

# **Dr. Brad Shamis & Associates, L.L.C.**

Tel: (215) 752-2287 / Fax: (215) 752- 7094

## ***Neshaminy Medical/Professional Center***

4802 Neshaminy Blvd. - Ste. 6  
Bensalem, PA 19020

## ***Makefield Executive Center***

301 Oxford Valley Road - Ste. 1001-A  
Yardley, PA 19067

## **WELCOME TO OUR PRACTICE**

Our practice is a practical, interactive, solution-focused therapy. Our treatment approach provides support and practical feedback to help patients resolve current problems and longstanding patterns, with sensitivity and compassion.

### **RESPONSIBILITIES OF THE MENTAL HEALTH REPRESENTATIVES**

Our responsibilities include the expectation that services will be provided to the patient according to the highest standard of care within their profession and as expected by Dr. Brad Shamis and Associates, LLC.

### **RESPONSIBILITIES OF THE PATIENT & PARENT/GUARDIAN**

Successful treatment also requires patient and parent/guardian participation as members of the team including:

Participate in sessions at least once per week or as determined by the treatment plan. Sessions last for 45 minutes.

Attend all scheduled appointments and participate in development of the treatment plans and goals.

Comply with treatment plans and goals as determined by the patient, family, and Mental Health Professionals. Provide open and honest communication with all members of the treatment plan.

### **FINANCIAL RESPONSIBILITY**

Although Dr. Brad Shamis & Assoc., LLC accepts payment from most insurance companies, the patient's parent/guardian must assure financial responsibility for the services. The parent/guardian must inform Dr. Brad Shamis & Assoc., LLC / therapist of any changes in insurance coverage, address or telephone number during treatment.

The parent/guardian may be required to pay in full (unless limited by contract)

A co-payment is absolutely required for each session of treatment as required by the insurance company.

We ask that your payments are made at time of appointment. We accept Personal Checks and Cash ONLY! Please note that our bank charges \$20.00 for a bounced check.

\*\*As a courtesy to our clients our practice will send a reminder of your appointment 48 hours in advance via Text/Voice Mail. Please confirm via Text/Voice Mail within 48 hours.

**\*\*We have a No Show / Late-Cancellation Policy and Statement of Disclosure\*\***

Our cancellation policy reads as follows: A cancelled appointment delays our work.

When you must cancel, please give me 48 hours notice. We are rarely able to fill a cancellation unless we know At Least 24 Hours in Advance. If you are unable to provide AT LEAST 24 Hours Notice when you cancel, you will be charged the full fee for your session. (if we are in network with your insurance carrier you will be charged “the contracted rate from the insurance” carrier including the co-pay), unless we are able to fill it with another client. (You should note that insurance companies do not typically reimburse for missed appointments.) THE ONLY TIME WE WILL WAIVE THIS FEE IS IN THE EVENT OF SERIOUS OR CONTAGIOUS ILLNESS OR EMERGENCY.

Signatures:

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Print Name/parent/guardian Date:

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Psychologist and or Office Manager Date:

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## Dr. Brad Shamis & Associates, LLC

### Updated policy on Letters, Forms, and Legal Documents effective January 1, 2017

The following policies are guidelines and all letters and forms are subject to the discretion of our therapists:

You must be an existing and active client or at least 90 days in order to request any form or letter (Exceptions apply at the discretion of the Provider and or Office Manager.) Any letter written for personal, employment or school use will be given within 14 business days and will carry a fee of \$35.00.

Any form for employment, medical leave, school or disability will be given within 7 business days and will carry a fee of \$55.00.

\*\* Dr. Brad Shamis & Associates, LLC will not be involved in any legal matters. We will not write letters or fill out forms for lawyers, custody issues, court cases or any legal issues.

Dr. Brad Shamis & Associates, LLC will not fill out forms or write letters for homebound Services.

As always, your medical records can be requested at any time and will carry an administrative fee of \$35.00 which must be paid at the time of request. Please allow 7-10 business days to receive your medical records.

I have read, understand and agree to the above mentioned policies:

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Patient Name (Please Print)

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Patient Signature/Date

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Office manager Signature/Date  
And or Provider

4802 Neshaminy Blvd. - Ste - 6  
Bensalem, PA 19020

Phone: 215 - 752-2287  
Web-Site: [bradshamis.com](http://bradshamis.com)

301 Oxford Valley Road - Ste. - 1001-A  
Yardley, PA 19067

Fax 215 / 752-7094  
E-Mail: [shamisbrad@comcast.net](mailto:shamisbrad@comcast.net)

## Authorization to Disclose Protected Health Information to Primary Care Physician

Communication between behavioral health providers and your primary care physician (PCP) is important to ensure that you receive comprehensive and quality health care. This form will allow your Behavioral Health Provider to share protected health information (PHI) with your Primary Care Physician (PCP). This information will not be released without your signed authorization. This PHI may include diagnosis, treatment plan, progress, and medication if necessary.

\_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
(Patient Name – Please Print) (Patient Identification Number) (Patient Date of Birth – MM/DD/YYYY)

I authorize \_\_\_\_\_, to release protected health information related to my evaluation and treatment to:

PCP Name: \_\_\_\_\_ PCP Phone: \_\_\_\_\_

PCP Address: \_\_\_\_\_  
(Street) (City) (State) (Zip Code)

### Information to be completed by Behavioral Health Provider

I saw: \_\_\_\_\_ on \_\_\_\_\_ for \_\_\_\_\_  
(Patient Name – Please Print) (Date) (Reason / Diagnosis)

Summary: \_\_\_\_\_

The following medication was or will be started (indicate medication & dosage): \_\_\_\_\_

### If no medication is indicated, check as appropriate:

\_\_\_\_\_ Medication not prescribed \_\_\_\_\_ Patient refused medication \_\_\_\_\_ Psychotherapy suggested before trying medication

### Treatment recommendations:

Lab tests for the following: \_\_\_\_\_ CBC \_\_\_\_\_ Thyroid Studies \_\_\_\_\_ Chem Panel \_\_\_\_\_ EKG

Other treatment recommendations: \_\_\_\_\_

If you have any questions or would like to discuss this case in greater detail, please call me at: \_\_\_\_\_  
(Phone Number)

\_\_\_\_\_  
(Provider Signature) (Provider Printed Name) (Licensure)

### Patient Rights

- You can end this authorization (permission to use or disclose information) any time by contacting: \_\_\_\_\_
- If you make a request to end this authorization, it will not include information that has already been used or disclosed based on your previous permission. For more information about this and other rights, please see the applicable Notice of Privacy Practices.
- You cannot be required to sign this form as a condition of treatment, payment, enrollment, or eligibility for benefits.
- Information that is disclosed as a result of this Authorization Form may be re-disclosed by the recipient and no longer protected by law.
- You do not have to agree to this request to use or disclose your information.

### Patient Authorization

I, the undersigned understand that I may revoke this consent at any time except to the extent that action has been taken in reliance upon it and that in any event this consent shall expire six (6) months from the date of signature, unless another date is specified. I have read and understand the above information and give my Authorization:

### PATIENT PLEASE CHECK ONE

- \_\_\_\_\_ To release any applicable mental health / substance abuse information to my primary care physician.  
\_\_\_\_\_ To release only medication information to my primary care physician.  
\_\_\_\_\_ I **DO NOT** give my authorization to release any information to my primary care physician.

\_\_\_\_\_  
(Patient Signature) (Date) (Signature of Patient's Authorized Representative) (Date)

If signed by Authorized Representative, describe relationship to patient: \_\_\_\_\_

**PROVIDER: PLEASE SEND A COPY OF THIS SIGNED FORM TO THE PRIMARY CARE PHYSICIAN AND KEEP THE ORIGINAL IN THE TREATMENT RECORD**

# DR. BRAD SHAMIS & ASSOCIATES, LLC

## NOTICE OF HIPPA 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.

We have a legal obligation to protect your health information. We are required by law to:

- Assure 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
- Follow the terms of notice that is currently in effect.

You may request a copy of his notice at any time by contacting our Complaints/Client Rights Officer.

Dr. Brad Shamis & Assoc., LLC collects health information from you and stores it in a paper chart and on a computer.

We use and disclose your information as explained below:

1. Use and disclosures that require your consent and authorization:
  - a. Consent/Authorization: With your consent/authorization, we may use/disclose your protected health information (PHI) to anyone with your written permission. Unless you give us written authorization, we cannot use or disclose your PHI for any reason except those described in this notice. If you request, we will fax or email the information to the recipient identified on the authorization. However, the privacy of either of these alternate delivery methods cannot be assured by Dr. Brad Shamis & Assoc., LLC.
  - b. To Your Family, Friend, Employers or Others: We may disclose your PHI to a family member, friend, employer, or other persons to the extent necessary to help with your health care or with payment of your health care if you give us written authorization to do so.
2. Use and disclosure that do not require your consent/ authorization:
  - a. For Treatment: We may use medical information about you to provide you with behavioral health and medical treatment or services. We may disclose information to other practice personnel such as doctors, nurses, counselors, etc., or people outside the practice who may be involved in your care.
  - b. For Payment: We may use and disclose medical information about you to our Billing Services and your health plan so that the treatment and service you receive from us may be billed to and payment may be collected from you, your insurance company, or third party.
  - c. For HealthCare Operations: We may use and disclose information about you necessary to operate our business and to make sure that all our clients receive quality care. For example, we may use medical information to review our treatment and services and evaluate the performance of our staff in caring for you. We may use and disclose information about you to health oversight agencies for audits, surveys, inspections, certification and investigations.
  - d. When required by Federal State, or Local law, judicial or administrative proceeding or law enforcement: We will disclose your information when a law requires that we report information to government agencies and law enforcement personnel about victims of abuse, neglect or domestic violence, in response to a court order, when necessary to avert serious threat to your health and safety and health of another person or the public.
  - e. Appointment Reminders: We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or services. We will contact you by telephone at the number you provide us to confirm appointments; and if you are not available, we will leave a message regarding an appointment or ask that you call Dr. Brad Shamis & Assoc., LLC, unless you tell us not to call.
  - f. Eligibility Determination Enrollment: We may disclose medical information for eligibility determination or enrollment into public benefit programs according to specific requirements.
  - g. Health-Related Benefits & Services/Treatment Alternative: We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you or tell you about or recommend possible treatment options or alternatives that may be of interest to you.
  - h. For Public Health Activities: To report information about births, deaths and various diseases to government officials in charge of collecting that information.
  - i. Correctional Institutions/Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose medical information about you to the correctional institution or law enforcement official. This disclosure would be necessary for the institution to provide you with health care; to protect your health and safety or the health and safety of others; or for the safety and security of the correctional institution.
  - j. Specific Government Functions: We may disclose your information to authorized federal officials or intelligence, counterintelligence, and other national security activities such as protective services for the President and others.
  - k. Workers' Compensation: We may disclose medical information about you for Workers' Compensation or similar programs. These programs provide benefits for work-related injuries and illness.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

1. You have the right to consent to the use and disclosure of your PHI for the limited purpose of diagnosing you and administering and paying for your treatment.
2. You have the right to authorize the sharing of your PHI for other purposes.
3. You have the right to inspect and obtain a copy of your PHI. Your request must be in writing. Dr. Brad Shamis & Assoc., LLC must respond to your request within 30 days from the date of your request. If your request to receive a copy of your PHI is approved, we may charge a reasonable fee for the costs of copying, mailing or other supplies associated with the request. In certain situations we may deny your request. If we so do, we will let you know in writing, our reason why and explain how you can have the denial reviewed.
4. You have the right to request that we amend you PHI, if you believe the information we have about you is incorrect or incomplete. You have the right to request an amendment as long as this information is kept by Dr. Brad Shamis & Assoc., LLC. Your request, including a reason for the amendment must be in writing. Dr. Brad Shamis & Assoc., LLC will respond to your request to amend your PHI within 60 days from the date of your request. We may deny your request to amend your PHI in certain situations. If we do, we will let you know, in writing our reason why and explain how you can have the denial reviewed.
5. You have the right to request confidential communication about medical matters in a certain way or at a certain location. We will accommodate all reasonable requests. Your request must be in writing and specify how or where you wish to be contacted.
6. You have the right to restrict how we use and disclose your PHI. We do not have to agree on your restrictions. If we do agree, we must follow your restrictions.
7. You have the right to request an accounting of disclosures. This is a list of disclosures we made of medical information about you. Your request must be in writing and must state a time period that may not be longer than six years and may not include dates for March 1, 2008.
8. You have a right to have a copy of this Privacy Notice.

Change to this notice

If our privacy policies should change at any time in the future, we will promptly change and post the new notice. We reserve the right to apply any changes to our privacy policies of this notice to all of the protected health information that we maintain including information collected before the date of the change.

REVOCATION: You may revoke your consent authorization for us to use and disclose PHI. You must do so in writing. We are permitted to use and disclose your PHI based on your consent/authorization until we receive your revocation. However, if you revoke your consent, we reserve the right to refuse to provide further treatment to you, on the basis of your refusal to allow us to share your information for the purposes of treatment, payment, and healthcare operations.

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 authorization to use or disclose medical information about you, you may revoke that authorization in writing at any time.

If you revoke your authorization, we will no longer use or disclose information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your authorization, and that we are required to retain our records of the care that we provide you.

FOR REQUESTS OR COMPLAINTS: If you have any questions about this notice or complaints about your privacy practices please contact: Dr. Brad Shamis & Assoc., LLC.

INITIAL HERE: \_\_\_\_\_

# Dr. Brad Shamis & Associates, LLC

Phone: 215-752-2287

Fax: 215-752-7094

## INFORMATION AND DISCLOSURE POLICY

Information is not disclosed without written permission. However, there are a number of exceptions to the rule.

### EXCEPTIONS:

1. Suspected child abuse or dependent adult or elderly abuse. The therapist is required by LAW to report this to appropriate authorities IMMEDIATELY.
2. If patient is threatening serious bodily harm to another person, the therapist Must Notify the police and inform the intended victim.
3. If patient intends to harm him/herself. The therapist will make every effort to enlist their cooperation in insuring their safety. If they do not cooperate, further measures may be taken without their permission in order to ensure their safety.

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(Please Print) Name of Patient and Date:

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Please Sign Name of Patient and Date:

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(Please Print) Patient/Parent/Guardian and Date:

---

Signature Patient/Parent/Guardian and Date:

**BRAD SHAMIS & ASSOCIATES, L.L.C.**

**BRAD SHAMIS, PhD**

***Neshaminy Medical/Professional Center***

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**PATIENT DATA**

Patient's Name: \_\_\_\_\_

Patient's Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Patient's Phone #: Home ( ) \_\_\_\_\_ Cell: ( ) \_\_\_\_\_

Patient's DOB: \_\_\_\_\_ Sex: M (\_\_\_\_) F (\_\_\_\_)

Marital Status: Married (\_\_\_\_) Single (\_\_\_\_) Social Security #: \_\_\_\_\_

Employer Name: \_\_\_\_\_

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

Emergency Contact: Name: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Phone #: ( ) \_\_\_\_\_ Cell #: ( ) \_\_\_\_\_

**Health Insurance Data**

**Insurance Company Name:** \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Phone Number: ( ) \_\_\_\_\_

Insurance Company I D #: \_\_\_\_\_ Group #: \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Subscriber's Telephone #: Home ( ) \_\_\_\_\_ Cell: ( ) \_\_\_\_\_

Subscriber's Social Security #: \_\_\_\_\_ Sex: M (\_\_\_\_) F (\_\_\_\_)

Relationship to Subscriber: Self: (\_\_\_\_) Spouse: (\_\_\_\_) Dependent: (\_\_\_\_)

**Secondary Ins. Co:** \_\_\_\_\_ I.D. # \_\_\_\_\_ Group #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Phone Number: ( ) \_\_\_\_\_

I have no Secondary Insurance: (\_\_\_\_)

Please sign: \_\_\_\_\_ Date: \_\_\_\_\_



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DR. BRAD SHAMIS, Ph.D.  
GILBERT SCHWARTZ, L.C.S.W.  
TAX ID: 23-3081378

**Insurance Authorization Form**

DATE: \_\_\_\_\_ EFF. DATE: \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

INS. CO. \_\_\_\_\_

TELEPHONE #: \_\_\_\_\_

# OF VISITS: \_\_\_\_\_

AUTHORIZATION #: \_\_\_\_\_

DEDUCTIBLE \$: \_\_\_\_\_ MET: ( ) Y \_\_\_\_\_ ( ) N \_\_\_\_\_

COPAYMENTS\$: \_\_\_\_\_

SUBMIT CLAIM TO: \_\_\_\_\_

\_\_\_\_\_  
SPOKE TO: \_\_\_\_\_

TIME OF CALL: \_\_\_\_\_

CALL RECORDED: ( ) Y \_\_\_\_\_ ( ) N \_\_\_\_\_

PRE-CERTIFICATION REQUIRED: ( ) Y \_\_\_\_\_ ( ) N \_\_\_\_\_

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### **Consent to use or disclose your health information.**

This form is an agreement between you, \_\_\_\_\_  
and me Dr. Brad Shamis & Associates, LLC. When we use the word, you, below, it will mean  
your child, relative or other person if you have written his or her name here  
\_\_\_\_\_.

When we examine, diagnose, treat or refer you, we will be collecting what the law calls Protected Health Information (PHI) about you. We need to use this information here to decide on what treatment is best for you and to provide treatment to you. We may also share this information with others who provide treatment to you or need it to arrange payment for treatment or for other business or government functions.

By signing this form you are agreeing to let us use your information here and send it to others. The notice of Privacy Practices explains in more detail your rights and how we can use and share your information. Please read this before you sign this consent form. If you do not sign this Consent Form agreeing to what is in our Notice of Privacy Practices we cannot treat you.

If there is a breach of your confidentiality, then I must inform you as well as Health and Human Services. A breach means that information has been released without authorization or without legal authority unless I (the covered entity) can show that there was a low risk that the PHI has Been compromised because the unauthorized person did not view the PHI or it was de-identified. If you are self-pay, then you may restrict the information sent to insurance companies.

Most uses and disclosures of psychotherapy notes and of protected health information for marketing purposes and the sale of protected health information require an authorization. Other uses and disclosures not described in the notice will be made only with your written authorization. You must sign a (release of information form) for releases that are not mentioned in this Privacy Notice (such as mandated reporting of child abuse, reporting of elder abuse, reporting of impaired driver, etc.) You have a right to receive a copy of your Protected Health Information in an electronic format or (through a written authorization) designate a third party who may receive such information.

In the future we may change how we use and share your information and so may change our Notice of Privacy Practices. If we do change it you may get a copy by calling (215) 752-2287, or from our Privacy Officer. If you are concerned about some of your information, you have the right to ask us to not use or share some of your information for treatment, payment or administrative purposes. You will have the right to tell us what you want in writing. Although we will try to respect your wishes, we are not required to agree to these limitations. However, if we do agree, we promise to comply with your wishes.

After you have signed this consent, you have the right to revoke it, (by writing a letter telling us you no longer consent) and we will comply with your wishes about using or sharing your information from that time on but we may have already used or shared some of your information and cannot change that.

.....  
Signature of client or his or her personal representative

.....  
Date

.....  
Printed name of client or personal representative

.....  
Relationship to client

.....  
Description of personal representative's authority

Date of NPP, April 14, 2003, revised September 23, 2013  
Copy given to the client/parent/personal representative

**Dr. Brad Shamis & Associated, LLC**

Phone: 215-752-2287

Fax: 215-752-7094

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

Date: \_\_\_\_\_

**INFORMED CONSENT and DISCLOSURE FOR TREATMENT**

I \_\_\_\_\_ (name of patient) agree and consent to participate in behavioral health care services offered and provided at/by \_\_\_\_\_ (name of provider) a behavioral health care provider. I understand that I am consenting and agreeing only to those services that the above named provider is qualified to provide within: (1) the scope of the provider's license, certification, and training; or (2) the scope of license, certification, and training of the behavioral health care providers directly supervising the services received by the patient.

I also authorize the following:

- (A.) The use of this form on all my insurance submissions.
- (B.) The responsibility to pay for my bill if my insurance company does not pay for it.
- (C.) The release of information to all my insurance carriers.
- (D.) I authorize my doctor to act as my agent in helping me obtain payment from my insurance carriers.
- (E.) Direct insurance payments to my doctor.
- (F.) I permit a copy of this authorization to be used in place of the original.

If the patient is under the age of eighteen or unable to consent to treatment, I attest that I have legal custody of this individual and am authorized to initiate and consent for treatment and/or legally authorized to initiate and consent to treatment on behalf of this individual.

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

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

Relationship to Patient ( If applicable ): \_\_\_\_\_

TEL: (215) 752-2287 / FAX: (215) – 752-7094

**DR. BRAD SHAMIS & ASSOCIATES, LLC**  
**LICENSED PSYCHOLOGISTS**

---

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

**Statement of Member's Right**

Members have the right to fair treatment, regardless of their race

Members have the right to fair treatment, regardless of their race, religion, gender, ethnicity, age disability or source of payment.

Members have the right to have their treatment and other member information kept private. Only where permitted by law, may records be released without member permission.

Members have the right to easily access timely care in a timely fashion.

Members have the right to know about their treatment choices. This is regardless of cost or coverage by the member's benefit plan.

Members have the right to share in developing their plan of care

Members have the right to information in a language they can understand.

Members have the right to have a clear explanation of their condition and treatment options.

Members have the right to information about your managed care, company, its practitioners, services and role in the treatment process.

Members have the right to information about your managed care. used in providing and managing their care.

Members have the right to ask their provider about their work history and training.

Members have the right to give input on the Member's Rights and Responsibilities policy.

Members have the right to know about advocacy and community groups and prevention services.

Members have a right to feely file a complaint or appeal and to learn how to do so.

Members have a right to know of their rights and responsibilities In the treatment process.

Members have the right to receive services that will not jeopardize their employment.

Members have the right to list certain preferences in a provider.

**Statement of Member's Responsible**

Members have the responsibility to treat those giving them care with dignity and respect.

Members have the responsibility to give providers information they need. This is so providers can provide their best possible care.

Members have the responsibility to ask questions about their care. This is to help them understand their care.

Members have the responsibility to follow the treatment plan. The plan of care is to be agreed upon by the member and provider.

Members have the responsibility to follow the agreed upon medication plan,

Members have the responsibility to tell their provider and primary care physician about medication changes including medications given to them by others.

Members have the responsibility to keep their appointments. Members should call their provider as soon as they know they need to cancel visits.

Members have the responsibility to let their provider know when the treatment plan isn't working for them.

Members have the responsibility to let their provider know about any problems with paying fees.

Members have the responsibility to report abuse and/or fraud.

Members have the responsibility to openly report their concerns about the quality of care they receive.

My signature shows that I have been informed of my rights and responsibilities, and that I understand this information.

\_\_\_\_\_  
Member signature

\_\_\_\_\_  
Date

The signature below shows that I have explained this statement to the patient. I have offered the member a copy of this form.

\_\_\_\_\_  
Provider

\_\_\_\_\_  
Date

Approved August 2, 2002