Liability **Adult**

Name: _____
Last First Middle

Male ___ Female ____ Date of Birth _____ Age _____

Marital Statues: Married Single Divorced Widowed Separated

Social Security #: _____-____-_____ Email: _____

Address: _____
Street City State Zip Code

Mailing Address: _____
Street City State Zip Code

Home #:_____ Work #:_____ Cell #:_____
Is it OK for Keith Clinic to send you text messages and/or voicemails? **Yes** **No**

Occupation: _____ Employer: _____

Employer Address: _____ Phone #_____

Emergency Contact: _____ Phone #: _____

How did you hear about our office? _____

Have you had other chiropractic care? _____ Reason _____

AUTHORIZATION FOR RELEASE OF INFORMATION AND PAYMENT OF MEDICAL BENEFITS

"I understand that I am responsible for all charges incurred by me WHETHER OR NOT the insurance company pays. I herby assign all medical payments to Keith Clinic of Chiropractic; if there is any over payments it will be promptly refunded to me by Keith Clinic of Chiropractic. I authorize the release of any medical information needed to process my insurance claims. I agree to pay any/all collection cost, court cost and attorney's fees in addition to my chiropractic charges. Further more, I give Keith Clinic of Chiropractic Power of attorney to endorse checks made out to me, to be credited to my account. I understand that I am subject to a credit check before having any credit extended to me."

KEITH CLINIC OF CHIROPRACTIC FINANCIAL POLICY

We are committed to providing you the best possible chiropractic care. If you have Medical Health Insurance or Medpay we can help you receive your maximum allowable benefits.

In order to achieve these goals, we need your assistance and your understanding of our payment policy.

We will work with any insurance companies or attorney involved, but please remember that you are ultimately responsible for your bill if payment cannot be obtained from another party.
"I have read and understand the above FINANCIAL POLICY and understand and will comply with these terms as stated."

_____ _____
Patient Signature Date of Signature

AUTOMOBILE ACCIDENT INFORMATION

1. What was the date of the accident? _____
2. Describe the accident in your own words:

   _____

   _____

   _____
3. In which city and state did the accident occur? _____
4. What type of impact was the auto accident?

   ❑ Rear-ended ❑ hit on driver's side ❑ hit another vehicle from behind ❑ hit on passenger side

7. Did your vehicle hit anything after the accident? If yes, please describe _____
8. Where were you sitting in the vehicle during the accident?

   ❑ driver ❑ rear left passenger ❑front passenger ❑rear right passenger

9. Did you know the accident was coming?

❑ unaware of impending collision ❑ aware of impending collision ❑ aware of impending collision and I braked

10. What type of vehicle were you in?

    ❑ compact car ❑ mid size car ❑ full size car ❑ truck
    ❑ SUV ❑ minivan ❑ van ❑ other

11. What type of vehicle impacted yours?

    ❑ compact car ❑ mid size car ❑ full size car ❑ truck
    ❑ SUV ❑ minivan ❑ van ❑ other

12. At the time of impact, how fast was your vehicle moving?

    ❑ slowing down ❑ stopped ❑gaining speed ❑moving steady speed

13. Did you strike anything in your vehicle at the time of impact? ❑ Yes_____ ❑No
14. Did you lose consciousness during the accident? ❑Yes ❑No
15. Did you have your seatbelt on during the accident? ❑ Yes ❑No
16. Did you go to the hospital? ❑ Yes ❑ No If no, why and skip 17-22 _____
17. How did you get to the hospital?

    ❑ ambulance ❑ police car ❑ walked ❑ helicopter ❑ drove self ❑ other

18. What was the name of the hospital? _____
19. Were you hospitalized over night? ❑Yes ❑No
20. What were you prescribed at the hospital? _____
21. Did you receive any stitches for any cuts at the hospital? ❑Yes_____ ❑ No
22. Where x-rays taken at the hospital? If yes, which are was taken?

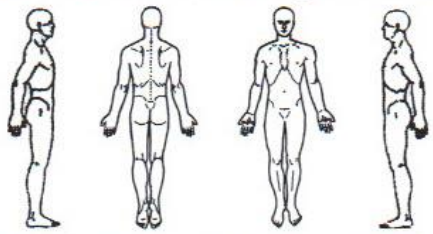
    ❑ neck ❑ skull ❑ mid back ❑ lower back ❑ pelvis ❑ hips
    ❑ leg ❑ knee ❑ foot ❑ shoulder ❑ arm ❑ other

Patient Name (print) _____ Date _____

Patient Signature _____

Patient Intake Form

1. Indicate with an X on the drawings below where you have pain/symptoms.



Please list/Describe your symptoms in order of Severity

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

2. How often do you experience your symptoms?
   - ❑ Constantly (76-100% of the time)
   - ❑ Frequently (51-75% of the time)
   - ❑ Occasionally (26-50% of the time)
   - ❑ Intermittently (1-25% of the time)

3. How would you describe the type of pain?
   - ❑ Sharp
   - ❑ Diffuse
   - ❑ Dull
   - ❑ Electric like with motion
   - ❑ Tingly
   - ❑ Shooting
   - ❑ Achy
   - ❑ Numb
   - ❑ Stiff
   - ❑ Burning
   - ❑ Other _____
   - ❑ Sharp with motion
   - ❑ Shooting with motion
   - ❑ Stabbing with motion

4. How are your symptoms changing with time.
   - ❑ Getting Worse
   - ❑ Not Changing
   - ❑ Getting Better

5. Using a scale from 0-10 (10 being the worst), how would you rate your problem?
   0 1 2 3 4 5 6 7 8 9 10 *(Please Circle)*

6. How much has the problem interfered with your work?
   - ❑ Not at all
   - ❑ A little bit
   - ❑ Moderately
   - ❑ Quite a bit
   - ❑ Extremely

7. How much has the problem interfered with your social activities?
   - ❑ Not at all
   - ❑ A little bit
   - ❑ Moderately
   - ❑ Quite a bit
   - ❑ Extremely

8. Who else have you seen for your problem?
   - ❑ Chiropractor
   - ❑ ER Physician
   - ❑ Massage Therapist
   - ❑ Neurologist
   - ❑ Orthopedist
   - ❑ Physical Therapist
   - ❑ Primary Care Physician
   - ❑ Other _____
   - ❑ No One

9. How long have you had this problem? _____

10. How do you think your problem began?

_____

11. Do you consider this problem to be severe?
    - ❑ Yes
    - ❑ Yes, at times
    - ❑ No

12. What aggravates your problem?

_____

13. What makes your problem better?

_____

14. What concerns you the most about your problem; what does it prevent you from doing?

_____

15. What is your: Height_____ Weight_____ Date of Birth_____
    Occupation_____

16. How would you rate your overall Health?
    - ❑ Excellent
    - ❑ Very Good
    - ❑ Good
    - ❑ Fair
    - ❑ Poor

17. What type of exercise do you do?
    - ❑ Strenuous
    - ❑ Moderate
    - ❑ Light
    - ❑ None

(PLEASE TURN OVER)

18. Indicate if you have any immediate family members with any of the following:
    - ❑ Rheumatoid Arthritis ❑ Diabetes ❑ Lupus
    - ❑ Heart Problems ❑ Cancer ❑ ALS

19. What treatment have you already received for your condition? ❑ Medications ❑ Surgery ❑ Physical Therapy
    ❑ Chiropractic Services ❑ None ❑ Other _____

    Name and address of other doctor(s) who have treated you for your condition _____

    Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____
    Spinal Exam _____ Chest X-Ray _____ Urine Test _____
    Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

    Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	❑ Yes	❑ No	Diabetes	❑ Yes	❑ No	Liver Disease	❑ Yes	❑ No	Rheumatoid Arthritis	❑ Yes	❑ N
Alcoholism	❑ Yes	❑ No	Emphysema	❑ Yes	❑ No	Measles	❑ Yes	❑ No	Rheumatic Fever	❑ Yes	❑ N
Allergy Shots	❑ Yes	❑ No	Epilepsy	❑ Yes	❑ No	Migraine			Scarlet Fever	❑ Yes	❑ N
Anemia	❑ Yes	❑ No	Fractures	❑ Yes	❑ No	Headaches	❑ Yes	❑ No	Sexually Transmitted		
Anorexia	❑ Yes	❑ No	Glaucoma	❑ Yes	❑ No	Miscarriage	❑ Yes	❑ No	Disease	❑ Yes	❑ N
Appendicitis	❑ Yes	❑ No	Goiter	❑ Yes	❑ No	Mononucleosis	❑ Yes	❑ No	Stroke	❑ Yes	❑ N
Arthritis	❑ Yes	❑ No	Gonorrhea	❑ Yes	❑ No	Multiple Sclerosis	❑ Yes	❑ No	Suicide Attempt	❑ Yes	❑ N
Asthma	❑ Yes	❑ No	Gout	❑ Yes	❑ No	Mumps	❑ Yes	❑ No	Thyroid Problems	❑ Yes	❑ N
Bleeding Disorders	❑ Yes	❑ No	Heart Disease	❑ Yes	❑ No	Osteoporosis	❑ Yes	❑ No	Tonsillitis	❑ Yes	❑ N
Breast Lump	❑ Yes	❑ No	Hepatitis	❑ Yes	❑ No	Pacemaker	❑ Yes	❑ No	Tuberculosis	❑ Yes	❑ N
Bronchitis	❑ Yes	❑ No	Hernia	❑ Yes	❑ No	Parkinson's			Tumors, Growths	❑ Yes	❑ N
Bulimia	❑ Yes	❑ No	Herniated Disk	❑ Yes	❑ No	Disease	❑ Yes	❑ No	Typhoid Fever	❑ Yes	❑ N
Cancer	❑ Yes	❑ No	Herpes	❑ Yes	❑ No	Pinched Nerve	❑ Yes	❑ No	Ulcers	❑ Yes	❑ N
Cataracts	❑ Yes	❑ No	High Blood			Pneumonia	❑ Yes	❑ No	Vaginal Infections	❑ Yes	❑ N
Chemical			Pressure	❑ Yes	❑ No	Poilo	❑ Yes	❑ No	Whooping Cough	❑ Yes	❑ N
Dependency	❑ Yes	❑ No	High Cholesterol	❑ Yes	❑ No	Prosthesis	❑ Yes	❑ No	Other _____		
Chicken Pox	❑ Yes	❑ No	Kidney Disease	❑ Yes	❑ No	Psychiatric Care	❑ Yes	❑ No	_____		

20. What habits do you currently do?
    ❑ Smoking Packs/Day _____ ❑ Alcohol Drinks/Week _____
    ❑ Coffee/Caffeine Drinks Cups/Day _____ ❑ High Stress Level Reason _____

21. Are you pregnant? ❑ Yes ❑ No Due Date _____

22. List all prescription medications/supplements you are currently taking:
    _____

23. List all of the over-the-counter medications you are currently taking:
    _____

24. List all surgical procedures you have had:
    _____

25. What activities do you do at work?

❑ Sit:	❑ Most of the day	❑ Half the day	❑ A little of the day
❑ Stand:	❑ Most of the day	❑ Half the day	❑ A little of the day
❑ Computer work:	❑ Most of the day	❑ Half the day	❑ A little of the day
❑ On the phone:	❑ Most of the day	❑ Half the day	❑ A little of the day

26. What activities do you do outside of work?
    _____

27. Have you ever been hospitalized? ❑ No ❑ Yes
    If yes, why _____

28. Have you ever seen a chiropractor? ❑ No ❑ Yes
    If yes, what was your experience? _____

29. Have you had significant past trauma? ❑ No ❑ Yes

30. Anything else pertinent to your visit today? _____

Print Patient Name _____ DOB: _____

Patient Signature _____ Date: _____

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

YOUR RIGHTS

Get an electronic or paper copy of your medical record

You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.

ONLY if you pay for a service or health care item out-of-pocket, in full, at the time of service, can we comply with your request not to share that information for the purpose of payment or our operations with your health insurer. (i.e. - comply with your request not to file your claims to your insurance company). Otherwise, we will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

You can complain if you feel we have violated your rights by contacting us. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share.

If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- **Share information with your family, close friends, or others involved in your care**
- **Share information in a disaster relief situation**
- **Contact you for fundraising efforts**

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- **Marketing purposes**
- **Sale of your information**

In the case of fundraising: We may contact you for fundraising efforts, but you can tell us not to contact you again.

OUR USES AND DISCLOSURES

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

- **Treat you**
  We can use your health information and share it with other professionals who are treating you. Example: A doctor treating you for an injury asks another doctor about your overall health condition.
- **Run our organization**

We can use and share your health information to run our practice, improve your care, and contact you when necessary. Example: We use health information about you to manage your treatment and services.

- **Bill for your services**

We can use and share your health information to bill and get payment from health plans or other entities. Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information? **We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.**

Help with public health and safety issues

We can share health information about you for certain situations such as preventing disease; helping with product recalls; reporting adverse reactions to medications; reporting suspected abuse, neglect, or domestic violence; and, preventing or reducing a serious threat to anyone's health or safety.

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you for workers' compensation claims, for law enforcement purposes, or with a law enforcement official. We can also use or share health information about you with health oversight agencies for activities authorized by law for special government functions such as military, national security, and presidential protective services.

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

OUR RESPONSIBILITIES

We are required by law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

For more information: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

CHANGES TO THE TERMS OF THIS NOTICE

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Effective September 23, 2013

Patients Name (printed) : _____ **Date:** _____

Patient Signature of Acceptance: _____ **Date:** _____

Witness: _____

INFORMED CONSENT

Disclosure & Consent
Chiropractic adjustments and Care

TO THE PATIENT: You have a right as a patient to be informed about your condition and the recommended chiropractic adjustments and other chiropractic procedures to be used so that you may make the decision whether or not to undergo the procedure after knowing the potential risk and hazards involved. This disclosure is not meant to scare or alarm you: it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.

I herby request and consent to performance of chiropractic adjustment and other chiropractic procedures, including carious modes of physical therapy and diagnostic x-rays, on me (or the patient named below, for whom I am legally responsible) by the Doctor of Chiropractic named below and/or other Licensed Doctors of Chiropractic or those working at the clinic or office who now or in the future treat me while employed by, working or associated with, or serving as a backup for the Doctor of Chiropractic named below.

I have had the opportunity to discuss with the Doctor of Chiropractic named below my diagnosis the nature and purpose of chiropractic adjustments and other procedures and alternatives. I understand and I am informed that in the practice of chiropractic there are some risk to exam and treatment including, but not limited to fractures, disc injuries, strikes, dislocations, sprains and increased symptoms and pain or no improvement of symptoms or pain. I do not expect the doctor to be able to anticipate and explain all risk and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts the known, is in my best interest. I further acknowledge that no guarantees or assurance have been made to me concerning the results intended from the treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions and all my questions have been answered fully and satisfactorily. By signing below, I consent to the treatment plan. I intend this consent from to cove treatment for my present condition and for any future condition(s) for which I seek treatment.

To be completed by the patient:

_____
Print name

_____
Signature of Patient

_____
Date Signed

_____
Doctor Signature of Keith Clinic of Chiropractic P.A.

To be completed by the patient's representative:

_____
Print Name of Patient

_____
Print Name of Representative

_____
Signature of Representative

_____
Date Signed

Liability Adult

Keith Clinic Chiropractic in Monroe will bill any and all insurances involved (private and auto). We are extending credit to you while you are under our care. In return, we will file with your group insurance carrier so that payment can be received while you are being treated. Within two (2) weeks from the time you have been dismissed from care, we will send a report and complete bill to all auto insurance carriers for you. Once your bill is paid in full, any overpayment received will be refunded to you.

"I agree to pay all collection costs, court cost and attorney fees in addition to my charges. I give Keith Clinic Chiropractic in Monroe power of attorney to endorse any checks made out to me, to be credited to my account. I understand that I am subject to a credit check before credit is extended to me."

Signature:_____ Date:_____

Liability Insurance (insurance of party at fault)

Name of Insurance Company:_____

Address:_____

Abjuster:_____

Adjuster Phone Number:_____ Fax Number:_____

Name of Insured:_____

Policy Number:_____

Claim Number:_____

Date of Accident:_____

Medical Payment Coverage (Med pay benefits on your car or the car you were a passenger in)

Name of Insurance Company:_____

Adress:_____

Adjuster:_____

Phone Number:_____

Fax Number:_____

Policy Number:_____

Claim Number:_____

ARE YOU REPRESENTED BY AN ATTORNEY? YES NO

Attorneys Name:_____ Phone Number:_____

I understand that, whether or not I have obtained an attorney, COMPLETE liability information must be turned in to Keith Clinic Chiropractic in Monroe by my 3rd visit to avoid being personally charged for any treatment, x-rays, supplements or supplies.

Signature:_____ Date:_____

ASSIGNMENT OF PROCEEDS, LIEN, AND AUTHORIZATION

I herby authorize and direct any and all insurance carriers, attorneys, agencies, governmental departments, companies, individuals, and/or other legal entities ("payers"), which may elect or be obligated to pay, provide, or distribute benefits to me for any medical conditions, accidents, injuries, or illnesses, past, present, or future ("conditions") to pay directly and exclusively in the name of **Keith Clinic of Chiropractic in Monroe, P.A. ("office")** such sums as may be owing to **Office** for charges incurred by me at the Office relating to my condition ("charges"), with such payments to be made exclusively in the name of **Keith Clinic of Chiropractic in Monroe, P.A.** ("assignment"). I further grant a lien to **Office** with respect to my charges and authorize, grant and direct **Office** to file a UCC lien with the appropriate office at **Office's** discretion. This lien shall apply to all payers and to the full extent permitted by law. For the purposes of this document (herein, "Assignment and Lien"), "benefits" shall include, but not limited to, proceeds from any settlement, judgment or verdict, as well as any proceeds relating to commercial health or group insurance, attorney retainer agreements, medical payments benefits, personal injury protection, no-fault coverage, uninsured and underinsured motorist coverage, third party liability distributions, disability benefits, workers compensation benefits, and any other benefits or proceeds payable to me for the purposes stated herein.

Further, I herby authorize Keith Clinic of Chiropractic in Monroe, P.A. to file my claim with my health insurance. I understand, however, that in the event that my charges are submitted in their full amount to any other form of insurance (e.g., liability, medpay, etc), I herby authorize and direct Keith Clinic of Chiropractic in Monroe, P.A. to collect any and all write-offs or discounts, issued by my health insurance, out of the proceeds from the other insurance. This authorization cannot be revoked without the express written consent of Keith Clinic of Chiropractic in Monroe, P.A. Consistent with these terms, I herby direct any and all Payers, to pay the Proceeds directly to, immediately to, and exclusively in the name of, the Office to the full extent of my Charges. To the extent that any law, including without limit a lien statute, purports to limit, reduce, or modify the distribution of Proceeds in any manner inconsistent with this Assignment & lien including without limit through the reservation of a portion of the Proceeds exclusively to me, I herby waive such limits, reductions, or modifications. I further agree to and herby irrevocably waive any present or future right I may have, whether arising under a "Common Fund Doctrine" or other legal basis, to require the Office to reduce its Charges or balance by a proportionate or weighted share of my attorney's fees, costs, and other expenses of pursuing collection of my claims, including the Office's Charges.

In the event that I retain one or more attorneys to represent me in this matter, regardless of location (inside or outside of North Carolina), I will direct each attorney to issue an unrestricted letter of protection to this office regarding my charges. Upon issuance, I hereby agree that such letter(s) of protection cannot be revoked or modified without the express written consent of the office.

I authorize this office to release any information regarding my treatment or pertinent to my case(s) to all payers as defined above to facilitate collection under this Assignment and Lien. I further authorize and direct all payers to release to Office any information regarding any coverage or benefits which I may have including, but not limited to, the amount of the coverage, the amount paid thus far, and the amount of any outstanding claims. I herby direct this office to file a copy of this Assignment and Lien, together with any applicable charges, with any or all payers, regardless of whether a claim has been established with said payers, including but not limited to, group health insurance, medpay, liability and/or worker's compensation. I herby authorize Office to sign/ endorse my name on any and all checks listing me as payee, which are presented to this office for payment of an account relating me, my spouse, or any of my dependents. I further authorize **Office** to apply any credit balances on charges incurred by me to any other charges still owed by me, my spouse, or my dependents, regardless of these other charges are related to my condition.

I understand that I remain personally responsible for the total amount due **Office** for their services. This Assignment and Lien does not constitute consideration for this office to wait payment and it may demand payments from me immediately upon rendering services at this option. If this office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse office for all cost of such collection efforts, including, but not limited to, all court costs and all attorneys' fees.

This Assignment and Lien shall not be modified or revoked without the mutual written consent of Office and myself. I herby revoke any previously signed authorization, whether executed in this office or any other office or any other office to the extent that the terms of those authorizations conflict with the terms of this Assignment and Lien.

Patient Name (Please Print):_____ Date:_____

Patient Signature:_____ Date:_____

Name of Custodial Parent or Legal Guardian (Please Print):_____

Date:_____

Parent/ Guardian' Signature:_____ Date:_____