATION

Note: The Responsible Party is the person who obtains insurance coverage for themselves and/or their dependents.

Full Name_____

Address_____ APT _____

City_____ State _____ Zip _____

Phone Number _____

DOB____/____/____ SSN_____-_____-_____

Employer _____

Employer Phone # _____

EMERGENCY CONTACT INFORMATION

Full Name _____

Relationship to patient _____

City_____ State_____ Zip _____

Phone #_____Alt Phone #_____

Nearest Relative (not living w/you) _____

City_____ State_____ Zip _____

Phone #_____Alt Phone #_____

Family Physician/Clinic_____

INSURANCE INFORMATION (Complete All Insurance Information Thoroughly)

*****Please provide a drivers license and all insurance coverage cards with your completed information*****

PRIMARY INSURANCE: *(circle type of insurance below)*
Insurance Medicare Medicaid Self Pay Worker's Comp

Name of Insurance Co._____

Ins. Billing Address_____

Ins. City/State/Zip _____

Ins. Phone # _____ Fax #_____

Subscriber Name _____

Sub. DOB____/____/____Sub. SSN____-____-____

Group # _____ Policy # _____

SECONDARY INSURANCE:*(circle type of insurance below)*
Insurance Medicare Medicaid Self Pay Worker's Comp

Name of Insurance Co._____ _____

Ins. Billing Address_____

Ins. City/State/Zip _____

Ins. Phone # _____ Fax #_____

Subscriber Name _____

Sub. DOB____/____/____ Sub. SSN_____-____-_____

Group # _____ Policy # _____

I Certify that the information provided is correct. I understand that the information provided will be used to manage my account and process insurance claims.

Patient/Parent-Guardian Signature:_____ **Date:** _____

NOTICE OF PRIVACY PRACTICES

Panhandle Sports Medicine Institute is committed to maintaining the privacy of our clients' Protected Health Information (PHI), while providing high quality service. In accordance with the HIPAA regulations all patients will receive a full written notice of our client's privacy practices at their first office visit after April 14, 2003. This notice will explain your privacy rights regarding your PHI and our obligations concerning the use and disclosure of your PHI.

Panhandle Sports Medicine Institute may use and disclose your PHI for treatment, payment, and health care operations as well as other times in order to provide you with quality service.

You have the right to inspect, copy, and amend your PHI. You have the right to request restrictions on the use of your PHI. You have the right to an accounting of the disclosures of your PHI for other than TPO.

You have the right to complain about alleged violation to our practice privacy officer and the U.S. Department of Health and Human Services.

Panhandle Sports Medicine Institute will provide you a full Notice of Privacy Practices (NPP). Please read it and if you have questions, please contact our privacy officer for clarification or assistance.

Indicate any persons authorized to discuss your PHI with our office or authorized to receive copies of your medical records. Include the persons name and relationship to yourself. Include a start date and an end date to set restrictions for any individual(s).

Name	Relationship	Start Date	End Date

FINANCIAL POLICIES

Payment of Benefits: I understand that Panhandle Sports Medicine Institute will bill my insurance company if I have provided adequate information (full insurance information - ID #'s, group #'s, insurance cards). I authorize payment of benefits by my insurance company directly to Panhandle Sports Medicine Institute. I agree that after 60 days all balances due to Panhandle Sports Medicine Institute become my responsibility. I acknowledge I am responsible for all charges incurred. Panhandle Sports Medicine Institute will accept partial payments whether or not marked 'Paid in full' without losing our rights under this agreement.

Authorization for Release of Medical Records: I authorize my insurance company, organization, employer, hospital, or health care provider to release any information requested with regards to processing of my claim. I certify that the information which I furnish on this registration form is true and correct, know that it is a crime to fill out the form with facts I know are false or leave out facts that I know are important.

Terms: Deductibles and insurance co-payments are due from patients at time of service. If no insurance coverage, full payment is require at the time of service. There is a $25.00 fee per returned check from your bank. In the event that there is no insurance coverage, and surgery is deemed necessary, Panhandle Sports Medicine Institute will require a $1000.00 deposit for surgical fees prior to the surgery being performed. Workers' compensation claims must be verified with both the employer and the insurance carrier. Claims not verified are the financial responsibility of the patient and are payable at the time of service. Refunds will be available when the insurance carrier has settled the account. Panhandle Sports Medicine Institute does not accept third party liability claims. If your account is turned to a collection agency, an additional prevailing fee will be added to your account for collection agency fees. I understand and agree to the above financial policies of Panhandle Sports Medicine Institute.

Firstcare Notice of Financial Responsibility (The following applies to Firstcare members only): Firstcare will not pay for services rendered by specialist physicians and certain providers when those services are not properly referred by the primary care physician or are not prior authorized by Firstcare when applicable. Firstcare is likely to deny payment for health care services because: You do not have a referral from your primary care physician; This visit will exceed the number of visits previously authorized and your PCP has not approved additional visits; The services you are requesting have not been properly authorized by Firstcare; and/or The services you are requesting typically are not covered by Firstcare. If Firstcare denies payment, I agree to be personally and fully responsible for payment.

Patient/Parent-Guardian Signature:_____ **Date:** _____

Witness Signature: _____ **Date:** _____

BARNHILL SPORTS MEDICINE

7000 W. 9th Ave • Amarillo, TX 79106 • (806) 350-3500 • www.barnhillsportsmed.com

Patient Information

Last Name_____ First Name_____ MI _____ Circle (if applies) Jr. Sr. III

Date of Birth ____/____/____ Age _____Home Phone _____Cell/Message Phone _____

Mailing Address_____ APT# _____City_____

State_____ Zip Code_____ Social Security #_____-_____-_____ Marital Status _____

Physical Address_____APT# _____ City_____State_____Zip_____

Employer/School_____ Employer/School City_____ Employer/School Phone #_____

Date Of Injury ___/___/___ Were You Referred To Us? (circle one) **YES NO** If YES, by whom? _____

IF MARRIED: Name of Spouse_____ Cell/Alternate Phone # _____

Spouse Employer _____ Spouse Employer Phone # _____

RESPONSIBLE PARTY INFORMATION

Note: The Responsible Party is the person who obtains insurance coverage for themselves and/or their dependents.

Full Name_____

Address_____ APT _____

City_____ State _____ Zip _____

Phone Number _____

DOB____/____/____ SSN_____-_____-_____

Employer _____

Employer Phone # _____

EMERGENCY CONTACT INFORMATION

Full Name _____

Relationship to patient _____

City_____ State_____ Zip _____

Phone #_____Alt Phone #_____

Nearest Relative (not living w/you) _____

City_____ State_____ Zip _____

Phone #_____Alt Phone #_____

Family Physician/Clinic_____

INSURANCE INFORMATION (Complete All Insurance Information Thoroughly)

Please provide a drivers license and all insurance coverage cards with your completed information*

PRIMARY INSURANCE:

Name of Insurance Co._____

Ins. Billing Address_____

Ins. City/State/Zip _____

Ins. Phone # _____ Fax #_____

Subscriber Name _____

Sub. DOB____/____/____Sub. SSN____-____-____

Group # _____ Policy # _____

SECONDARY INSURANCE:

Name of Insurance Co._____

Ins. Billing Address_____

Ins. City/State/Zip _____

Ins. Phone # _____ Fax #_____

Subscriber Name _____

Sub. DOB____/____/____ Sub. SSN_____-____-_____

Group # _____ Policy # _____

I Certify that the information provided is correct. I understand that the information provided will be used to manage my account and process insurance claims.

Patient/Parent-Guardian Signature:_____ **Date:** _____

BARNHILL SPORTS MEDICINE

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Today's Date ___/___/___

PATIENT INFORMATION

Patient Name _____ Occupation/School _____

Age _____ Sex _____ Height _____ Weight _____

REASON FOR TODAY'S VISIT

Explain Problem or Injury _____

(circle one) *Right Left Chronic Acute* Date Of Injury/Symptom ___/___/___ Reinjury Date ___/___/___

(circle one) *Football Basketball Baseball Track Wrestling Volleyball Tennis Rodeo Gymnastics Soccer Hockey*

Other _____

HAVE YOU SOUGHT PRIOR MEDICAL ATTENTION FOR THIS PROBLEM ____YES ____NO

If YES, check all that apply: ____Has the problem ever been operated on? ____Has there ever been any therapy/rehab?
____Has there ever been any type of cast? ____Has there ever been any type of brace?

Explanation: _____

MEDICAL HISTORY

List all Prior Surgeries _____

List of Current Medications and Dosages or check: ____None

_____

List all Allergies and/or Allergies to Medication or check: ____None

_____

HABITS Tobacco Use: ____ Yes ____ No Type and Amount / Day _____

Drink Alcohol: ____ Yes ____ No How Often _____

ILLNESSES (Check all of the Medical Conditions that you have or have had)

__ Arthritis	__ Asthma	__ Anemia	__ AIDS
__ Bleeding Disorders	__ Blood Clot/Embolus	__ Cancer	__ Colitis
__ Diabetes	__ Liver Disease	__ Kidney Disease	__ High Blood Pressure
__ Ulcers	__ Hernia	__ Hepatitis	__ Epilepsy
__ Heart Failure	__ Peripheral Vascular Disease	__ Gout	__ Skin Disease
__ Heart Arrhythmia		__ Neurological Disease	__ Other

Explanation _____

_____

_____

PHARMACY OF CHOICE _____

REFERING DOCTOR, COACH, TRAINER OR OTHER _____

I certify that the information provided above is correct and true.

SIGNATURE _____ **DATE** _____