Ludy Lukose, M.D.

407 East Maple Street
Suite 101
Cumming, GA 30040
P:770-888-6697 / F:877-892-0151
PremierMedicalAssociatesPC.com

PATIENT DEMOGRAPHIC FORM

First Name: _____ MI: _____ Last Name: _____

Date of Birth _____ SS# _____

□ Male □ Female Race _____ Ethnicity _____ Language _____

Address: _____

City _____ State _____ Zip Code _____

Primary Phone # _____ Alternate Phone #: _____

Email _____

Marital Status: □ Married □ Single □ Divorced □ Widowed □ Other _____

EMERGENCY CONTACT INFORMATION

Contact _____ Relationship _____ Phone #_____

EMPLOYMENT INFORMATION

□ Full Time □Part Time □ Student □Retired □Disabled

Place of Employment: _____

Work phone #: _____ Occupation: _____

PHARMACY INFORMATION

Preferred Pharmacy: (Name, City, Street & Phone #) _____

_____

PLEASE NOTE: WE WILL NOT CALL IN PRESCRIPTION REFILLS ON WEEKENDS OR AFTER HOURS
Refills are handled Monday-Thursday 8:00am-4:30pm and Friday 7:00am-3:30pm ONLY!!!!

*****YOU MUST PROVIDE 24 HOURS ADVANCED NOTICE.*****

_____ Please initial here that you have read and understand the above.

Please tell us how you heard about us:

- ☐ Newspaper / Magazine (which one) _____
- ☐ Emergency Room (which one) _____
- ☐ Friend (who) _____
- ☐ Doctor (which one) _____
- ☐ Insurance _____
- ☐ Other _____
- ☐ Internet Search (search engine) _____
- ☐ Phonebook

Medical History Information

Name: _____ _____ Date of Birth: _____

PAST MEDICAL HISTORY (Please list any medical issues/diagnosis such as; Cancer(type), Diabetes, High Blood Pressure, High Cholesterol, Thyroid problems, Alzheimer's, etc.)

_____

_____

_____

ALLERGIES (drug ,food or contact): _____

IMMUNIZATIONS (List late date or year of any below):

Tetanus Booster (Bite/cut) _____
Influenza _____
Pneumonia _____
Shingles _____
Hepatitis A/B _____
TDap _____
(Tetanus, Diphtheria & Pertussis)

FAMILY HISTORY (Please list any medical issues/diagnosis such as; Cancer(type), Diabetes, High Blood Pressure, High Cholesterol, Thyroid problems, Alzheimer's, etc.)

Mother: _____
Father: _____
Sister: _____
Brother: _____
Maternal Grand Mother: _____
Maternal Grand Father: _____
Paternal Grand Mother: _____
Paternal Grand Father: _____
Maternal Aunts/Uncles: _____
Paternal Aunts/Uncles: _____

SOCIAL HISTORY:

Tobacco Use (Past or Present): YES NO ___ Packs per day Date Quit:_____ Type: _____

Alcohol Use (Past or Present): YES NO ___Drinks per day Type:_____ How long?_____

Status: Married Single Divorced Widowed Life Partner

Number of Children: _____

Work Status/Profession: _____ RETIRED DISABLED

Do you wear your seatbelt? YES NO

CURRENT MEDICATIONS: (Please include over the counter, vitamins, supplements dose & frequency.)

Name Example: Lipitor	Strength 10mg	How many times a day once daily
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PAST SURGICAL (Please put the date. If you are unsure of the exact date, please put the year. Examples: Gallbladder, Tonsil, Joint Replacements, Biopsies, Cataracts, Mole Removal, Oral Surgeries, etc.)

_____
_____
_____
_____

DIAGNOSTIC STUDIES

Cardiovascular Stress Test: _____
Chest X-ray: _____
Coronary Angiogram: _____
Echocardiogram: _____
Endoscopy: _____
Carotid Ultrasound: _____
Other: _____

HEALTH MAINTENANCE: (List late date of any below & results if known):

Bone Density: _____
Mammogram: _____
Pap Smear: _____
Colonoscopy: _____
Testicular Exam: _____
Rectal Exam: _____
Eye Exam:_____
Glaucoma Screening: _____
Dental Exam: _____

PREVIOUS DOCTORS AND SPECIALISTS: (PCP, Cardiologist, Neurologist, Rheumatologist, etc.)

Name	Specialty	Phone / Fax
Example: Dr. Ludy Lukose	**Primary Care**	**770-888-6697 / 877-892-0151**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please check symptoms that apply to today's visit:

GENERAL
□ chills
□ fatigue
□ fever
□ medication changes
□ obesity
□ weight changes

SKIN
□ bruising
□ dryness
□ sweating
□ hair growth
□ hair loss
□ hives
□ itching
□ nail changes
□ sores/lesions
□ rash
□ skin changes

EAR, NOSE & THROAT
□headache
□tearing
□eye pain
□ eye redness
□hearing loss
□ ear infection
□ ear pain
□ ear ringing
□ runny nose
□nose bleed
□frequent colds
□ nasal congestion
□allergies
□ sinus pain
□sore throat

RESPIRATORY
□coughing up blood
□cough
□snoring
□sputum production
□wheezing
□shortness of breath

CARDIOVASCULAR
□chest pain
□hypertension
□palpitations
□low blood pressure
□swelling of extremities

GASTROINTESTINAL
□abdominal pain
□black/tarry or bloody stools
□change in bowel habits
□constipation
□diarrhea
□gas
□heartburn
□jaundice
□nausea
□rectal bleeding
□vomiting

GENITOURINARY
□missed periods
□blood in urine
□vaginal discharge
□urinary frequency
□urinary hesitancy
□incontinence
□painful intercourse
□painful urination
□pelvic pain .
□urethral discharge
□urinary urgency
□urination at night

MUSCULOSKELETAL
□back pain
□decreased range of motion
□joint pain
□joint stiffness
□joint swelling
□muscle cramps
□muscle pain
□muscle weakness
□swelling of extremities

NEUROLOGY
□aura
□decreased memory
□difficulty speaking
□dizziness
□fainting
□headaches
□numbness
□seizures
□stroke
□tremor
□unsteadiness

PSYCHIATRY
□crying spells
□difficulty sleeping
□mania
□anxiety
□delusions
□depression
□fearful
□inability to concentrate
□mood changes
□panic attacks
□suicidal thought or plans

ADVANCE HEALTH CARE DIRECTIVE

If I am in any condition that I can no longer communicate my treatment preferences after reasonable and appropriate efforts have been made to communicate with me about my treatment preferences, then I direct the application of life sustaining procedures to my body be as follows:

_____**Full efforts:** Try to extend my life for as long as possible, using all medications, machines, or other medical procedures that in reasonable medical judgment could keep me alive. If I am unable to take nutrition or fluids by mouth, then I want to receive nutrition or fluids by tube or other medical means.

_____**No efforts:** Allow my natural death to occur. I do not want any medications, machines or other medical procedures that in reasonable medical judgment could keep me alive but cannot cure me. I do not want to receive nutrition or fluids by tube or other medical means.

OR

_____ I do not want any medications, machines or other medical procedures that in reasonable medical judgment could keep me alive but cannot cure me, except as follows:

_____I want to receive artificial life support

_____I want to receive blood transfusions

_____ I want to receive nutrition/fluid by tube or other medical means.

_____I want to receive electrical cardioversion.

_____ I want to receive artificial ventilator support.

_____I want to receive cardiopulmonary resuscitation (CPR).

_____ I want to receive any medications for pain/illness as needed.

_____ _____

Patient Signature Date

**** If you have a power of attorney or a living will please provide a copy.**

Patient Financial Responsibility Form

The following information is provided to avoid any misunderstanding or disagreement concerning payment for professional services rendered. Prompt payment allows us to control costs. Outstanding accounts cost you and the practice time and money; therefore all patients will be required to establish financial agreements for payment of their account.

It should be noted that your insurance coverage is an agreement between you and your insurer, NOT OURS. It is YOUR responsibility to remit payment for charges not covered by your insurance carrier and to ensure your carrier remits payments on your account.

As a courtesy to you, we will file all claims with your insurance company. HOWEVER, if we do not have a signed contract with your insurance company and they fail to pay your claim within 45 (forty five) days, the account balance will be transferred to YOUR responsibility. It is then your responsibility to contact the insurance company about processing your claim. You will be required to make payments on your account during this time. If the insurance company does pay, you will receive any necessary refund immediately.

Each month you will receive a statement for services which is due and payable within thirty days of the statement date, unless our records indicate insurance is still pending. If your payment is late, or if you have not made financial arrangements, we will mail you a reminder notice indicating a problem with your account. It is imperative that you contact us immediately upon receipt of such notice.

If you experience a set of financial circumstances beyond your control, please call our practice and we will be happy to make special payment arrangements.

Failure to adhere to the above policies could result in your account being turned over to an outside collection agency and dismissal from the practice.

Premier Medical Associates firmly believes that a good doctor/patient relationship is based upon understanding and open communication; our staff had been instructed to make every effort to assist you in managing your account. We hope to avoid any disagreement over payment for professional services by clearly defining our policies at the onset. If you have any questions concerning this policy or need assistance with your account in the future, please contact us immediately.

I HAVE READ THE ABOVE FINACIAL AGREEEMENT AND AGREE TO ABIDE BY THE TERMS SET FORTH IN IT.

_____ _____

Signature Date

APPOINTMENT POLICY

To Our Valued Patients:

Premier Medical Associates takes pride in giving complete and thorough medical care to our patients. In order to fulfill this goal it is important that our patients make every effort to be at their appointed time. Please realize that when you miss your appointment you are negatively impacting the financial viability of the practice and denying the needed care of someone else in the community.

Premier Medical Associates requires 24 hour notice if you need to cancel your appointment with our doctors. Be aware that failure of a 24 hour notice will result in a $35.00 charge to your account. Our goal is to make your wait time minimal; we do not double book appointments so that you are seen in a timely manner. To continue to do this, it is imperative that you adhere to the date and time that was reserved for you. We appreciate you kind consideration of the medical staff and we will always strive to provide you with the best care possible.

Please help us keep the scheduling of appointments fair to everyone.

Thank you,
Dr. Ludy Lukose

If your account is ever sent to an outside collection agency, please be aware that ALL collection fees WILL be added to your balance.

_____ _____

Signature Date

Ludy Lukose, M.D.

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PATIENT INSURANCE AND LAB WAIVER:

Our office appreciates your assistance in keeping insurance information current with **EACH** visit. This information helps our staff to properly bill your medical claims. It is vital for you to provide a current copy of your insurance card to the receptionist & the phlebotomist.

All lab specimens are sent to an outside lab company (Lab Corp or Quest). Please make sure you present your lab card or make us aware if your insurance company requires that your labs be sent to a specific lab.

I fully understand and agree that I may be responsible for the following charges:

- Any non-covered services as deemed by my insurance company.
- Any Out-of Network charges.
- Co-Payments or Deductibles as deemed by my insurance company.
- If this office is not contracted with my insurance company, I understand that I will pay in full and file my insurance myself.
- Additional outside Lab fees from the Laboratories (all labs are sent to an outside lab- Please make sure you present your current insurance card or lab card to indicate whether your insurance company dictates you a certain laboratory. The lab card will charge (or file to your insurance company) for the reading of the specimen. **THIS WILL BE AN ADDITIONAL BILL FROM THE LAB- NOT FROM OUR OFFICE.**

Please Print Name: _____

Signature: _____ **Date**: _____

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HIPPA

My request is to be contacted in the following manner

(check ALL that apply):

Home Telephone: _____

□ My approval to leave message with detailed information

□ Leave a message with a call back number ONLY

Work Telephone:_____

□ My approval to leave message with detailed information

□ Leave a message with a call back number ONLY

Written Communication:_____

□ Approval to mail to my home address

□ Approval to mail to my work / office address

□ Approval to fax to the following number: _____

Please list name and relation of persons we are allowed to release your medical information to. If no one is authorized, please write "N/A" below.

Names Authorized on Account:

_____

_____

_____

_____

_____ _____

Patient Signature **Date**

_____ _____

Printed Name **Date of Birth**

HIPPA

NOTICE OF PRIVACY PRACTICES

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*.**

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU. The following categories describe different ways that we use and disclose health information. For each category of uses or disclosures we elaborate on the meaning and provide more specific examples, if you request. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive at our practice may be billed to and payment may be collected from you, an insurance company or a third party. For example: we may disclose you record to an insurance company, so that we can get paid for treating you.

For Treatment. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you at the practice or hospital. For example, we my disclose medical information about you to people outside the practice who may be involved in your medical care, such as family members, clergy or there persons that are part of you care.

For Health Care Operations. We may use and disclose medical information about you for health care operations. These uses and disclosures are necessary to run our practice and to make sure that all patients receive quality care. We may also disclose information to doctors, nurses, technicians, medical students, and other practice personnel for review and learning purposes. For example, we may review your record to assist our quality improvement efforts.

WHO WILL FOLLOW THIS NOTICE: This notice describes our practice's policies and procedures and that of any health care professional authorized to enter information into your medical chart, any member of a volunteer group which we allow to help you, as wee as all employees, staff and other practice personnel.

POLICY REGARDING THE PROTECTION OF PERSONAL INFORMATION. We create a record of care and the service you receive at the practice. We need this record in order to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the practice, whether made by practice personnel or your personal doctor. The law requires us to: make sure that medical information that identifies you is kept private; give you this notice of our legal duties and privacy practices with respect to medical information about you; and to follow the terms of the notice that is currently in effect. Other ways we may use or disclose your protected health care information include: appointment reminders; as required by law, for health-related benefits and services; to individuals involved in your care or payment for your care; research; to avert serious threat to health or safety; and for treatment alternatives. Other uses and disclosures of your personal information could include disclosure to, or for: coroners; medical examiners and funeral directors; health oversight activities; inmates; law enforcement; lawsuits and disputes; military and veterans; national security and intelligence activities; organ and tissue donation; protective services for the President and others; public health risks; and worker's compensation.

NOTICE OF INDIVIDUAL RIGHTS

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of certain disclosures we made of medical information about you. To request this listing or accounting of disclosures, you must submit your request in writing to the Privacy Officer.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to our Privacy Officer and you must provide a reason that supports you request. We may deny your request for an amendment.

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. We may deny your request to inspect and copy in certain very limited circumstances.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment of health care operation purposes. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. ***We are not required to agree to your request***. If we do agree, we will comply with your request unless the information in needed to provide you emergency treatment. To request restrictions, you must submit your request in writing to the Privacy Officer.

CHANGES TO THIS NOTICE: We reserve the right to change this notice. We will post a copy of the current notice in our practice.

COMPLAINTS: If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact our Privacy Officer. All complaints must be submitted in writing. **You will not be penalized in any way for filing a complaint**.

OTHER USES OF MEDICAL INFORMATION: Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written authorization. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time.

If you have any questions about this notice or would like to receive a more detailed explanation, please contact our Privacy Officer.

I acknowledge by signing below that I have read and received the Notice of Privacy Practices and Notice of Individual Rights.

_____ _____

Patient or Patient's Personal Representative **Date**

HEALTH INFORMATION EXCHANGE STANDARD ADDENDUM TO THE NOTICE OF PRIVACY PRACTICES

Premier Medical Associates ("Practice") participates in various regional Health Information Exchanges (HIE). Generally, a HIE is an organization that regional providers participate in to exchange patient information in order to facilitate health care, avoid duplication of services (such as tests) and to reduce the likelihood that medical error will occur. By participating in a HIE, the Practice may share certain of your health information with other providers that participate in the HIE (each a "Participating Provider") or participants of other health information exchanges. This health information includes, but is not limited to:

- General laboratory results including microbiology
- Pathology test results including biopsies, Pap smears, etc.
- Radiology results including Xrays, MRIs, CT scans etc.
- Results of outpatient diagnostic testing including GI testing, cardiac testing, neurological testing, etc.
- Health Maintenance documentation
- Problem list documentation
- Allergy list documentation
- Immunization profiles
- Medication lists
- Progress notes
- Consultation notes

All Participating Providers of a HIE have agreed to a set of standards relating to their use and disclosure of health information available through the HIE. These standards are intended to comply with all applicable state and federal laws. As a result, you understand and agree that unless you notify the Practice that you do not wish for your health information to be available through a HIE ("Opt-Out"):

- Health information that results from any Participating Provider providing services to you will be made available through HIEs in which the Practice participates. For clarity, if you Opt-Out, your health information will no longer be accessible through the HIEs in which Practice participates. However, your opt-out does not affect health information that was disclosed through a HIE prior to the time that you opted out;
- Regardless of whether you choose to opt-out, your health information will still be provided to the HIEs in which Practice participates. However, if you choose to Opt-Out, the HIEs will not exchange your health information with other providers. Additionally, you cannot choose to have only certain providers access your health information; All Participating Providers who provide services to you will have the ability to access to your information. However, Participating Providers that do not provide services to you will not have access to your information;
- Information available through a HIE may be provided to others as necessary for referral, consultation, treatment and/or the provision of other treatment-related healthcare services to you. This includes providers, pharmacies, laboratories, etc.
- Your information may be disclosed for payment related activities associated with your treatment by a Participating Provider; and your information may be used for healthcare operations related activities by Participating Providers.

You may Opt-Out at any time by notifying the Practice.

I acknowledge by signing below that I have read and received the Health Information Exchange addendum to the Notice of Privacy Practices.

_____ _____

Patient or Patient's Personal Representative **Date**

CONTROLLED DRUG POLICY

Patient Controlled Substance Agreement Informed Consent Form

The following agreement relates to my use of controlled substance prescribed by Premier Medical Associates. I recognize that these are policies regarding the use of controlled substances that are followed by the staff. I will be provided controlled substances while actively participating in my treatment plan ONLY if I adhere to the following regulations:

1. Patients must be seen every 3 months in order to receive any controlled substance prescription from any physician at Premier Medical Associates**. NO EXCEPTIONS!!**
2. Patients **MUST BRING THE PILL BOTTLES** with them **EVERY** time they come in. **NO EXCEPTIONS!!**
3. Pills must be counted by the nurse in front of patients **EVERY** visit.
4. A drug screen MUST be done **EVERY** visit. **NO EXCEPTIONS**. The patient will be responsible for paying for this procedure.
5. All controlled substance prescriptions **MUST** be picked up at the office. They will not be called into the pharmacy.
6. I will use the substances only within the parameters given by my treating physician.
7. I will not receive replacement medications for "lost" or "stolen" medications without presenting a valid police report.
8. I will receive controlled substances only from Premier Medical Associates relating to my treatment plan. Any controlled substances prescribed outside Premier Medical Associates will lead to discontinuation of treatment.
9. I will not expect to receive additional medication prior to the time of my next scheduled refill regardless if my new prescription runs out. I will be responsible for "stretching out" my medications if my new prescription is dated for a weekend, holiday or any other date when I cannot refill my prescription. I understand that prescriptions will not be rewritten for a new day under any circumstances.
10. Under no circumstances will a refill of a Schedule II narcotic (controlled substance) prescription be given over the telephone.
11. By law, a maximum of thirty (30) days supply of medicine will be prescribed at any one time.
12. I will accept generic brands of my prescription medications.
13. If it appears to the physician that there are no demonstrable benefits to my daily function or quality of life from the controlled substance, I will gradually taper my medications as prescribed by the physician. I will not hold any member of Premier Medical Associates liable for problems caused by discontinuation of controlled substances, provided that I receive 15 days notice of termination.
14. I agree to medication counts as needed, within a 24-hour notice.
15. I recognize that my chronic pain represents a complex problem which may benefit from behavioral medicine strategies and psychotherapy. I also recognize my active participation in the management of my pain/depression/attention disorder is extremely important. I agree to actively to participate in all aspects of my treatment plan as directed by my physician in order to secure increased function and improvement in learning how to cope with my condition.
16. I am permitting the right of disclosure to law enforcement in the event of violation or breach of this agreement.

If you fail to comply with ANY of these regulations, Premier Medical Associates **WILL NOT REFILL YOUR PRESCRIPTION!!!!**

_____	_____
Patient Signature	Date
_____	_____
Physician Signature	Date
_____	_____
Witness Signature	Date

PATIENT AUTHORIZATION/AGREEMENT AND CONSENT TO CARE

The undersigned, for myself, or a minor child, or another person for whom I have legal authority to sign (hereinafter referred to as I, me, or my), intend this Patient Authorization/Agreement and Consent to Care to be effective for all outpatient services rendered and/or billed by Premier Medical Associates, (PMA) to me, whether for this medical condition or for subsequent medical conditions that may arise that require treatment. This Authorization is intended to include all services rendered during the course of my care and treatment, unless revoked in writing. I understand that I may revoke this Authorization at any time, but such revocation shall not become effective until PMA receives my written revocation. Revocation of this Authorization shall not be effective as to any actions PMA has already taken in reliance upon it.

GENERAL CONSENT TO CARE
I hereby consent to routine medical care and treatment as ordered or instructed by a PMA physician, or associates, as allowed by law. This includes my consent for PMA services, diagnostic procedures and medical care and treatment including, but not limited to: examinations, radiology and laboratory procedures, other tests and treatments, medication, monitoring, EKGs, general nursing care or other routine procedures. This consent also includes certain invasive procedure(s) which will be explained to me prior to the procedure(s) being performed on me, but which do not require my separate, written informed consent.

I understand that I will be under the direct care of physician(s) while a patient at PMA and that the employees of PMA will carry out the orders and instructions of those physicians. I understand that PMA employed physicians, as well as independent contractor physicians who have been granted the privilege of using PMA's facilities, may provide care and treatment to me at PMA facilities. I also recognize that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made or will be made to me. I have also been or will be reasonably informed of the risks, benefits and possible consequences involved in my care and treatment and that unforeseen results may occur.

ACKNOWLEDGMENT OF NOTIFICATION OF PATIENT ACCESS TO HEALTH CARE RECORDS
I understand that I may review and/or receive copies of my PMA health care records. Requests may be made anytime during regular business hours upon reasonable notice to PMA and at my own expense. I may authorize other persons to review and /or receive copies of my health care records by submitting a written request to PMA. I may also request that a copy of my health care records be referred to another health care provider of my choice, all upon payment of reasonable costs.

HEALTH CARE EDUCATION
PMA participates in health care provider education. I agree that students may observe and/or participate in my care and treatment while they are under the supervision of a physician or other authorized PMA representative. I will be notified before a student observes and/or participates in my care and treatment and I may decline the student's observation and/or participation.

PERSONAL VALUABLES
I understand and agree that PMA assumes no liability for any loss of or damage to any money or personal articles brought to PMA. I understand that PMA assumes no control over money or personal articles, and is not responsible for storage or safe keeping of such articles. PMA employees do not have the authority to assume liability or take action to safe keep money or personal articles. I, therefore, release PMA from any responsibility due to the loss or damage of any money or personal articles.

FOLLOW-UP RESPONSIBILITY
I understand that I may return home before all my medical problems are known or treated. I may be given instructions to follow-up with my physician or other PMA provider. It is my responsibility to arrange follow-up care and to follow through on any instructions provided to me.

_____ _____

Signature Date