Patient Intake Form

Patient information contained within this form is considered strictly confidential.

Your responses are important to help us better understand the health issues you face and ensure the delivery of the best possible treatment.

Name: _____ **Date:** _____ (dd/mm/yr)

Insurance: _____

Date of Birth: _____ ☐ male ☐ female

Address: _____

_____

_____

Marital status

S	M	W	D	SEP

Phone #: home: _____ **work:** _____

E-mail address: _____

Occupation: _____ **Employer:** _____

Check ☑ and indicate the age when you had any of the following:

General
- ☐ Allergies
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fatigue
- ☐ Fever
- ☐ Headaches
- ☐ Loss of sleep
- ☐ Mental illness
- ☐ Nervousness
- ☐ Tremors
- ☐ Weight loss / gain

Muscle / Joint
- ☐ Arthritis / rheumatism
- ☐ Bursitis
- ☐ Foot trouble
- ☐ Muscle weakness
- ☐ Low back pain
- ☐ Neck pain
- ☐ Mid back pain
- ☐ Joint pain

Skin
- ☐ Boils
- ☐ Bruise easily
- ☐ Dryness
- ☐ Hives or allergies
- ☐ Itching
- ☐ Rash
- ☐ Varicose veins

Eye, Ear, Nose & Throat
- ☐ Colds
- ☐ Deafness
- ☐ Ear ache
- ☐ Eye pain
- ☐ Gum trouble
- ☐ Hoarseness
- ☐ Nasal obstruction
- ☐ Nose bleeds
- ☐ Ringing of the ears
- ☐ Sinus infection
- ☐ Sore throat
- ☐ Tonsillitis
- ☐ Vision problems

Gastrointestinal
- ☐ Abdominal pain
- ☐ Bloody or tarry stool
- ☐ Colitis / Crohn's
- ☐ Colon trouble
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficult digestion
- ☐ Diverticulosis
- ☐ Bloated abdomen
- ☐ Excessive hunger
- ☐ Gallbladder trouble
- ☐ Hernia
- ☐ Hemorrhoids
- ☐ Intestinal worms
- ☐ Jaundice
- ☐ Liver trouble
- ☐ Nausea
- ☐ Painful deification
- ☐ Pain over stomach
- ☐ Poor appetite
- ☐ Vomiting
- ☐ Vomiting of blood

Genitourinary
- ☐ Bed-wetting
- ☐ Bladder infection
- ☐ Blood in urine
- ☐ Kidney infection
- ☐ Kidney stones
- ☐ Prostate trouble
- ☐ Pus in urine
- ☐ Stress incontinence

Urination
- ☐ Overnight more than twice
- ☐ More than 8x in 24hrs
- ☐ Decreased flow/force
- ☐ Painful urination
- ☐ Urgency to urinate

Cardiovascular
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Hardening of the arteries
- ☐ Irregular pulse
- ☐ Pain over heart
- ☐ Palpitation
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Slow heart beat
- ☐ Swelling of ankles

Respiratory
- ☐ Chest pain
- ☐ Chronic cough
- ☐ Difficulty breathing
- ☐ Hay fever
- ☐ Shortness of breath
- ☐ Spitting up phlegm / blood
- ☐ Wheezing

Women only
- ☐ Congested breasts
- ☐ Hot flashes
- ☐ Lumps in breast
- ☐ Menopause
- ☐ Vaginal discharge

Menstrual flow
☐ Reg. ☐ Irreg. ☐ Pain / cramps

Days of flow: ____ Length of cycle: ____

Date - 1st day last period: _____

Are you pregnant? ☐ yes, ☐ no

If yes, how many months? ____

How many children do you have? ____

Birth control method: _____

Date of last PAP test: _____

☐ normal, ☐ abnormal

Date of last mammogram: _____

☐ normal, ☐ abnormal

Check any of the conditions you have or have had:
- ☐ Alcoholism
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Asthma
- ☐ Bronchitis
- ☐ Cancer
- ☐ Chicken pox
- ☐ Cold sores
- ☐ Diabetes
- ☐ Eczema
- ☐ Edema
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Goiter
- ☐ Gout
- ☐ Heart burn
- ☐ Heart disease
- ☐ Hepatitis
- ☐ Herpes
- ☐ High cholesterol
- ☐ HIV/AIDS
- ☐ Influenza
- ☐ Malaria
- ☐ Measles
- ☐ Miscarriage
- ☐ Multiple sclerosis
- ☐ Mumps
- ☐ Numbness/tingling
- ☐ Pace maker
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatic fever
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Ulcers

Please list any medication you are currently taking and why:

_____

_____

_____

_____

Patient Intake Form (side 2)

Give a brief detailed description of the problem you are currently experiencing: _____

_____

_____

_____

_____

How long have you had this condition? _____ Is it getting worse? □ yes, □ no _____

Does it bother you (check appropriate box): □ work, □ sleep, □ other: _____

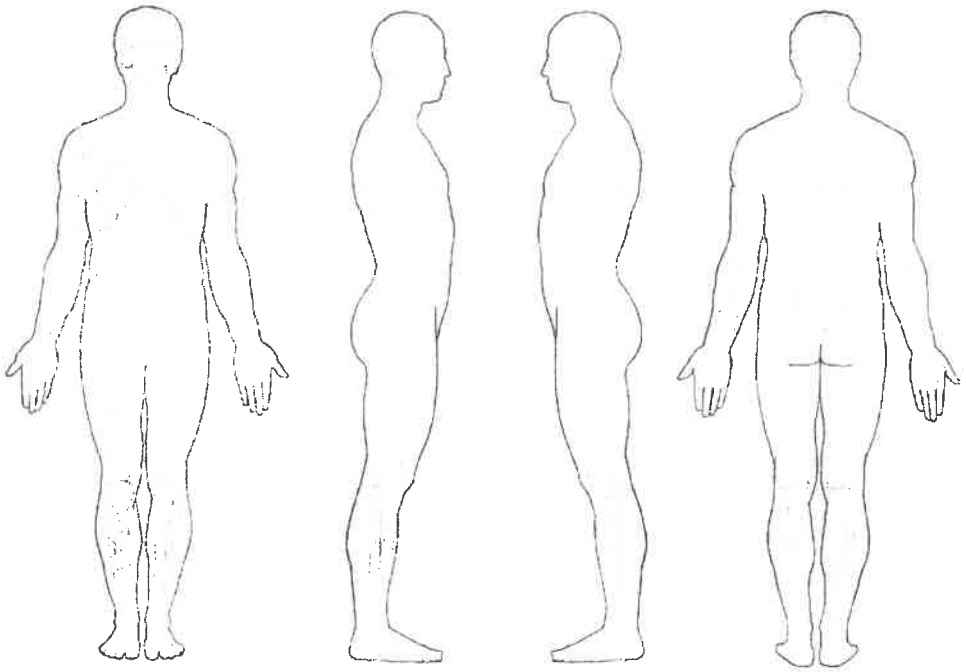
What seemed to be the initial cause: _____

Please mark you area(s) of pain on the figure below

Please place a mark at the level of your pain on the scale below:

Worst Possible Pain

No Pain



Past health history

Have you...	Yes	No	If yes, explain briefly
... been hospitalized in the last 5 year?	□	□	_____
... had any mental disorders?	□	□	_____
... had any broken bones?	□	□	_____
... had any strains or sprains?	□	□	_____
... ever used orthotics?	□	□	_____
Do you take minerals, herbs or vitamins?	□	□	_____

How is most of your day spent? □ standing, □ sitting, □ other: _____

How old is your mattress? _____

When was your last physical exam? _____

Habits	none	light	mod.	heavy
Alcohol	□	□	□	□
Coffee	□	□	□	□
Tobacco	□	□	□	□
Drugs	□	□	□	□
Exercise	□	□	□	□
Sleep	□	□	□	□
Soft drinks	□	□	□	□
Salty foods	□	□	□	□
Water	□	□	□	□
Sugar	□	□	□	□

Family history

If any blood relative has had any of the following conditions, please check and indicate which relative(s)

- □ Alcoholism
- □ Anemia
- □ Arteriosclerosis
- □ Arthritis
- □ Asthma
- □ Bleed easily
- □ Cancer
- □ Diabetes
- □ Emphysema
- □ Epilepsy
- □ Glaucoma
- □ Heart disease
- □ High blood pressure
- □ High cholesterol
- □ Multiple sclerosis
- □ Osteoporosis
- □ Stroke
- □ Thyroid disease

Do you have any other health issues or concerns that our staff should be made aware of? _____

_____

Auto / Work Related Accident

About You

Today's Date:_____/_____/_____

Work Related Accident

Date of Accident _____/_____/_____
Time of Accident _____
Address of employer

Employers Telephone _____
Name of your supervisor:

Have you reported your accident to your employer?

Yes No

Briefly describe the events that occurred just before and during your accident:_____

Have you had an accident before? Y N

Auto Related Accident

Date of Accident _____
Time of Accident _____
Were you the: 1- Driver 2-Front Passenger
3-Rear Passenger 4-Pedestrian
How many people were in your car? _____
Was a police report filed? _____
Were you wearing a seat belt? _____
Did your car strike the other car? Y N
Did the other car strike your car? Y N
If Yes, from which side were you struck from? (circle one)
Rear Front Rt. Side Lt. side
Who received a traffic violation?

Make & Model of the car you were occupying?_____

Make & Model of the other person's car:

During impact, were you facing: (circle one)
Right, Left, Forward, I don't remember
Were you aware or surprised by the impact?

Did any part of your body collide with any part of the inside of the car? Please describe._____

In your words, please describe the accident

After the Injury

Did the accident render you unconscious?
Yes No

Please describe how you felt immediately after the accident?

_____
_____
_____
_____

Have you gone to a hospital? Y N
How did you get there?
Ambulance or private transportation
Describe any treatment you received:

_____
_____
_____

Was medication prescribed? Y N
Have you missed any days work? If yes, list the dates.

_____
_____

Place an X next to the symptoms that are a result of this accident:

	Neck Pain		Numbness in legs
	Mid-back Pain		Numbness in Arms
	Low-back Pain		Numbness in Hands
	Headaches		Difficulty Sleeping
	Shoulder Pain		Pins & Needles in Arms
	Leg Pain		Pins & Needles in Legs
	Foot/Ankle Pain		Chest Pain
	Nervousness		Dizziness
	Fatigue		Nausea
	Loss of Balance		General Tension
	Jaw Pain		Depression
	Buzzing in Ears		Stomach Upset
	Loss of Memory		Shortness of Breath

Indicate your degree of comfort while performing the following activities by placing an X in the box:

	No Pain	Uncomfortable	Painful
Lying on back			
Lying on side			
Lying on stomach			
Sitting			
Standing			
Stretching			
Walking			
Running			
Bending			
Kneeling			
Pulling			
Pushing			
Reaching			

Recovery

Please place an X in the box next to your daily job duties and any activities that you are occasionally asked to perform:

Hours per day	1-4	4-6	6-8
Standing			
Sitting			
Kneeling/Squatting			
Twisting			
Bending/Stooping			
Pushing/Pulling			
Overhead reaching			
Other reaching			
Grasping/Squeezing			
Typing			
Climbing stairs/ladders			
Walking			
Running			
Operating equipment			
Crawling			
Lifting			
Answering the telephone			

While in recovery, is there any light duty work you could request?

_____
_____

How many hours are in your normal workday?

_____

I hereby swear that all the information given is factual.

_____
Print Name

_____
Signature **Date**

New Mexico Chiropractic Center (NMCC)
Informed Consent

To the patient: Please read this entire document prior to signing. It is important that you understand the information contained in this consent. Please ask questions before you sign if there is anything that is unclear to you. Thank you.

Analysis/Examination/Treatment:
I understand that I am consenting to a diagnostic and/or chiropractic adjustment and associated therapies. The examination may included but is not limited to vital signs, neurological and orthopedic testing, palpation/touch and radiographic images. The recommended treatment may include chiropractic spinal and extremity joint manipulations, trigger point acupressure, massage therapy, ice or heat therapy, electrical muscle stimulation, inter-segment traction, manual traction and professional advice. The primary treatment employed is manipulative therapy in which I might feel movement and/or hear an audible 'pop'. I understand, as with all health care approaches, results are not guaranteed and there is no promise to cure.

Material risks inherent in the chiropractic adjustment and/or therapy:
I understand that there are certain risks to the procedures, especially if I have any predisposing conditions. These complications include but are not limited to muscle soreness, muscle spasm, joint pain and stiffness, inflammation, headache, back pain, or bruising. More serious injuries can occur, such as cardiovascular complications like stroke, fracture, or disc complications. While many of the risks are rare, I understand that they are inherent in physical medicine. I understand that the doctors at NMCC will make every reasonable effort during the examination to screen for complications or contraindications to care; however, if I have a condition that would otherwise not come to his/her attention, it is my responsibility to inform my doctor.

The availability and nature of other treatment options:
Rest, self-administered over the counter medications, medical care and prescription medications, Oriental medicine and acupuncture, Physical Therapy, bracing, injections, hospitalization or surgery. I have the right to a second opinion and to secure other opinions about my circumstances and health care as I see fit. If I choose one of the options above, I should be aware that there are risks and benefits associated with these options, and I should discuss those with my primary care provider.

DO NOT SIGN THIS DOCUMENT UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION.
I have read or have had read to me the above explanation of the chiropractic adjustment and related treatments. I recognize that informed consent is a dynamic process that fully rests on open and honest communication by all parties and can be changed at any time. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended by NMCC. Having been informed of the risks, I hereby give my consent to the recommended treatment.

Patient's name (Printed): _____

Patient's Signature: _____ Date: _____

Signature of Parent or Guardian _____ Date: _____

Witness: _____ Date: _____

NMCC - Patient Financial Responsibility Disclosure Statement

Your signature below forms a binding agreement between New Mexico Chiropractic Center and the patient who is receiving services. Your clear understanding of our financial policy is important to our professional relationship.

Welcome to our office! We are pleased you have chosen Chiropractic for your health care needs. Your health is your greatest asset, and, therefore one of the best things you can invest in financially.

Insurance

Patients with private health insurance policies for which the doctor is a contracted provider are responsible for deductibles, co-payments, co-insurance and non-covered services. All services rendered during office visits must be paid for at that time. Many private health insurance policies have visit limitations, maximum daily payout limitations, and/or calendar or contract year dollar amount limitations. If, at any time during the course of treatment, all insurance benefits have been exhausted, the patient will be treated on a cash basis.

All payments are expected in full at time of service.

Personal Injury/ Motor Vehicle Accident

Please inform us if there is a lawyer handling your case, as we require a Letter of Protection (LOP). Obtaining legal representation does not negate the patient's responsibility of payment in any way. If for any reason, the case is dropped or does not result in settlement, ***you are responsible for payment of services rendered.***

Self-pay

Patients with no insurance coverage are expected to *pay in full at the time of service.*

Missed Appointments/ Cancellation fees

Missed appointments or cancellations with less than 24 hour notice will be charged a $25.00 fee*.

If you have questions regarding prices, payment options or costs please feel free to ask the staff at New Mexico Chiropractic Center. We strive to make care affordable and convenient for you and your family.

I understand and will abide by the above policies,

Patient's name (print): _____

Patient's signature: _____

Date: _____

*exception at the doctor's discretion.

New Mexico Chiropractic Center

10555 Montgomery Blvd. NE Bldg. 1 Suite 30

Albuquerque, NM 87111

PH: 505-299-6622 Fax: 505-323-4419

Office Policies for Personal Injury Patients

This office will accept you as a new patient based on our clinical examination and belief that chiropractic care will be effective for the treatment of you injuries. Your responsibility to this office will be to follow the doctor's recommend treatment plan and to provide the appropriate financial information so that payment for services can be received.

Patients need to bring the following by the second visit

1. Name of insurance company for the responsible party
2. Claim number
3. Adjusters name and phone number
4. Name and phone number of attorney if one has been retained-(if at any point an attorney is retained or if a change of representation occurs, it is your responsibility to inform our office)

If you need to miss an appointment, it is your responsibility to make up that appointment within 7 days or your case may be terminated and released from our care.

Following completion of you treatment and care in this office, your bill will be forwarded to the appropriate party (third party insurance/ attorney). Please note that this account is still your responsibility and will be subject to monthly interest charges of 2.5% effective immediately after the date of any settlement made with non-payment to our office.

Name: _____

Signature:_____ Date: _____

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Medical Payments (Medpay) Information

A lot of people have benefits (Medpay) included as an extra benefit on their automobile insurance policies and don't even realize it. Our office highly recommended that you use your Medpay coverage, if you have it, in the event that you have been injured in an automobile accident, regardless of who's at fault.

Here are 3 reasons why we recommend that we file to your Medpay.

1. **Medpay is similar to regular health insurance. It is an extra payment you make on top of your regular premium**-The benefits is usually in the amount of 5,10,20 or 25 thousand. Please inform us of the amount available to you so we make keep track during the course of treatment. Using your Medpay benefits will not cause your rate to increase like a bodily injury claim would. If your rates increase, it is not because you filed to your Medpay, its most likely because a) it was determined the accident was your fault, b) you received the police citation or ticket, or c) you've been involved in numerous reported auto accidents within a brief period of time and therefore are now considered "high-risk".
2. **Filing your Medpay doesn't relieve the other party form having to pay in full for your loss.** On the contrary, by filing your Medpay, when you collect from the other driver's liability insurance, a greater amount of settlement will go directly to you because your bill in our office may* be paid in full by your Medpay. If the other driver's liability insurance refuses to make payment to you for whatever reason, filing to you Medpay will help to insure that you are not stuck with all the medical bills.
3. **If you have Medpay coverage and choose not to file it, then you are paying for an extra option and not receiving the benefit.**

Name: _____ Date: _____

Signature: _____

*if the total balance for services rendered is more than your medical payments and the Medpay is exhausted we may still be able to file the remaining to a liable third party. If the accident was deemed your fault then the remainder of the bill after medical payments is your responsibility.

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Motor Vehicle Accident coverage

(Check each that apply to your personal injury case)

_____ **Liability** (this is the other persons insurance/responsible party)

Name of Insured: _____

Name of Insurance Co.: _____

Claim #: _____

Claims Adjuster name: _____

Adjuster phone #: _____

Insurance mailing address: _____

_____

_____ **Medical payments** (benefit under your own auto insurance)

Name of Insured: _____

Name of Insurance Co.: _____

Claim #: _____

Claims Adjuster name: _____

Adjuster phone #: _____

Insurance mailing address: _____

_____

_____ **Attorney Representation** (must have letter of representation by third visit)

Law Firm: _____

Phone #: _____ Contact Person: _____

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To any insurance company with coverage applicable to my claim(s) and to any attorney representing me:

IN CONSIDERATION of the willingness of **New Mexico Chiropractic Center** to treat me on credit without demand for payment at the time the services are rendered, I hereby agree and stipulate as follows: I irrevocably assign to **New Mexico Chiropractic Center** any proceeds or compensation that I am or may become entitled to receive as a result of my injuries that occurred on _____ to the extent of the chiropractic services rendered. I make this agreement without prejudice to any rights I may have to prosecute legal claims against any party who may be liable for my injuries, but I hereby authorize and instruct you to directly pay **New Mexico Chiropractic Center** from any disability benefits, medical payments benefits, Liability benefits, health and accident benefits, workers compensation benefits, judgments, settlements, or proceeds of any kind that would otherwise be payable to me, such sums as are due to **New Mexico Chiropractic Center** for its services rendered.

I hereby elect any payment issued for the balance accrued at New Mexico Chiropractic Center, by myself or any minor child in my guardianship, to be issued directly to **New Mexico Chiropractic Center.** I authorize **New Mexico Chiropractic Center** to release to any insurer with applicable coverage or to my attorney or successor attorney any information regarding my injuries, prior medical history, or treatment as may be necessary to facilitate collection of proceeds under this assignment. I acknowledge that I remain personally liable for the total amount due to **New Mexico Chiropractic Center** for services rendered, including any balance remaining after the application of insurance payments and settlement or judgement proceeds. If New Mexico Chiropractic Center is required to take legal action against me to recover any unpaid balance on my account, I agree to reimburse **New Mexico Chiropractic Center** for its cost of recovery, including reasonable attorney's fees.

Patient: _____ Date: _____

Witness: _____ Date: _____

Pursuant to N.C.G.S 44-49 and 44-50, New Mexico Chiropractic Center hereby asserts and gives notice of a lien upon any sums recovered in damages for personal injury in any civil action and also upon all funds paid to the above named patient in compensation for or settlement of injuries sustained, whether in litigation or otherwise. New Mexico Chiropractic Center hereby requests that if its claim is not paid in full from the foregoing proceeds, a full discloser and accounting of proceeds be provided in conformity with N.C.G.S 44-50. New Mexico Chiropractic Center agrees to be bound by any confidentiality agreements regarding the contents of accounting

Patient: _____ Date: _____

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Election to Pursue Liability Claim and NOT Health Insurance Claim

The staff of New Mexico Chiropractic Center has advised me that the cost of any treatment for injuries subsatined in an automobile accident that occurred on _____ may be covered in whole or part by both my own health insurance and by the liability insuance of the party at fault.

The clinic staff has informed me that if I file to my own health insurance, I will be responsible for paying deductibles, Co-insurance and Co-payments according to your insurance benefits and that any such payment is due at the time treatment is received. The office will be required to inform your insurance that the claims are due to an auto accident. The staff has also informed that if my health insurance makes any payments towards the cost of treatment and I sucessfuly pursue a claim against the liable party, I will be required to reimburse my health insurer for any sums it has paid either to me or to my treating physicians.

I have decided that I do not wish to file any claims on my own health insurance. I hereby direct and authorize the clinic to send bills and treatment records only to my attorney, or the liability insurance carrier, or to my own automobile insurer for the purpose of receiveing payment under my Medical Payments, Uninsured or Under-Insured motorist coverage is applicable.

I understand that the clinic will rely on my decision and render treatemtne based on the assumption that payment will be recvied from sources other than my health insurance. I will not be expected to pay deductible and co-payments, and third-party payers will be billed at the clinic's usual rates rather that at a discounted rate that may apply to in-network providers.

I understand for that if for any reason, my liability cliam is ultimately denied, compromised or ligated unsuccessfully, I will remain personally liable for the reasonable value of the treatment rendered to me by the clinic.

Patient signature: _____ Date: _____

Witness: _____

Agreement for Chiropractic Services (Personal Injury)

_____(hereinafter referred to as "Patient"), in consideration of the terms and conditions set forth herein, agrees to accept full financial responsibility for all professional services rendered by New Mexico Chiropractic Center including but limited to chiropractic treatments, examinations, adjustments, x-rays, computer-related analysis, treatments, other therapies and supplies. In the event payment is not received within 45 days of a Patient's release from care, Patient hereby authorizes New Mexico Chiropractic Center to charge the Patient's credit card noted below in full the outstanding balance owed by Patient plus a 2.5% processing fee. By signing below, Patient acknowledges and agrees the authorization to charge Patient's credit card shall automatically transfer to any successors or assigns of New Mexico Chiropractic Center. In the event the outstanding balance due is not satisfied in full from Patient's credit card, the Patient agrees to pay the outstanding balance upon demand by New Mexico Chiropractic Center. Patient agrees to pay attorney fees and costs incurred by New Mexico Chiropractic Center in connection with efforts to collect any balance owed by Patient along with interest at the rate of 1 ½ percent per month on the outstanding balance due from the date of last service or treatment until paid in full.

Patient name on credit card:_____

Billing address:_____

_____

Type of card: Visa, Mastercard, Discover

Card Number:_____ **Expiration Date:**_____

Three digit verification code from back of card:_____

Authorized Signature:_____ **Date:**_____

New Mexico Chiropractic Center

HIPAA = Health Information Portability and Accountability Act

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT & HEALTHCARE OPERATIONS

I consent to the use or disclosure of my health information to New Mexico Chiropractic Center for the purpose of diagnosing or providing treatment to me, obtaining payment for my health bills or to conduct health care operations of New Mexico Chiropractic Center. I understand that diagnoses or treatment may be continued upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. New Mexico Chiropractic Center is not required to agree to the restrictions that I may request; however, if New Mexico Chiropractic Center agrees to the restrictions, the restriction is binding on New Mexico Chiropractic Center

I have the right to revoke this consent, in writing, at any time, except to the extent that New Mexico Chiropractic Center has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review New Mexico Chiropractic Center Notice of Privacy Practices prior to signing this document. New Mexico Chiropractic Center Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosure of my protected health information that will occur in my treatment, payment of my bills or in the performance of healthcare operations of New Mexico Chiropractic Center. The Notice of Privacy Practices also describes my rights and New Mexico Chiropractic Center duties with respect to my protected health information.

New Mexico Chiropractic Center reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Signature of Patient or Personal Representative: _____

PRINT Name of Patient or Personal Representative: _____

Date: _____

New Mexico Chiropractic Center
X-RAY PREGNANCY WAIVER

I hereby acknowledge New Mexico Chiropractic Center has informed me prior to being x-rayed of the risk and the probable consequences of receiving x-rays during pregnancy. Prior to being x-rayed, I state of my own volition I am not pregnant and do hereby release and hold harmless New Mexico Chiropractic Center from any legal action or responsibility associated with the x-ray procedure.

Print Name: _____ Date: _____

Signature: _____