

MEDICAL POLICY AND CONSENT TO TREATMENT

Eligibility for Service

Mental health services are not denied any person on the basis of race, color, gender, sexual orientation, creed, handicap, national origin, duration of residence, or age unless these issues are not within the clinicians' training or scope of practice.

Appointments

All services are provided by appointment. Following your initial interview, additional appointments are to be scheduled by office personnel.

On arrival to your appointment, check-in at the front desk and make payment due for service(s). Providers may elect to reschedule your appointment if co-payment, co-insurance, deductible, and/or no show fees are not paid and current.

A 24-hour advance notice **MUST** be given for cancelled appointments. If you do not show for your appointment or cancel with less than 24-hour notice, you will be charged for the scheduled time that was reserved. Insurance companies will not reimburse for sessions that you miss or do not attend. Payment for the no-show fee will be expected at your next session.

To make, change or cancel an appointment, you must speak directly to a Receptionist or Provider. In case of illness, you must call as soon as you know you can't come. Reasonable advance notice in appointment changes is still expected. If you leave a message on the phone recorder after business hours, that message will not be received until the next working day. Do not call the Answering Service regarding appointments.

We offer the option of a reminder call. These are not automatic. Due to confidentiality and staffing issues we are not always able to reach you. Missing or not receiving a reminder call does not remove your obligation for your appointment time.

Weather extremes are an occasional factor with appointments in the winter. If you are in doubt, call the office or listen to the radio. We follow the North Clackamas School District advisories. If the schools are closed, expect our office is closed, but it still helps to check. Providers will update their message on their individual voice mail as long as the phones are working.

Medication Treatment Services

Medication treatment is one of the options offered by Psychiatrists (medical doctors) and PMHNP (psychiatric mental health nurse practitioners).

Your Provider will encourage you to ask questions about the medications prescribed and possible side-effects that may occur. Your Provider will attempt to give the most up-to-date information about the medications, alternative treatments, risks or side effects. In the allotted time it is impossible to cover every single side effect you may encounter. Full prescribing information is available at your request for any medication. If you have any specific concerns or have had any previous bad reactions (especially allergies) to a medication, tell your Provider.

All other medical conditions that you have may also impact your treatment. Please provide your treating practitioner with a list of all medications you take. If you are not sure, look them up and report back with notes on doses and frequency. Medication interactions are a significant cause of unwanted side effects and may be avoided if your Provider is informed of changes you have made. Even if the changes are with “over-the-counter” or “natural” agents, they may have significant interaction risks. This especially includes “St. John’s Wort”, “5-HT”, “Melatonin” or other vitamin supplements.

Primary Care Doctors are an important link in continuity of care. As well, medical treatment records are very important to providing an accurate assessment. If there are records from your Primary Care or other providers, please inform the staff. They will have you sign a Release of Information form so it can be sent for records.

Medication Refill Policy

Prescriptions and prescription refills need to be written during your scheduled appointment. If you need medications refilled prior to your next scheduled appointment, contact your pharmacy to fax the prescription refill to this office. Some medications can not be refilled by phone or fax. These are called “controlled” or “scheduled” medications. They require written and hand signed prescriptions each month. Providers are available to fill refill request Monday through Thursday during regular office hours (8am to 5pm), only. Allow 48 hours for completion of written prescriptions.

For all other prescription refills, call the pharmacy and ask them to fax over the refill request. Allow 3-5 days for completion. We can not guarantee same day or 24 hour service.

Your Provider may decline refill requests if clients fail to keep scheduled appointments or have not been seen for evaluation within the past six months.

Please do not call the Answering Service for prescription requests.

Confidentiality

In general, the law protects the confidentiality of all communications between the client and mental health care provider. We can only release information to others with your written permission. However, there are exceptions. A Provider may be subpoenaed to testify in court and information may be required to be given without your permission. If we are subpoenaed, we will make an effort to contact you. If you oppose release of information, a court may nevertheless require compliance with a subpoena. In some circumstances, a judge may require testimony even though we have claimed client-doctor privilege on your behalf. The judge may determine that resolution of the issue(s) demands it. If you claim an emotional condition in a civil or criminal court proceeding, this also removes confidentiality.

There are some situations in which the Provider is legally required to take action to protect others from harm. This may require revealing information about treatment. Clients should be aware if we believe or it is mentioned to us that a child, an elderly person or disabled person is being abused, we are legally required to report the instance(s) to the appropriate agency.

If a client threatens to harm him/herself, we may be required to seek hospitalization, contact family members or contact others who can provide protection. This would include calling civil authorities. If we believe the client is threatening serious bodily harm to another, we may be required to take protective action. This may include notifying the potential victim, the police, or seeking appropriate hospitalization for the client. These situations have rarely arisen in our practice but, should such a situation occur, we would make every effort to discuss it with you before taking action.

If you are seeing more than one clinician at Cornerstone, we may occasionally find it helpful to consult with the other clinician(s) to attempt to coordinate your care. This may be done through case review without requesting your written permission. Please understand that this will be standard of care unless you choose to place a restriction upon the sharing of information.

Because of confidentiality, we can not release information about your visits or treatment to anyone without your knowledge and written consent. Help us honor your privacy by informing us of any exceptions and completing a Release of Information Form for the exceptions.

This practice reviews cases for quality assurance. A utilization review/quality assurance group set up by your insurance company or members of this practice may review your case.

Minors

If you are under 18 years of age, the law may require we provide your parents with the right to examine your treatment records. It is our policy to request an agreement from parents that they will not ask what you are specifically saying in therapy. If they agree, we will provide them only with general information on how your treatment is proceeding. If we feel there is a high risk that you will seriously harm yourself or another, we will have to notify them of our concern. We will also be available to answer general questions to provide family sessions.

Parents of minor clients hold the legal Right of Privilege or Confidentiality. A non-custodial parent who wants to learn about their child's treatment may have the right to review the child's record and discuss their child's care with the Provider. It is our experience that therapy can be greatly hindered if teens feel the clinician is simply a conduit to their parents and many are reluctant to discuss personal issues about privacy. Therefore, the office has the following policy: parents are given general information about therapeutic progress. Teens are informed of phone calls or contact by the parents. When parents are consulted, minors are given the option to remain or leave the room. For difficult issues, family sessions are encouraged with the child's therapist and parents.

Professional Fees, Billing, Payment of Fees

Fees for services are based on a schedule set by each Provider. Charges are based on length of appointment and complexity involved in the management of care. Additional charges may be incurred for report writing that is outside routine treatment plan request that insurance will not cover.

In accepting treatment at Cornerstone Clinical Services, the client agrees to pay for professional fees at time they are rendered. Payment is expected at time of check-in for appointment. Payments may be made to Cornerstone Clinical Services by cash, check or credit card. There is a \$25.00 service charge for NSF / Returned checks.

If services are covered by insurance, we will bill the insurance company directly. It is the client's responsibility to inform Cornerstone of any changes to insurance coverage, eligibility or personal information, such as address or phone number. Clients are responsible to pay at time of service any amounts due for deductibles, co-insurance, or co-payments.

Clients should be aware insurance billing requires us to provide a clinical diagnosis. Depending on the insurance carrier, additional clinical information may be requested. This may include treatment plan, summary or in rare cases a copy of the entire record. This information will become part of the insurance company files. Insurance companies claim to keep information confidential, but once it is in their hands, Cornerstone has no

control over what they do with it. In some cases they may share the information with a national medical information databank. If you request, we will provide you with a copy of any report that we submit. It is important to remember you have the right to pay for services yourself and avoid the complexities that are described above, in which case the insurance company would not be billed.

If you have a balance on your account, a statement will be mailed on a monthly basis. All accounts are due and payable upon receipt of notification. Consistent payment must be made or services will be discontinued. In the case of minors or when other arrangements are made, the person receiving the service is financially responsible.

If you have questions regarding the payment of fees, please discuss it with office personnel or the billing department. If a client fails to be responsible for the account and it is necessary to refer a delinquent account to a collection agency or attorney, the client agrees to pay all costs affixed by the court, collection agency or attorney.

Emergencies

While we are usually in the office during normal business hours, we are not always available to answer questions. If you have a non-emergency during business hours, be prepared to leave a short message along with a phone number and time we can reach you.

In case of an immediate emergency, first contact 9-1-1 or go to an Emergency Department at the nearest hospital for evaluation and treatment. In the event you need to contact the Provider call the office directly. The clinic has a 24 hour Answering Service, which you may call to request your Provider contact you. Please *specify it is a medication related issue*, or they may contact the Psychologist on-call, thus delaying response time to you. If your Provider is not on-call, another Cornerstone Clinical Services medical Provider will contact you. In the event that a delay in response could be a risk or result in injury, you must call 9-1-1 or go to the nearest Emergency Department.

The Answering Service is only to be called when Cornerstone Clinical Services is not open. **USE THE ANSWERING SERVICE FOR EMERGENCIES AND THE RESPONSE TIME IS NOT CRITICAL.** Do not contact them for cancellation of appointments or medication refills. Call the office and / or your Pharmacy for those issues.

Grievances

If you have a grievance regarding any services received at Cornerstone Clinical Services, please note your right to explore these concerns with your specific clinician, the owners of the corporation, your specific health insurance company or the Oregon State licensing board for the discipline of your provider.

Client Endorsement

After reading these policies, please sign below. By signing you express you have read and understand the policies. Return the form to the front desk. You may request a copy for your records.

I have read and understand this policy in its entirety and accept its provisions.

SIGNED _____ **DATE** _____
(parent or legal guardian , if patient is a minor)

PRINT NAME _____

WITNESS _____ **DATE** _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW CLINICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW IT CAREFULLY

*If you have questions about this notice, please contact the privacy officer at
Cornerstone Clinical Services, P.C.
6400 SE Lake Road, Suite 325, Milwaukie, OR 97222*

WHO WILL FOLLOW THIS NOTICE

This notice describes the information privacy practices followed by our employees, staff and other office personnel.

YOUR HEALTH INFORMATION

This notice applies to the information and records we have about your health, health status, and the health care and services you receive at this office. Your health information may include information created and received by this office, may be in the form of written or electronic records or spoken words, and may include information about your health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose health information for the following purposes:

For Treatment. We may use health information about you to provide you with clinical treatment or services. We may disclose health information about you to doctors, nurses, technicians, office staff or other personnel who are involved in taking care of you and your health.

For example, your doctor may be treating you for a heart condition and may need to know if you have other health problems that could complicate your treatment. The doctor may use your clinical history to decide what treatment is best for you. The doctor may also tell another doctor about your condition so that doctor can help determine the most appropriate care for you.

Different personnel in our office may share information about you and disclose information to people who do not work in our office in order to coordinate your care, such as phoning in prescriptions to your pharmacy, scheduling lab work and ordering x-rays. Family members and other health care providers may be part of your clinical care outside this office and may require information about you that we have.

For Payment. We may use and disclose health information about you so that the treatment and services you receive at this office may be billed to and payment may be collected from you, an insurance company or a third party.

For example, we may need to give your health plan information about a service you received here so your health plan will pay us or reimburse you for the service. We may also tell your health plan about a treatment you are going to receive to obtain prior approval, or to determine whether your plan will pay for treatment.

For Health Care Operations. We may use and disclose health information about you in order to run the office and make sure that you and our other patients receive quality care.

For example, we may use your health information to evaluate the performance of our staff in caring for you. We may also use health information about all or many of our patients to help us decide what additional services we should offer, how we can become more efficient, or whether certain new treatments are effective.

We may also disclose your health information to health plans that provide you insurance coverage and other health care providers that care for you. Our disclosures of your health information to plans and other providers may be for the purpose of helping these plans and providers improve care, reduce cost, coordinate and manage health care and services, train staff and comply with the law.

Appointment Reminders. We may contact you as a reminder that you have an appointment for treatment or clinical care at the office.

Treatment Alternatives. We may tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Health-Related Products and Services. We may tell you about health-related products or services that may be of interest to you.

Please notify us if you do not wish to be contacted for appointment reminders, or if you do not wish to receive communications about treatment alternatives or health-related products and services. If you advise us **in writing** (at the address listed at the top of this Notice) that you do not wish to receive such communications, we will not use or disclose your information for these purposes.

SPECIAL SITUATIONS

We may use or disclose health information about you for the following purposes, subject to all applicable legal requirements and limitations:

To Avert a Serious Threat to Health or Safety. We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Required by Law. We will disclose health information about you when required to do so by federal, state or local law.

Research. We may use and disclose health information about you for research projects that are subject to a special approval process. We will ask you for your permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the office.

Military, Veterans, National Security and Intelligence. If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you. We may also release information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation. We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.

Health Oversight Activities. We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.

Law Enforcement. We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.

Information Not Personally Identifiable. We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

Family and Friends. We may disclose health information about you to your family members or friends if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment, that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse when you bring your spouse with you into the exam room during treatment or while treatment is discussed.

In situations where you are not capable of giving consent (because you are not present or due to your incapacity or medical emergency), we may, using our professional judgment, determine that a disclosure to your family member or friend is in your best interest. In that situation, we will disclose only health information relevant to the person's involvement in your care. For example, we may inform the person who accompanied you to the emergency room that you suffered a heart attack and provide updates on your progress and prognosis. We may also use our professional judgment and experience to make reasonable inferences that it is in your best interest to allow another person to act on your behalf to pick up, for example, filled prescriptions, medical supplies, or X-rays.

OTHER USES AND DISCLOSURES OF HEALTH INFORMATION

We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written *Authorization*. If you give us *Authorization* to use or disclose health 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*, but we cannot take back any uses or disclosures already made with your permission.

In some instances, we may need specific, written authorization from you in order to disclose certain types of specially-protected information such as HIV, substance abuse, mental health, and genetic testing information.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the following rights regarding health information we maintain about you:

Right to Inspect and Copy. You have the right to inspect and copy your health information, such as clinical and billing records, that we keep and use to make decisions about your care. You must submit a written request to Cornerstone Clinical Services, P.C. in order to inspect and/or copy records of your health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other associated supplies.

We may deny your request to inspect and/or copy in certain limited circumstances. If you are denied copies of or access to health information that we keep about you, you may ask that our denial be reviewed. If the law gives you a right to have our denial reviewed we will select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

Right to Amend. If you believe health 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 as long as the information is kept by this office.

To request an amendment, complete and submit a CLINICAL RECORD AMENDMENT/CORRECTION FORM to Cornerstone Clinical Services, P.C.

We may deny your request for an amendment if your request is not **in writing** or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- We did not create, unless the person or entity that created the information is no longer available to make the amendment
- Is not part of the health information that we keep
- You would not be permitted to inspect and copy
- Is accurate and complete

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of clinical information about you for purposes other than treatment, payment, health care

operations, and a limited number of special circumstances involving national security, correctional institutions and law enforcement. The list will also exclude any disclosures we have made based on your written authorization.

To obtain this list, you must submit your request **in writing** to Cornerstone Clinical Services, P.C. It must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example: on paper, electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you may complete and submit the REQUEST FOR RESTRICTION ON USE/DISCLOSURE OF CLINICAL INFORMATION to Cornerstone Clinical Services, P.C.

Right to Request Confidential Communications. You have the right to request that we communicate with you about clinical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you may complete and submit the REQUEST FOR RESTRICTION ON USE/DISCLOSURE OF CLINICAL INFORMATION AND/OR CONFIDENTIAL COMMUNICATION to Cornerstone Clinical Services, P.C. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

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. Even if you have agreed to receive it electronically, you are still entitled to a paper copy.

To obtain such a copy, contact Cornerstone Clinical Services, P.C.

CHANGES TO THIS NOTICE

We reserve the right to change this notice, and to make the revised or changed notice effective for clinical information we already have about you as well as any information we receive in the future. We will post a summary of the current notice in the office with its effective date in the top right hand corner. You are entitled to a copy of the notice currently in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact the privacy officer at Cornerstone Clinical Services, P.C. *You will not be penalized for filing a complaint.*

ACKNOWLEDGMENT AND CONSENT

I understand that Cornerstone Clinical Services, P.C. will use and disclose health information about me. I understand that my health information may include information both created and received by the practice/facility, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that Cornerstone Clinical Services, P.C. may use and disclose my health information in order to:

- ❖ Make decisions about and plan for my care and treatment;
- ❖ Refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
- ❖ Determine my eligibility for health plan or insurance coverage, and submit bills, claims, and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- ❖ Perform various office, administrative, and business functions that support my practitioner/provider's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how Cornerstone Clinical Services, P.C. will handle health information about me. This written description is known as a Notice of Privacy Practices and describes the uses and disclosures of health information made and the information practices followed by the employees, staff, and other office personnel of Cornerstone Clinical Services, P.C., and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of Cornerstone Clinical Services' Notice of Privacy Practices in effect will be posted in the waiting/reception area.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices and I understand that Cornerstone Clinical Services, P.C. is not required by law to agree to such requests.

By signing below, I agree that I have received and understand the information above and that I have received a copy of the Notice of Privacy Practices.

By: _____	Date: _____
(Patient)	

-- OR --

By: _____	Date: _____
(Patient's Representative)	
Description of Representative's Authority: _____	

Cornerstone Clinical Services, P.C.

Please complete ALL sections

Clinician: _____

Patient Registration Form

Patient's full name _____ Age _____ DOB _____ M/F Marital M S D W
Street Address _____ City _____ State _____ Zip _____
SS# _____ Driver's License # _____ Employer _____
Home Phone _____ Work Phone _____ Cell Phone _____
May we leave messages for you at home? Yes _____ No _____ May we leave messages at work? Yes _____ No _____

Person Responsible for Account (if other than above)

Name _____ Relationship _____ Phone _____ Birthdate _____
Address _____ City/State _____ Zip _____ SS # _____
Employer _____ Employer's Phone _____ Driver's License _____

If you would like our office to bill your insurance company, the following information will be required

Primary Insurance

Insurance Company _____ Phone _____
Address _____ City/State _____ Zip _____
Name of Insured _____ DOB _____ Group _____ SS # _____
Insured's Employer _____ Address _____
Primary Care Physician _____ Address _____ Phone _____

Secondary Insurance

Insurance Company _____ Phone _____
Address _____ City/State _____ Zip _____
Name of Insured _____ DOB _____ Group _____ SS # _____
Employer _____ City/State _____ Zip _____

Assignment of Insurance Benefits and Agreement to Pay

I have completed the above to the best of my knowledge. If the information changes, I will notify Cornerstone Clinical Services. They are not liable for incorrect information. Cornerstone Clinical Services has my permission to bill my insurance company(ies). I authorize the release of any medical information necessary to process these claims. I authorize medical benefits to be paid to Cornerstone Clinical Services or to the clinician rendering services.

INSURED SIGNATURE

(Continued on reverse)

DATE

Billing Policies

Payment is required at the time of service. If you have insurance coverage, the business office will calculate your estimated co-insurance to be paid at the time of service.

We accept personal checks, money orders, cash, VISA, and MasterCard.

We will bill your insurance. You will be billed for unpaid balances after your insurance processes. The office does not accept responsibility for collecting your insurance claim or for negotiating a settlement on a disputed claim. You are responsible for payment of your account, including any unpaid insurance claims.

If payment arrangements must be made, please contact the business office.

Client balances that are 60+ days past due will be assessed a 1-1/2% per month (18% annual) service charge.

Accounts carried 90 days without payment may be turned over to a collection agency. In that event, the contingency fee assessed by the collection agency will be added to the principal and service charges due. You will be additionally liable for attorney fees. Both collection agency fees and attorney fees will increase the balance you owe. If your account is turned over to a collection agency, it may affect your credit rating. In most cases, the only information that is released to a collection agency about a client's treatment would be the client's name, the nature of the services provided, and the amount due.

We require a 24-hour notice for cancellations. If a 24-hour notice is not given, a late cancellation or no show charge of \$100 (minimum) will be assessed. Insurance companies will not be billed for this fee; it is the client's responsibility. In case of illness, please contact the office as soon as possible to cancel your appointment. If you need to cancel your appointment when the office is closed, please leave a message on our voice mail.

Please sign below indicating your understanding of the information above. If you wish, the office will provide you with a copy of this policy.

Signature of Responsible Party

Date