NP

SELIM
SURGERY CENTER

Selim Metabolic and Bariatric Center
215 W. Prien Lake Rd.
Lake Charles, LA 70601

Phone: (337) 502-8706 **Fax:** (337) 210-1271

PATIENT DEMOGRAPHIC SHEET

Today's Date: _____

Patient Name_____ Birth Date_____ Sex: M F
SSN_____-_____-_____ Marital Status: M S D W O Race: _____
Address _____ City_____ State_____ Zip_____
Phone: Home: (____)_____-_____ Cell: (____)_____-_____ Work: (____)_____-_____
What is your preferred method of contact: phone ____ text message ____ email____
Is it okay to leave a message regarding medications, labs, appointments, or instructions? Yes No
Is it okay to text a message for reminder of appointments? Yes No

Email address: (for communication from our office, notice of upcoming events, and our office appointments) _____

INSURANCE INFORMATION

Primary Insurance_____
Subscriber name: (if not patient)_____
Relationship_____ DOB_____ SSN_____-_____-_____
Insurance ID/Policy ID: _____ Group # _____
Employer Of Insured:
Secondary Insurance (YES NO)_____Subscriber (if different)_____
Relationship_____ DOB_____ SSN_____-_____-_____
Insurance ID/Policy ID: _____ Group # _____
Employer of Insured: _____

EMERGENCY CONTACT

Name: Relation to contact:
Phone: Home: (____)_____-_____ Cell: (____)_____-_____ Work: (____)_____-_____
Full Address: _____

PHYSICIAN INFORMATION

Primary care physician: _____ Referring physician: _____

How did you hear about our office? _____

Chief Complain today: _____

Selim Metabolic and Bariatric Surgery Center
GASTROINTESTINAL, MINIMALLY INVASIVE, ROBOTIC AND BARIATRIC SURGERY

NIAZY SELIM, MD, PHD, FACS
215 W. Prien Lake Rd.
LAKE CHARLES, LA. 70601

TEL: (337) 502-8706
FAX: (337) 210-1271
WWW.SELIMSURGERYCENTER.COM

MEDICATION: Current Medications: (List all, including oral contraceptives, over the counter, herbal, or health supplements)

Drug	Dose	How often each day	Why do you take this medication
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			

➡ Have you been prescribed narcotic pain medications in the past 1-year (if not listed above)? ☐ Yes ☐ No

If so, describe: _____

ALLERGIES AND RESTRICTION:

Drug (medication allergies:
Drug Name / Reaction

_____
_____
_____
_____

☐ **I have no drug allergies**

Contact Allergies:
☐ Latex ☐ adhesive
☐ tape
☐ Other
☐ I have no contact allergies.

Food Allergies:
☐ Yes ☐ No
_____ **(name of food)**
_____

☐ **I have no food allergies**

Dietary Restrictions:
☐ Vegetarian
☐ Vegan
☐ Kosher
☐ No Porc
☐ Lactose Intolerant
☐ Gluten
☐ Other:

☐ **I have no dietary restrictions**

PAST MEDICAL HISTORY:
1. _____
2. _____
3. _____
4. _____

NP

SURGICAL HISTORY: **DIAGNOSTIC PROCEDURES:**

☐ **I have never had any surgery**			**Test**	**Date**	**Location**	**Reason**
Abdominal Surgeries:	**Year**		Last set of Blood work			
Gallbladder removal: ☐ Laparoscopic ☐ Open			Upper GI			
C-section:			Upper Endoscopy			
Appendix removal: ☐ Laparoscopic ☐ Open			Lower GI			
Hysterectomy: ☐ Transvaginal ☐ Abdominal ☐ Total ☐ Partial			Colonoscopy			
Tubal Ligation: ☐ Laparoscopic ☐ Open			Abdominal Ultrasound			
Hernia Repair: Mesh Placed ☐ Yes ☐ No			EKG or Stress test			
Bowel Resection: ☐ Laparoscopy ☐ Open ☐ Small Intestin ☐ Colon			Echo-Cardiogram			
Anti-reflux procedure:			Heart cath			
Nissen Fundoplication:			Sleep Study			
Vagatomy:			Pulmonary Function test			
Plastic Surgery: (Abdominal) ☐ Yes ☐ No			Chest x-ray			
Non-abdominal Operations:	**Year**		CT scan			
Peripheral vascular procedure:			MRI			
Knee replacement:			Manometry			
Hip replacement:						
Other hospitalization without surgery:			**Surgical or Anesthesia problems:** ☐ Nausea and/or Vomiting ☐ Malignant Hyperthermia ☐ Bleeding tendency ☐ Difficult incubation ☐ **Complication after surgery:** _____			

FAMILY HISTORY:

Members	**Status**	**Diabetes**	**Hypertension**	**Heart Disease**	**Stroke**	**Mental Illness**	**Cancer**	**Unknown**
Father	Alive ☐ Deceased ☐							
Mother	Alive ☐ Deceased ☐							
Siblings	Alive ☐ Deceased ☐							
Children	Alive ☐ Deceased ☐							
Grandfather	Alive ☐ Deceased ☐							
Grandmother	Alive ☐ Deceased ☐							

FAMILY HISTORY CONT'D:

Siblings (how many?): _____ Brothers: _____ Sisters:_____ Healthy:☐Yes ☐No
Children (how many?): _____ Sons: _____ Daughters:_____ Healthy:☐Yes ☐No

Please explain any other information about your family which you want us to know:

SOCIAL HISTORY:

Race: ☐Black or African American ☐White ☐Decline to Specify
Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Decline to Specify
Language: ☐English ☐Spanish ☐Arabic ☐French ☐Chinese ☐Vietnamese ☐Korean ☐Japanese ☐Other: _____

Disability: Are you disabled? ☐No ☐Yes Type of Disability→_____

Have you used any of the following substances?	Substance	Currently Use?	Previously Used?	How many/much a day?
	Caffeine :coffee, tea, soda	☐Yes ☐No	☐Yes ☐No	
	Tobacco	☐Yes ☐No	☐Yes ☐No	
	Alcohol: beer, wine, liquor	☐Yes ☐No	☐Yes ☐No	
	Recreational/Street Drugs	☐Yes ☐No	☐Yes ☐No	

Have you ever had a blood transfusion? : ☐Yes ☐No

Have you had any travel in the past 6 months? ☐Yes ☐No If yes Where? _____ _____

REVIEW OF SYSTEMS:

➡ Do you have or have had any of the following problems on a **Persistent or Recurring** basis:

General:	☐difficulty with sleep	☐trouble sleeping	☐fever
	☐loss of sleep	☐poor appetite	☐weakness
	☐tire easily	☐weight change	☐bleeding problems
	☐sleepy during the day	☐loss of appetite	☐fatigue
	☐unexplained weight loss	☐unexplained weight gain	☐**None of the above**

Skin:	☐itching	☐bruising	☐dry sensitive skin
	☐tattoos	☐rash	☐hives
	☐body piercings	☐moles	☐keloid formation
	☐sores	☐lumps	☐acne
	☐dryness	☐hx of flexural eczema	☐skin cancer
	☐cellulitis (infection)	☐**No skin problems**	

Neuro:	☐lightheadedness	☐paralysis	☐seizures
	☐blackouts	☐confusion	☐insomnia
	☐fainting	☐headache	☐memory loss
	☐tremors	☐numbness/tingling	☐dizziness
	☐gait abnormality	☐stroke/CVA	☐pseudotumor cerebri
	☐nerve problems	☐migraines	☐**None of the above**

Eyes:	☐ yellow eyes	☐ contact lenses/ glasses	☐ drainage from eyes
	☐ eye pain	☐ glaucoma	☐ blurring of vision
	☐ redness	☐ diminished vision	☐ seasonal eye sx
	☐ cataract	☐ eye irritation	☐ dander related eye sx
	☐ loss of vision	☐ vision change	☐ **None of the above**

ENT:	☐ shortness of breath	☐ frequent sore throats	☐ cough
	☐ earaches	☐ sore tongue	☐ epistaxis (nosebleed)
	☐ history of emphysema	☐ sore mouth	☐ hearing loss
	☐ hearing problems	☐ excessive tooth decay	☐ change in voice
	☐ infection	☐ chronic cough	☐ sore throat
	☐ hay fever	☐ wheezing	☐ ringing in ears
	☐ frequent nosebleeds	☐ Asthma	☐ sinus pain
	☐ hoarseness	☐ sinus trouble	☐ bad breath
	☐ cold	☐ **None of the above**	

Neck:	☐ goiter	☐ pain/stiffness	☐ lumps	☐ swollen glands

Cardiology:	☐ hypertension	☐ chest pain	☐ cyanosis
	☐ rheumatic fever	☐ murmur	☐ shortness of breath
	☐ palpitations	☐ edema	☐ varicose veins
	☐ irregular heart beat (a-fib)	☐ heart disease	☐ cardiomyopathy
	☐ congestive heart failure	☐ heart valve problems	☐ heart attack (MI)
	☐ high cholesterol	☐ high triglycerides	☐ diseased leg arteries (PVD)
	☐ cardiac catheterization	☐ heart bypass	☐ syncope (passing out)
	☐ diseased neck arteries (carotids)	☐ **No heart or blood vessel problems**	
Respiratory:	☐ asthma	☐ home oxygen use	☐ obstructive sleep apnea
	☐ pulmonary embolus (clot in lungs)	☐ pulmonary hypertension	☐ COPD (emphysema or chronic bronchitis)
	☐ productive cough	☐ coughing up blood	☐ pain with deep breath
	☐ nighttime snoring (any)	☐ loud snoring	☐ shortness of breath with activity
	☐ shortness of breath at rest	☐ **None of the above**	

Hematology:	☐ history of blood transfusion	☐ easy bleeding	☐ fatigue
	☐ transfusion reactions	☐ easy bruising	☐ loss of appetite
	☐ anemia	☐ swollen glands	☐ varicose veins
	☐ clotting problems	☐ HIV or AIDS	☐ personal history of blood cots
	☐ family history of blood clots	☐ cancer history	☐ enlarged lymph nodes
	☐ **No hem/onc problems**		

GI:	☐ indigestion	☐ straining	☐ difficulty swallowing
	☐ excessive thirst	☐ excessive flatus (gas bloating)	☐ abdominal pain
	☐ milk intolerance	☐ rectal pain	☐ diarrhea
	☐ abdominal swelling	☐ Trouble controlling bowel movements/accidents	
	☐ vomiting blood	☐ nausea	☐ constipation
	☐ hard stools	☐ heartburn	☐ change in bowel habits
	☐ use finger to evacuate stool	☐ vomiting	☐ blood in stool

Other GI:
- ☐ Gallstones
- ☐ history of pancreatitis
- ☐ inflamed or diseased gallbladder
- ☐ fatty liver (NASH)
- ☐ hepatitis (type: _____)
- ☐ GERD
- ☐ bile reflux
- ☐ Barrett's esophagus
- ☐ Schatzki's ring
- ☐ stomach or intestinal ulcer
- ☐ Crohn's disease
- ☐ Ulcerative Colitis
- ☐ colon cancer
- ☐ fecal incontinence (leaking)
- ☐ irritable bowel disorder
- ☐ diverticulitis
- ☐ hemorrhoids
- ☐ reflux /regurgitation
- ☐ jaundice (yellow tint to eyes or skin)
- ☐ hernia (☐ Hiatal ☐ incisional ☐ umbilical ☐ inguinal)
- ☐ **None of the above**

Endocrine:
- ☐ polyuria
- ☐ cold intolerance
- ☐ excessive sweating
- ☐ weight loss
- ☐ heat intolerance
- ☐ polydipsia
- ☐ sleep disturbance
- ☐ diabetes (type 1 or type 2)
- ☐ diabetes nerve problems
- ☐ diabetes eye problems
- ☐ diabetes ulcers
- ☐ glucose intolerance/pre-diabetes
- ☐ low thyroid level (hypothyroid)
- ☐ high thyroid level (hyperthyroid)
- ☐ infertility
- ☐ hypoglycemia (low blood sugar)
- ☐ metabolic syndrome
- ☐ morbid obesity
- ☐ excessive thirst
- ☐ excessive hunger
- ☐ excessive urination
- ☐ Polycystic Ovary Syndrome (PCOS)
- ☐ **No endocrine problems**

Extremities:
- ☐ muscle pain
- ☐ varicose veins
- ☐ leg cramps
- ☐ gout
- ☐ joint pain
- ☐ cold sensitivity
- ☐ ulcers on legs and feet
- ☐ backache
- ☐ redness and swelling of joints.
- ☐ **None of the above**

Musculo-Skeletal:
- ☐ back pain
- ☐ joint pain
- ☐ sciatica
- ☐ gout
- ☐ joint swelling
- ☐ fracture
- ☐ joint stiffness
- ☐ leg cramps
- ☐ carpal tunnel
- ☐ osteoarthritis
- ☐ Rheumatoid arthritis
- ☐ degenerative joint disease
- ☐ degenerative disk disease
- ☐ herniated disk
- ☐ fibromyalgia
- ☐ lymphedema
- ☐ neck pain
- ☐ hip pain
- ☐ knee pain
- ☐ ankle or foot pain
- ☐ back pain
- ☐ wrist pain
- ☐ shoulder pain
- ☐ muscle weakness
- ☐ **None of the above**

Psych:
- ☐ nervousness
- ☐ tension/stress
- ☐ eating disorders
- ☐ manic symptoms
- ☐ sleep disturbance
- ☐ mental or physical abuse
- ☐ bad mood
- ☐ suicidal thoughts
- ☐ anxiety
- ☐ depression
- ☐ ADHD
- ☐ bipolar disorder
- ☐ schizophrenia
- ☐ prior psychiatric hospitalization
- ☐ eating disorder
- ☐ panic attacks
- ☐ hallucinations
- ☐ memory loss/confusion

Genito Urinary Female:
- ☐ excessive urination
- ☐ past sexually transmitted disease
- ☐ urgency
- ☐ burning
- ☐ loss of interest in sex
- ☐ heavy periods
- ☐ kidney stones
- ☐ excessive blood loss
- ☐ difficulty urinating
- ☐ sores
- ☐ menopause
- ☐ increased urinary frequency
- ☐ lumps
- ☐ difficulty holding urine/accidents
- ☐ pelvic pain
- ☐ Pain during intercourse
- ☐ last menstrual period
- ☐ dysmenorrhea
- ☐ hernia
- ☐ blood in urine
- ☐ vaginal discharge
- ☐ hot flashes
- ☐ kidney failure
- ☐ **No kidneys and GU problems**

Genito	☐ blood in urine	☐ impotence	☐ hernia
Urinary	☐ excessive urination	☐ loss of interest in sex	☐ undescended testicle
Male:	☐ burning	☐ difficulty holding urine/accidents	☐ kidney disease
	☐ sores	☐ kidney stones	☐ hard testicle
	☐ lumps	☐ difficulty urinating	☐ hypospadias
	☐ vaginal discharge	☐ increased urinary frequency	☐ retractile testicle
	☐ past sexually transmitted disease	☐ kidney failure	☐ urinary stress incontinence
	☐ **No kidneys and GU problems**		

Please provide details of medical history marked above or any other condition you have that is not listed above:

Last menstrual period: _____

Pap Smear date: _____ ☐ **Normal** ☐ **Abnormal**

Mammogram date: _____ ☐ **Normal** ☐ **Abnormal**

Pharmacy Contact Information:

Pharmacy Name: _____

Pharmacy Address:_____

Pharmacy Phone: _____

By signing below, you authorize Louisiana Surgeons of Excellence to obtain your list of medications.

_____ _____

Patient Signature *Date*

I authorize release of any information concerning me (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor.

_____ _____

Patient Signature or Parent if minor *Date*

Employment Status: ☐ Full Time ☐ Part Time ☐ Homemaker ☐ Student ☐ Retired ☐ Disabled ☐ Unemployed

Occupation:_____

Employer: _____

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Please List all The Healthcare Providers who have treated you in the last 5 years:

Provider (MD,DO, NP, PA)	Address	Phone
PCP:		
Cardiologist:		
Pulmonologist:		
Neurologist:		
Mental Health:		
OB/GYN:		
Pain Management:		
Oncologist:		
Surgeon:		
Other		

Designation of Personal Representative

As required by the Health Insurance Portability and Accountability Act of 1996 you have a right to nominate one or more persons to act on your behalf with respect to the protection of health information that pertains to you. By completing this form you are informing us of your wish to designate the named person as your personal representative. You may revoke this designation at any time by signing and dating the revocation of your copy of this form and return it to the office.

I, _____ (**patient name**) herby nominate the following person to act as my personal representative with respect to decision involving the use and/or disclosure of health information that pertains me. You may list as many people as you like just list them below.

I hereby authorize medical providers and personnel of Selim Surgery Center to discuss my protected health information with(*This person is to be afforded all of the privileges that would be afforded to me with respect to my health)*:

(**Print Name of Personal Representative)** _____
(Relationship to Patient) _____
(Phone # of Personal Representative) _____

_____ _____
Signature *Date*

_____ _____
Witness *Date*

***Your patient information is *confidential*, by naming someone as your personal representative this gives us your permission to discuss your patient information with that person. (Example: Spouse, daughter, son, etc.) ***

Or

I understand that I may revoke this designation at any time by signing the revocation section of my copy of this form and returning it to 215 W. Prien Lake Rd., Lake Charles LA 70601-8450. I further understand that any such revocation does not apply to the extent that persons authorized to use of disclose my health information have already acted in reliance on this designation.

I hereby revoke this designation of a personal representative. _____ **I DO NOT** authorize Selim Surgery Center to release ANY medical or appointment information to anyone.
(this means we will only discuss your medical record with you)

_____ _____
Signature *Date*

_____ _____
Witness *Date*

APPOINTMENT POLICIES

Welcome to our practice. We are proud to serve as your choice for surgical intervention.

1. Due to an increase of patients not showing up for their appointments **we will now charge a fee of $50 for not notifying us at least 24 hours prior to your appointment**. This fee will need to be paid prior to any future visits.

2. For surgery patients that fail to show up or notify us of cancellation of their surgery or outpatient procedure there will be a **no show fee of $500.00** and this will need to be paid before any future office or surgery appointments will be made.

3. If you schedule and do not show up for three (3) appointments without valid reason we will discharge you from our care.

4. If you are more than 15 minutes late for your appointment and have not called to notify us that you will be late you will need to be rescheduled if we are unable to work you back into the schedule. If we have a cancellation or another patient that does not show up we can try to work you back into the schedule but that will be at the discretion of the staff.

5. If you are a "work in" patient for an ASAP appointment and you do not show up or if you cancel you will be given the next available appointment which could be 1 to 2 months later.

6. If you require paperwork to be filled out for supplemental insurance, leave for work, or other issues it will take approximately 72 hours to complete as Dr. Selim is only in the office a limited number of days due to his surgery schedule. **There is a $50 charge for all paperwork not including return to work excuses printed by this clinic**.

7. At the start of every new year you will be required to fill out update paperwork as it is state law that we must have updated signatures every new year.

8. If you need a refill, **please give at least 72-hour notice prior to running out of your medication**. If a nurse is not available leave a message with the receptionist for the doctor's approval and a nurse will call you back normally within 72 hours.

9. Please note that Dr. Selim is a surgeon and is not in the office every day, and this at times can cause a delay in the answering of patient messages. Please be patient and we will take care of you to the best of our ability.

10. Due to the various specialties offered by Dr Selim, your office wait time may exceed 2 hours. We thank you for your understanding, as all patients are afforded the necessary time to ensure the best plan of care is provided.

Thank you for allowing our office to participate in your care!

I acknowledge that I have read and understand the above and agree to follow these guidelines to allow for better patient care.

_____ _____

Patient Signature **Date**

_____ _____

Witness **Date**

HEALTH DECLARATION FORM-COVID-19

Patient Name:_____ DOB:_____

MRN:_____ Today's Date: _____

Coronavirus COVID19 is declared a global pandemic by the World Health Organization and has spread across multiple continents infecting tens of thousands across the globe.
The Centers for Disease Control and Prevention (CDC) has made recommendations to physicians and the general public for all patients seeking healthcare to follow recommended protocol.

Patients with a COVID19 infection may look like the cold and flu symptoms, or they may be infectious without any presenting symptoms. Following the CDC patient assessment protocol for early disease detection for patients presenting to the practice, the following criteria is essential for the safety of the patients and healthcare staff.

I attest that I am fully aware of the COVID19 that has impacted the countries healthcare environment and I have made an informed decision to seek healthcare from Dr. Niazy Selim, and I am aware of the risk involved in seeking care in a healthcare setting. I have answered the healthcare questions as thoroughly and honestly as possible. I understand the risk and ramifications of not answering the questions completely honestly including not only putting myself at risk but placing the provider and healthcare staff at risk.

I DO NOT HAVE ANY OF THE FOLLOWING SYMPTOMS:

Upper respiratory infection, cough, cold, flu like symptoms, elevated (fever), difficulty breathing

I, _____ hereby certify, represent and warrant as follows: Within the twenty one (21) days immediately preceding the Date of this Health Declaration Form ("Declaration"),

I HAVE NOT:

a. tested positive or presumptively positive with the Coronavirus or been identified as a potential carrier of the COVID-19 virus or similar communicable illness ("Coronavirus");
b. Travelled outside the country in the last 21 days or regions affected by the virus
c. Experienced any symptoms commonly associated with the Coronavirus;
d. Been in any location positively designated as hazardous and/or potentially infected with the Coronavirus by a recognized health or regulatory authority, such as a country for which the Center for Disease Control and Prevention ("CDC") issued a Level 3 Travel Advisory for Coronavirus;
e. Been in direct contact with or the immediate vicinity of any person I knew and/or now know to be carrying the Coronavirus or has been identified as a potential carrier of the Coronavirus.

I CAN account for all locations visited over the previous twenty one (21) days and shall provide an exhaustive list of all locations visited and modes of transportation used below (please attach an
Additional page as needed):

I AGREE to notify Louisiana Surgeons of Excellence, LLC (by email to naima@lasoemd.com or kat@lasoemd.com or phone: (337) 502-8706 of any change in status, including diagnosis with Coronavirus and/or quarantine, within thirty days either before or following an appointment.

I WILL, if asked, wear a mask (of the specifications recommended by the office personnel) at all times while a patient of Dr. Niazy Selim, and will take all reasonable prophylactic steps that may be recommended by Louisiana Surgeons of Excellence, any relevant public authority.

I WILL consent to having my temperature taken by any representative or staff of Louisiana Surgeons of Excellence prior, during, and after an office visit, and will provide any follow up information reasonably requested by Dr. Selim's office.

I ACKNOWLEDGE and ACCEPT that this Declaration will be considered as my consent to Louisiana Surgeons of Excellence to disclose, share, record and store this Declaration with any relevant authority or service provider for the purposes of ensuring the safety and security of any and all third parties that may come in contact with me prior, during, and after my office visit.

I AGREE to provide a written consent explaining that I understand the potential risks of being seen in the office setting. I understand patient will be triaged over the phone or via telemedicine and managed according to CDC recommendations.

I AGREE there will be a triage station outside the office before staff determine which patient can be managed safely in the office.

POTENTIAL RISKS:

a. There might be any foreseeable risks of getting infected by the virus even if the staff and physician take all precautionary measure to clean and disinfect after each patient by following guidelines of the infection control protocol plan in place.
b. There might be greater risks if you are immunocompromised so let the staff know about your health ahead of times if you have any specific condition.
c. If you believe you are pregnant ensure to let the staff know
d. elderly, those with medical co-morbidities, and potentially other persons who are at higher risk for complications from respiratory diseases, such as pregnant women.

In signing below, I, an individual over the age of 18 of sound mind, knowingly, voluntarily, and freely agree to the terms of this binding Declaration, and in doing so represent the truthfulness and veracity of the above answers.

I have read, or had read to me, the contents of this form and have no further questions. I wish to proceed with visit/care provided by Dr. Niazy Selim and Louisiana Surgeons of Excellence, LLC.

Print Patient Name	*Patient Signature*	*Date*
Print Witness Name	*Witness Signature*	*Date*
Niazy Selim, M.D., Ph.D, F.A.C.S.		
Print Surgeon Name	*Surgeon Signature*	*Date*

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24 Hour Cancellation & "No Show" Fee Policy

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, Louisiana Surgeons of Excellence Physicians reserve the right to charge a fee of $50.00 for all missed appointments ("no shows") and appointments which, absent a compelling reason, are not cancelled with a 24-hour advance notice.

"No Show" fees will be billed to the patient. This fee is not covered by insurance and must be paid prior to your next appointment. Multiple "no shows" in any 12-month period may result in termination from our practice.

Thank you for your understanding and cooperation as we strive to best serve the needs of all our patients.

By signing below, you acknowledge that you have received this notice and understand this policy.

_____ _____
Print Patient Name *Date*

_____ _____
Patient Signature *Date*