Mindful
Behavioral Healthcare

New Patient Information and Consent for Treatment Form

Formulario de Información Demográfica y Consentimiento para Tratamiento de Pacientes Nuevos

Date (Fecha): _____ ☐ New Patient ☐ Existing Patient

Last Name (Apellido): _____ **First Name** (Nombre): _____ **Middle Initial** (Inicial): _____

Address (Dirección): _____

City (Ciudad): _____ **State** (Estado): _____ **Zip Code** (Zona Postal): _____

Primary Phone (Telefóno Primario): _____ **Secondary Phone** (Telefóno Secundario): _____

Date of Birth (Fecha de Nacimiento): _____ **Social Security #** (Seguro Social): _____

Legal Status (Estatus Legal): ☐ **Minor** (Menor) ☐ **Single** (Soltero[a]) ☐ **Married** (Casado[a]) ☐ **Widowed** (Viudo[a])
☐ **Separated** (Separado[a]) ☐ **Divorced** (Divorciado[a])

Ethnicity (Etnicidad): ☐ **Hispanic/(Latino)** ☐ **Not Hispanic/(Not Latino)** ☐ **Prefer not to Answer** (Prefiero no Responder)

Race (Raza): ☐ **American Indian/Alaska Native** ☐ **Asian** ☐ **Black/African American** ☐ **White**
☐ **Other***:* _____ ☐ **I Prefer not to Answer**

Employer (Empleo): _____ **Occupation** (Ocupación): _____

E-mail: _____

Preferred method of contact (Método de contacto preferido) ☐ **Text** ☐ **E-mail** ☐ **Phone Call** (Llamada Telefónica)

Please be aware that if you choose the text or call option to receive appointment reminders, message and data rates may apply. (Queremos recordarle que si utiliza el sistema de mensajes or llamadas a través del teléfono, le podrían aplicar cargos).

If you are not 18 years of age, a parent or guardian must sign these forms for consent to treat you and financial responsibility. (Si es menor de 18 años de edad, el padre o guardián tiene que firmar el Formulario de Consentimiento para Proveer Tratamiento y confirmar la responsabilidad financiera).

Parent/Guardian Name (Nombre del Padre/Guardián): _____

Medical Insurance Information (Información de Seguro Médico)

Name of Insured (Nombre de Asegurado): _____ **Date of Birth** (Fecha de Nacimiento): _____

If you are financially responsible for all charges, please check here: ☐
(Si usted es responsable financieramente de todos los cargos, favor de marcar aquí)

Relation to Patient (Relación con el Paciente): _____ **Social Security #** (Seguro Social): _____

Insurance Company (Compañía de Seguro): _____ **Group #** (Número de Grupo): _____

ID # (Número de Identificación)**:** _____ **Phone**: (Teléfono): _____

Address (Dirección): _____ **City** (Ciudad): _____

State (Estado): _____ **Zip Code** (Zona Postal): _____

Primary Care Physician (Médico Primario)

Name (Nombre): _____ **Phone** (Teléfono): _____ **Fax**(Facsímil): _____

I do not have a Primary Care Physician (Yo no tengo un Médico Primario): ☐

Emergency Contact (Contacto en Caso de Emergencia)

Name (Nombre): _____ **Relationship** (Relación): _____ **Phone** (Telefóno): _____

Medications (Medicamentos)

Pharmacy Name (Nombre de la Farmacia): _____ **Phone** (Teléfono): _____

Current List of Medications (Lista de Medicamentos Actuales):

I am not currently on any medications (Yo no estoy tomando ningún medicamento en este momento): ☐

Include the Medication Name, Dosage and Frequency: (Incluya el Nombre del Medicamento, Dósis y Frecuencia)

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

If additional space is needed, please attach the list of medications or bring the list to your appointment
(Si se necesita espacio adicional, por favor adjunte la lista de medicamentos o traiga la lista a su cita)

Consent for Treatment *(Consentimiento Para Tratamiento)*

*I, _____, authorize **Mindful Behavioral Healthcare (MBH)** to provide evaluation and treatment of psychiatric and/or counseling services for myself or_____ (patient's name, if minor). I understand that although **MBH** strives in providing the best treatment possible for its patients, there are no guarantees that the treatment provided may yield the desired results. Every treatment will be conducted in a **confidential** manner, as stated under the **HIPAA Regulations.** Disclosure of confidential information will not be permitted unless specifically authorized in writing by the patient or guardian, or under a subpoena issued by a court. I understand that **MBH** is obligated by Florida Statutes 827.03 and 394.451-394.47892 to report any suspiciousness of child abuse and/or neglect or if they demonstrate potential to cause harm to self or others. In addition, I understand that **MBH** must report to the local Health Department any HIV status/infection or potential infection to a partner that the patient has identified pursuant to Florida Statute 456.061(1), F.S. and Rule 64D-2.00.(2)(I), F.A.C. I am aware that **MBH** is committed to the training and education of individuals in the mental health field. I have the right to authorize or decline giving information and/or be evaluated by any staff in training.*

*Yo, _____, autorizo a **Mindful Behavioral Healthcare (MBH)** a ofrecer servicios de evaluación y tratamiento psiquiátrico, y/o de consejería para mí o _____ (nombre del paciente, si es menor de edad). Entiendo que aunque **MBH** se esmera en proporcionar el mejor tratamiento posible a sus pacientes, el tratamiento provisto no siempre produce ni garantiza los resultados deseados. Cada tratamiento se llevará a cabo de manera **confidencia**l, según las **reglamentaciones de HIPAA**. No se permitirá la divulgación de información confidencial sin la autorización escrita del paciente o guardián, o bajo una orden judicial emitida por un tribunal. Entiendo que **MBH** está obligado por ley en el estado de la Florida, Estatuto 827.03 y 394.451-394.47892, a reportar cualquier sospecha de abuso y/o abandono, o si un paciente demuestra la posibilidad de causar daño a sí mismo o a otras personas. En adición, nos reservamos el derecho de reportar al Departmento de Salud o a terceras personas la posibilidad de Infección o estatus de HIV de personas identificadas por el paciente de acuerdo a las leyes del estado de la Florida Estatuto 456.061(1), F.S. y 64D2.003(2)(I), F.A.C. Entiendo que **MBH** entrena y educa a individuos en el área de salud mental. Me reservo el derecho de autorizar o declinar dar información y/o ser evaluado por cualquier personal en entrenamiento.*

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I or my minor child, have a change in the health condition. *(Entiendo que la información provista es completa y correcta. Comprendo que es mi responsabilidad informar a mi médico si hay cambios en mi condición de salud o la de mi hijo(a) menor de edad).*

_____	_____	_____
Patient's Signature (Firma del Paciente)	*Printed Name (Nombre en Letra de Molde)*	*Date (Fecha)*
_____	_____	_____
If applicable, Signature of (Si aplica, firma del):	*Printed Name (Nombre en Letra de Molde)*	*Date (Fecha)*

☐ *Parent (Padre)* ☐ *Guardian (Guardián)* ☐ *Power of Attorney (Poder de Abogado)*
☐ *Healthcare Surrogate/Proxy (Apoderado para Atención Medica)*

Mindful
Behavioral Healthcare

Authorization to Release and/or Obtain Confidential Information

Primary Care Provider & Family/Personal Representative

Autorización para Divulgar y/u Obtener Información Confidencial

Proveedor Primario de Servicio y Representante Familiar/Personal

Patient Name (Nombre del Paciente): _____ **SSN**: _____ **DOB**(Fecha de Nacimiento): _____

Address (Dirección): _____ **City** (Ciudad): _____ **State** (Estado): _____ **ZIP**: _____

Please note that this form is not a full medical records access request. For additional records requests, a separate Release of Information must be signed by the patient for that purpose. (Esta no es una solicitud de acceso a expedientes médicos completos. Para solicitudes de expedientes adicionales, el paciente se debe firmar una Autorización para Divulgar Información.)

I. **Primary Care/Referring Provider Authorization** (Autorización para Proveedor de Servicios Primarios/Referido)

For the purposes of coordinating my medical care, I authorize MBH to forward a copy of the initial visit record to my PCP/referring provider. In addition, I authorize MBH to contact and/or release copies of my progress notes when requested.

(Para coordinación de mi tratamiento médico, autorizo a MBH a enviar una copia de mi expediente de la visita inicial a mi médico primario/referido. Además, autorizo a MBH a contactar y/o proveer copias de mis notas de progreso cuando se soliciten.)

Primary Care Provider ☐ Yes ☐ No **Physician's Name** (Nombre del Médico): _____

(Proveedor de Cuidado Primario) **Phone Number** (Teléfono): _____ **Fax** (Facsímil): _____

Referring Provider ☐ Yes ☐ No **Referring Provider's Name** (Nombre del Médico que Refiere): _____

(Proveedor de Servicios que Refiere) **Phone Number** (Teléfono): _____ **Fax** (Facsímil): _____

II. Family Member/Personal Representative Authorization (Autorización para Representante Familiar/Personal)

I hereby authorize MBH to disclose the above patient's health care information to the following family member(s)/personal representative(s), for the following purpose(s):
(Yo autorizo a MBH a divulgar la información médica del paciente en referencia a los siguientes miembros de la familia/representantes personales, con el propósito de:)

- ☐ **Billing Information** (Información de Facturación)
- ☐ **Pick Up Forms or Letters** (Recoger Formularios o Cartas)
- ☐ **Pick Up Medical Records** (Recoger Expedientes Médicos)
- ☐ **Create/Cancel Appointments** (Crear/Cancelar Citas)
- ☐ **Pick Up Prescriptions** (Recoger Recetas)
- ☐ **Psychotherapy Summary** (Resumen de Psicoterapia)

a. **Name (Nombre)**: _____ **DOB (Fecha de Nacimiento)**: _____ **Relationship (Relación)**: _____

b. **Name (Nombre)**: _____ **DOB (Fecha de Nacimiento)**: _____ **Relationship (Relación)**: _____

I do not authorize MBH to communicate any health care information to any family member(s)/personal representatives: ☐
(No autorizo a MBH a proveer información de mi cuidado medico a ningún representante familiar or personal:)

This form is valid for *one year* and can be revoked by the patient or their legal representative at any time in writing to MBH. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my/the patient's ability to obtain treatment, payment for health care services or eligibility for benefits.

(Este formulario es válido por *un año* y puede ser revocado por escrito a MBH por el paciente o su representante legal en cualquier momento. Entiendo que me puedo negar a firmar esta autorización y que mi negativa a firmar no afectará mi capacidad o la del paciente para obtener tratamiento, pago de los servicios de atención médica o elegibilidad para recibir beneficios.)

Patient Signature (Firma del Paciente): _____ **Date** (Fecha): _____

Legal Representative's Signature, if applicable, (Firma del Representante Legal, si aplica): _____

Legal Representative's Printed Name (Nombre del Representante Legal en Letra de Molde): _____

Relationship to Patient (Relación con el Paciente)**:** _____ **Date** (Fecha): _____
If the patient is an adult, documentation of the legal representative must be provided and attached to this form
(Si el paciente es un adulto, documentación del representante legal se debe proporcionar e incluir con este formulario)

Mindful
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Telemedicine Authorization Form
Formulario Para Autorización de Telemedicina

Patient's Name (*Nombre del Paciente*): _____ Date of Birth (*Fecha de Nacimiento*): _____

I authorize **Mindful Behavioral Healthcare (MBH)** and its contracted providers to provide me with their services by using telemedicine. I understand that telemedicine is the use of electronic information and communication technologies by a healthcare provider used to deliver services to an individual when they are located at a different location or site than I am. **MBH** and its contracted providers will not perform an in-person examination during the telemedicine visit. They will rely solely on the information telecommunicated.

I understand that there are risks involved with telemedicine, including but not limited to: loss of records from failure of electronic equipment; power failure with loss of communication; connections issues, etc. Additionally, signs and symptoms that might be detected during an in-person examination may not be detected through telemedicine.

I understand that the laws that protect privacy and the confidentiality of medical information, including HIPPA, also apply to telemedicine. I understand that I will be responsible for any copayments or coinsurances that apply to my telemedicine visit. I understand that I have the right to withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.

Yo autorizo **a Mindful Behavioral Healthcare (MBH)** y sus proveedores contratados a proveer sus servicios usando telemedicina. Entiendo que la telemedicina es el uso de tecnologías electrónicas de información y comunicación por parte de un proveedor de salud que se utiliza para proveer servicios a un individuo en un lugar o sitio diferente al que yo estoy. **MBH** y sus proveedores contratados no realizarán un examen físico en persona durante la visita de telemedicina. Se basarán únicamente en la información telecomunicada.

Entiendo que existen riesgos relacionados con la telemedicina, que incluyen, entre otros: pérdida de registros por falla de equipos electrónicos; falla de energía resultando en pérdida de comunicación; problemas de conexión, etc. Además, los signos y síntomas que pueden ser detectados durante un examen en persona pueden no detectarse a través de la telemedicina.

Entiendo que las leyes que protegen la privacidad y la confidencialidad de la información médica, incluyendo HIPPA, también se aplican a la telemedicina. Entiendo que seré responsable de cualquier copago o coseguro que se aplique a mi visita de telemedicina. Entiendo que tengo derecho a retirar mi consentimiento para el uso de la telemedicina en el transcurso de mi tratamiento en cualquier momento, sin afectar mi tratamiento en el futuro.

I have read and understood the information provided above and I consent to receiving telemedicine services.
Yo he leído y entiendo la información proporcionada anteriormente y consiento a recibir servicios de telemedicina.

_____	_____	_____
Patient's Signature (*Firma del Paciente*)	Printed Name (*Nombre en Letra de Molde*)	Date (*Fecha*)
_____	_____	_____
If applicable, Signature of (*Si aplica, firma de*):	Printed Name (*Nombre en Letra de Molde*)	Date (*Fecha*)

☐ Parent (*Padre*) ☐ Guardian (*Guardián*)
☐ Healthcare Surrogate/Proxy (*Apoderado para Atención Medica*)
☐ Power of Attorney (*Poder de Abogado*)

Mindful
Behavioral Healthcare

Office Policies

We are here to serve the mental health needs of every patient. We request your cooperation in adhering to the following office policies in order to better help you and others that are in need of these services.

If you require these policies in Spanish, please ask the front desk for a copy. Thank you.
(Si necesita estas políticas en español, solicite una copia en la recepción. Gracias.)

Patient Rights & Responsibilites

Confidentiality

It is the policy of **MBH** to handle all patient information confidentially. We make every effort to provide our patients with an environment that is safe, private and respectful taking into consideration their particular needs. If you have a concern, we want to hear from you. We will do everything we can to ensure that your experience with us is of the highest quality.

Issues of Clinical Care

Mindful Behavioral Healthcare is committed to your participation in clinical care decisions. As a patient, you have the right to ask questions and receive answers regarding the course of the clinical care recommended to you by any of our health providers, including discontinuing care. We urge you to follow the healthcare directions given to you by our providers. However, if you have any doubts or concerns regarding the care prescribed by our providers, please call our office staff.

Patient Rights

The patient has the right to receive information from health providers and to discuss the benefits, risks and costs of appropriate treatment alternatives. Patients should receive guidance from their health providers as to what is the optimal course of action. Patients are also entitled to obtain copies or summaries of their medical records, to have their questions answered, to be advised of potential conflicts of interest that their health providers might have, and to receive independent professional opinions.

- The patient has the right to make decisions regarding the health care that is recommended by his or her health provider. Accordingly, patients may accept or refuse any recommended medical treatment.
- The patient has the right to courtesy, respect, dignity, responsiveness and timely attention to his or her needs, regardless of race, religion, ethnic or national origin, gender, age, sexual orientation, or disability.
- The patient has the right to confidentiality. The health provider should not reveal confidential communications or information without the consent of the patient, unless provided for by law or by the need to protect the welfare of the individual or the public interest.
- The patient has the right to continuity of health care. The health provider has an obligation to cooperate in the coordination of medically indicated care with other health providers treating the patient. The health provider may discontinue care but must provide the patient reasonable assistance, direction, and sufficient opportunity to make alternative arrangements.

Patient Responsibilities

- Good communication is essential to a successful health provider-patient relationship. To the extent possible, patients have a responsibility to be honest and express their concerns clearly to their health providers.
- Patients have a responsibility to provide a complete medical history to the best of their knowledge, including information about past illnesses, medications, hospitalizations, family history of illness and other matters relating to their present health.
- Patients have a responsibility to request information or clarification about their health status or treatment when they do not fully understand what has been described.

- Once patients and health providers agree upon the goals of therapy, patients have a responsibility to cooperate with the treatment plan. Compliance with their health provider's instructions is often essential to public and individual safety. Patients also have a responsibility to truthfully disclose whether previously agreed upon treatments are being followed and to indicate when they would like to reconsider the treatment plan.
- Patients should also have an active interest in the effects of their conduct on others and refrain from behavior that places the health of others at risk.

Administrative Policies

Payments

Every patient is responsible for paying fees and balances that are not covered by his/her insurance at the time of the appointment. If the patient is in a grace period with their insurance company, then MBH reserves the right to charge our regular fee for that appointment. If you need to make special payment arrangements, please discuss this with our office staff before your visit. If a patient fails to make the proper restitution of any pending balance within a reasonable time, we will proceed to refer his/her account to a collection agency according to our financial policy and those terms under the Fair Debt Collection Practices Act.

Check-In Time

Appointments are reserved and should start promptly. **We advise that you arrive at the office at least 15 minutes prior to your scheduled appointment in order to ensure our ability to check you in on time.** If you arrive five minutes past your appointment time, we reserve the right to reschedule your appointment or have you seen by another available provider on that day.

No Show/Late Cancellations

Missed appointments or appointments that are not canceled with a minimum of 48 hours' notice, will be charged **a fee of $50.00. For Saturday and TMS (Transcranial Magnetic Stimulation) appointments, the fee will be $50.00.** Insurance companies will not reimburse the patient for this charge nor will **MBH** bill the insurance for it. Our Scheduling Department staff may call, e-mail and text patients to confirm their appointments as a courtesy service, but it is the patients' responsibility to keep track of their appointment dates.

Patient Responsibilities

It is the patient's and/or guardian's responsibility to inform **MBH** of any telephone, address, and insurance information changes in order to ensure proper continuation of services.

Other Service Charges

There will be a charge for the preparation and completion of reports, letters, certificates and forms related to the services provided at this office. With few exceptions, most fees for the completion of these documents will be the patient's responsibility. Please ask our front desk staff for more information regarding the service fees. **All photocopies and requests of patients' medical records will be charged $1.00 per page, plus an administrative fee of $15.00.** Any changes to these fees will be informed in advance.

Service Animals

Mindful Behavioral Healthcare welcomes all Service Animals in compliance with Florida Statute 413.081 (Title XXX Social Welfare), Individuals with Disabilities Education Act (IDEA), and Section 504 of the Rehabilitation Act per Title III of the Americans with Disabilities Act (ADA*). A Service animal is defined as an animal (dog or miniature horse) that is trained to do work or perform tasks for an individual with a disability, including physical, sensory, psychiatric, intellectual or other mental disability.* The work done or tasks performed must be directly related to the individual's disability. *Please restrain from bringing support animals to the office, as they do not qualify under this definition*. At our discretion, you and your service animal may be required to be seated within a designated area for the safety and security of other patients/staff.

Video Surveillance

To ensure the safety and security of all individuals visiting our facilities, **MBH** will be conducting ongoing video surveillance recordings throughout the premises, with the exception of restrooms. Video recordings will not contain audio and can only be accessed by authorized management staff, designated personnel, or law enforcement officials. The footage *may* be intermittently viewed for quality assurance purposes. **MBH** will not utilize any of these recordings for promotional purposes. We will remain compliant with all HIPAA, State, County and Federal regulations to ensure patient confidentiality and safety at all times.

Clinical Policies

Emergencies

In the event of an emergency situation (such as when a patient feels out of control, is unable to care for him/herself, or have serious thoughts of harming him/herself or others)**, call 911 or go to the nearest Emergency Room**. If you have an urgent concern that you need to discuss with the physician, please call our office to reschedule your appointment for an earlier date. All phone messages left in our voice mail messaging system will be responded within 48 business hours by the appropriate office staff, according to the order in which they were received.

Confidentiality

Mindful Behavioral Healthcare adheres to strict confidentiality rules in accord with federal laws, state laws and HIPAA regulations. No information will be disclosed unless specifically authorized in writing by the patient or his/her guardian, or under subpoena issued by a court. There are rare exceptions to confidentiality, for example, when a patient expresses or reports a specific and serious intent to inflict harm to him/herself or others, your physician may break this agreement but only when necessary in order to ensure the patient's and others safety. By law, **MBH** also has the responsibility to report cases of abuse when the victim is a minor, elderly or disabled.

Mental Health Assessments

I agree, upon a request made by **MBH**, to complete a free of charge computerized mental health assessment using an iPad or tablet provided by this office which may be administered prior to my appointment with the physician or nurse practitioner with the purpose of measuring, summarizing and determining if I have symptoms of depression, anxiety and/or chronic pain.

Drug Testing

I hereby agree, upon the drug/alcohol testing policy of **MBH**, to submit to a drug or alcohol test and to furnish a sample of my urine for analysis, when requested. I understand and agree that if at any time I refuse to submit to a drug or alcohol test under this company's policy or if I otherwise fail to cooperate with the testing procedures, I will be subject to the cancellation of my appointment until said sample is produced. I further authorize and give full permission to have **MBH's** medical assistants send the samples collected to a laboratory for a screening test in order to determine the presence of any prohibited substances under its policy. I also authorize for the laboratory or other testing facility to release any and all documentation relating to the results of such test to **MBH,** for the purposes of monitoring my treatment.

Prescription Refills and Prior Authorizations

An administrative fee of $25.00 will be charged to the patient's account, at the office's discretion, for pharmacy phone-in, mail away and faxed prescription requests that have to be re-arranged as a result of a patient's actions (such as: lost prescription, failure to fill new prescription on time at the pharmacy and/or missed appointments). Medications will be prescribed only if the physician feels it is clinically appropriate. Insurance will not reimburse the patient for these charges, nor will Mindful Behavioral Healthcare bill the patient's insurance for them**.** In the case of prescriptions requiring prior authorizations, Mindful Behavioral Healthcare will proceed with due diligence to obtain approval. If denied, our office will only appeal the decision per clinical request. Should a patient request this service, the same fee will be applied.

Lost or Stolen Controlled Prescriptions

If a script for a controlled medication is stolen or lost, the patient or guardian must make a report to the police and submit that report or its reference number to our office staff in order to document it in the patient's chart and receive a script replacement. Our office may replace a prescription at the provider's discretion, but is limited to one prescription per year per patient.

Discharge of Services

At the company's discretion, a patient will be discharged from receiving services at this practice due to one or more of the following reasons: a mutual agreement between the patient and provider, lack of compliance with the treatment's requirements, having 3 or more appointments' no-shows or late cancellations, lapse in office visits for a 6-month period, and/or inappropriate/disrespectful behaviors or conduct (verbal and/or physical) towards staff or other patients while at our facility or over the telephone. Mindful Behavioral Healthcare reserves the right to reopen a patient's clinical file in order to continue receiving treatment at our facilities.

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Office Policies Acknowledgement
Reconocimiento de las Políticas de la Oficina

Please read, check each boxe and sign below:
(Por favor lea, marque los encasillados de verificación y firme abajo).

☐ I hereby have read and understood my rights and responsibilities as a patient of Mindful Behavioral Healthcare as described in the document ***Mindful Behavioral Healthcare's Patient Rights and Responsibilities.***

He leído y entiendo mis derechos y responsabilidades como paciente de Mindful Behavioral Healthcare según descritos en el documento ***Derechos y Responsabilidades del Paciente de Mindful Behavioral Healthcare****.*

☐ I hereby understand and agree to follow the terms described in the ***Administrative & Clinical Office Policies of Mindful Behavioral Healthcare***. Any violations or non-compliance to these policies, may lead to my dismissal as a patient from this practice.

Por la presente entiendo y estoy de acuerdo en cumplir con los términos descritos en ***la Política Administrativa y Clínica de Mindful Behavioral Healthcare****. Cualquier violación o incumplimiento de dichas políticas podría resultar en mi terminación como paciente de esta práctica.*

☐ I understand that **MBH** reserves the right to amend their office polices at any time and that I have the right to request a paper copy of these policies at any time.

Entiendo que MBH se reserva el derecho de modificar las políticas de su oficina en cualquier momento y que tengo derecho a solicitar una copia impresa de estas políticas en cualquier momento.

_____	_____	_____
Patient's Signature (*Firma del Paciente*)	Printed Name (*Nombre en Letra de Molde*)	Date (*Fecha*)

_____	_____	_____
If applicable, Signature of (*Si aplica, firma de*):	Printed Name (*Nombre en Letra de Molde*)	Date (*Fecha*)

☐ Parent (*Padre*) ☐ Guardian (*Guardián*)
☐ Healthcare Surrogate/Proxy (*Apoderado para Atención Medica*)
☐ Power of Attorney (*Poder de Abogado*)