Four Seasons Pediatrics, LLC – Pediatric History Questionnaire

Patient Name _____ Date of Birth ____/_____/_____

Family Members:	**Name**	**DOB**	**Occupation/ Status**	**Employer**
☐ Father	_____	_____	_____	_____
☐ Stepfather	_____	_____	_____	_____
☐ Mother	_____	_____	_____	_____
☐ Stepmother	_____	_____	_____	_____
☐ Brothers & Sisters (please indicate if they are half or step siblings):				
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____

Are the **biological** parents living together? ☐ Yes ☐ No

Birth History:

Delivery - ☐ Vaginal ☐ C-section. What hospital was your baby born at? _____

If Cesarean delivery describe reason: _____ Was your baby full term? ☐ Yes ☐ No

Group B Strep Cervical Culture: ☐ Positive ☐ Negative.

Mother's Heb B test was : ☐ Positive ☐ Negative

Mother's Rubella Status was: ☐ Immune ☐ Nonimmune

Birth weight: _____lbs _____oz. Discharge weight from the hospital: _____lbs _____oz.

Was the hearing test passed in the hospital: ☐ Yes ☐ No

Please list any problems in the Nursery _____ ☐ None

Past Medical History – please list all medical problems and age of onset (place a comma after each problem):

_____

Past Surgeries - please list type and year : _____ ☐ None

Medications - please list medication currently being taken: _____ ☐ None

Allergies to food or medication – ☐ Yes ☐ No If YES list the food or medication and what reaction occurred:

_____

Development – please list any developmental problems your child has had: ☐ None

_____

Patient Name _____ Date of Birth ____/_____/_____

Family History – please check those that are positive(P).

Medical Condition	Mom	Dad	Child's Sister	Child's Brother	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad	Mom's Sister	Mom's Brother	Dad's Sister	Dad's Brother
Anemia												
Alcoholism												
Allergies												
Asthma												
ADHD												
Cancer												
Cystic Fibrosis												
Diabetes												
Eczema												
High Cholesterol												
Hypertension												
Kidney Disease												
Mental Retardation												
Heart Attack/Stroke												
Obesity												
Seizures												
Tuberculosis												

Other History

Is there any other behavioral health history for the family or patient (e.g. schizophrenia, stress, alcohol, prescription drug abuse, illegal drug use) _____

Are you anticipating or are you currently using a daycare for your child? ☐ Yes ☐ No

Was your house built before 1960? ☐ Yes ☐ No

Does anyone in the family currently smoke? ☐ Yes ☐ No

If YES, who? _____

Do they smoke inside? ☐ Yes ☐ No

Has anyone in the house ever smoked (in or outside)? ☐ Yes ☐ No

If YES, who? _____

Please list your water district (e.g. Clifton Park Water Authority) _____.

_____ _____ _____

Name of person who filled out form Relationship to child Date

_____ _____

Provider signature – Info reviewed and entered into EMR **Date**

Four Seasons Pediatrics, LLC 532 Moe Road Clifton Park, NY 12065

Family Last Name _____ Today's Date _____

Address: _____City _____ State ____ Zip _____

Please list all children:

Name _____ Middle Initial _____DOB _____ Sex male / female Allergies _____

Name _____ Middle Initial _____DOB _____ Sex male / female Allergies _____

Name _____ Middle Initial _____DOB _____ Sex male / female Allergies _____

Name _____ Middle Initial _____DOB _____ Sex male / female Allergies _____

What is your preferred number for reminders/ messages _____ ☐home ☐cell

Do you want to receive text messages at this number (e.g. your prescription has been sent to the pharmacy)? ☐ Yes ☐ No

Preferred time for reminders/messages: ☐ morning ☐ afternoon ☐ evening

E-mail address (for access to the patient portal) _____

Maiden Name **(the child's/children's biological mother)** _____ Mother's DOB _____

Parent/Guardian:

Last name_____ First name _____Middle initial _____

Relationship to the patient: ☐Mother ☐Father ☐Stepmother ☐Stepfather ☐Other _____

DOB: ____ / _____ / _____ ☐ male ☐female SS# _____

Home/cell phone: _____ Work phone: _____

Address: ☐ Same as patient. If not please list address here:

Street: _____City_____State _____ Zip _____

Other parent/guardian:

Last Name: _____ First Name: _____Middle Initial: _____

Relationship to the patient: ☐Mother ☐Father ☐Stepmother ☐Stepfather ☐Other _____

DOB: ____/ ____/ ____ ☐ male ☐ female SS#: _____

Home/cell phone: _____ Work phone: _____

Address: ☐ Same as patient. If not please list address here:

Street: _____City_____State _____ Zip _____

Please list your Pharmacy and the location _____

Please list any vision or hearing issues (related to communication) _____

Medical Insurance Information

Four Seasons Pediatrics does not participate in any direct Medicaid or Medicare program.

Primary Insurance _____

Subscriber/policy holder: _____

Policy # _____Group Number: _____ Policy Effective Date: _____

Employer: _____Co- Pay/deductible amount $ _____

Secondary Insurance _____

Subscriber/policy holder: _____

Policy # _____Group Number: _____ Policy Effective Date: _____

Employer: _____Co- Pay/deductible amount $ _____

- **PCP Change**: I understand that if my plan requires a Primary Care Provider, I must change this with the insurance before any claims are paid by the insurance. This change must be made effective on or before any dates of service billed by Four Seasons to the insurance. I am responsible for any charges and fees associated with unpaid medical claims for this reason.
- **Managed Medicaid / Child Health Plus:** Failure to name a provider at Four Seasons Pediatrics as my PCP will make any visits viewed as an uncovered service delivered on a Fee For Service basis. As a private pay patient, this and all other uncovered services will be delivered in this manor. I understand that I may obtain medical care at no cost from another provider that participates in my managed care plan.
- **COB Information**: I understand that if my insurance needs to verify that I have no other medical coverage (Coordination of Benefits information), I am responsible for providing this information to the insurance. I understand that no medical claims will be paid until this information is updated and I will be responsible for payment of unpaid claims.
- **Deductible:** I understand that if I have a deductible with my insurance, I will need to meet that deductible before any payment is made by my insurance. I understand that an office visit can typically range between $80 and $150 dollars after the insurance processes it to my deductible, and I am responsible for this charge. If I have any questions on how my deductible works I will inquire with the insurance directly or a representative from Four Seasons can help explain it to me upon request.
- **Copayment:** I understand that if my insurance requires a copay for any visits, I am responsible for paying this charge AT THE TIME OF THE VISIT. If this is not paid, I will be billed a $5.00 service charge for processing in addition to the copay. This policy applies to all visits even if I have another individual bringing the patient into the office for a visit.

I certify that all above provided information to be true to the best of my knowledge. Four Seasons Pediatrics LLC will use this information to properly bill my insurance company / invoice me for any patient responsibilities and correctly mail me any forms or documents needed for ongoing medical care.

_____ _____ _____

Printed Name Signature Date

Patient Consent for Treatment, Payment and Healthcare Operations
Four Seasons Pediatrics

We are a Patient Centered Medical Home. Patient Centered Medical Homes (PCMH) are about what patients want: a focus on patients themselves and their health care needs. Medical Homes are the foundation for a health care system that gives more value by achieving the "Triple Aim" of better quality, experience and cost. Four Seasons Pediatrics embodies the spirit and practice of the Patient Centered Medical Home. Everyone in the practice – from clinicians to front desk staff – works as a team to coordinate care from other providers and community resources. This maximizes efficiency by ensuring that highly trained clinicians are not performing tasks that can be accomplished by other staff, and helps avoid costly and preventable complications and emergencies through a focus on prevention and managing chronic conditions.

- We will deliver safe, effective and efficient care that is well coordinated across the medical neighborhood and optimizes the patient experience.
- We will provide whole person care at the first contact. Everyone in the practice – from physicians and practice nurses to medical assistants and frontline staff will practice to the highest level of their training and license in teams, to support better access, self care and care coordination.
- We will be respectful of and responsive to individual patient preferences, needs and values, and ensure that patient values guide all clinical decisions. Individuals and families will get help to be actively engaged in their own healthy behaviors, health care, and in decisions about their care.

What is your role in this process? We ask that you help us coordinate your care. If you seek care elsewhere (without us sending you there), kindly notify us about your visit (self referral to a specialist, visit to the urgent care or emergency room etc). We will obtain and review the records and send necessary information to coordinate your care.

Privacy Use: Patient Consent for Use and Disclosure of Protected Health Information

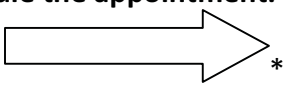
- With this consent, Four Seasons Pediatrics, LLC may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Four Seasons Pediatrics' Notice of Privacy Practices for a more complete description of such uses and disclosures.

- I have the right to review the Notice of Privacy Practices prior to signing this consent and acknowledge I have received a copy. Four Seasons Pediatrics reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Four Seasons Pediatrics, LLC Privacy Officer at 532 Moe Road, Clifton Park, NY 12065.

- With this consent, Four Seasons Pediatrics may call my home, cell phone numbers listed with Four Seasons Pediatrics, my work phone if designated by me, mail to my home, email me, or other designated location selected by me and leave a message on voice mail, by text message, or in person in reference to any items that assist the practice in carrying out treatment, payment and health care operations, such as appointment reminders, insurance items, billing and debt collection and any information pertaining to my clinical care, including test results and medical information. I also agree to accept email with PHI attached if I verbally request such information to be sent to my private email.

Financial Policy: Agreement for Payment

No Show/Late Cancellation Charges: Four Seasons Pediatrics cannot bill the insurance for these charges, but are permitted by insurance companies to bill the patient for them. We kindly ask for 24 hours notice if you are unable to come to an appointment previously made. Notifying us 24 hours in advance allows us to offer the appointment time to others. Failure to give 24 hours notice to cancel an appointment previously made is subject to a Late Cancellation charge (currently $25). Failure to show up for an appointment without notification is subject to a No Show charge (currently $50). I understand that if I miss appointments, I will be asked to transfer my records to another doctor and I will still be responsible for the balance owed. Please note - reminder calls are sent out as a courtesy, it is still the patient's responsibility to keep all appointments, unless there is 24 hours notice. **No Show fees and Late Cancellation fees must be paid to reschedule the appointment.**



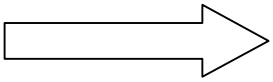
*Initial _____

Listing Four Seasons Pediatrics as Primary Care Provider (PCP): I understand that it is my responsibility to notify my insurance company of the change in PCP to Four Seasons Pediatrics prior to my first visit with Four Seasons Pediatrics. Failure to do so will make me responsible for the services rendered during any visits with Four Seasons Pediatrics.

Co-Payments are due at the time of the office visit. Failure to pay the co-payment at the time of service is subject to a co-pay surcharge (currently $5, subject to change).

Monthly Statements will reflect the amount I owe to Four Seasons Pediatrics. Unpaid balances will have a finance charge (currently $5 per month, subject to change).

Past Due Accounts: Accounts that are past due greater than 60 days are subject to being referred to a collection agency. Four Seasons Pediatrics will make every effort to inform me of this action. It is my responsibility to inform Four Seasons Pediatrics of any change in address, phone numbers, or insurance information important for medical payments and correspondence. Failure to notify Four Seasons Pediatrics of changes in address, phone number or insurance information does not relieve me of my responsibility of any charges incurred or balances due. Once accounts are turned over to collections, I understand that I will be responsible for late fees, and any collection costs incurred. If the account is turned over for legal action, I agree to pay all lawyers fees and court costs incurred by Four Seasons Pediatrics as a result of such action.



*Initial _____

Waiver of Confidentiality: I understand that if this account is submitted to an attorney or collection agency, if Four Seasons Pediatrics has to litigate in court, or if my past due status is reported to a credit reporting agency, the fact that I received treatment at your office may become a matter of public record.

Returned Checks: There is a fee (currently Four Seasons Pediatrics is charged $32) that will be passed on to me for any checks returned by the bank for insufficient funds.

Fees: I understand that Four Seasons Pediatrics may reasonably adjust the above fees, from time to time based on fees incurred by Four Seasons Pediatrics, and that these fees are re-assessed on an annual basis.

Copying of Records: I will need to request in writing and pay a reasonable fee (currently $0.75 per page) if I want copies of my records.

Forms

Forms completed during a physical appointment

- Four Seasons Pediatrics has developed computer generated forms. These forms are developed from state requirements and meet the demands for almost all situations. Forms generated from our system at the time of your child's physical exam will be given on request free of charge. The physical forms are good for one year and can be used for sports and camp (unless they have specific custom forms) so if you think you may need one for the upcoming year let our staff know. You will be given one copy. Additional copies or a computer generated form at times other than while you are in the office during your child's physical will be charged a fee of $5 per form, $1 additional if mailed to your home. Forms for siblings will also be charged this fee, unless they are requested at the time of their separate physical exam. School forms require an annual exam done within 12 months of the request.

Forms completed during a sick visit

- Forms will be filled out at no charge if they are related to the sick visit (e.g. note to return to daycare/school/work, note to administer medication related to a sick visit) and they are requested at the time of the visit. Additional copies or a request for a form not done while you are in the office at the time of the visit will be subject to a fee of $5 per form, $1 additional if mailed to your home.

Custom forms

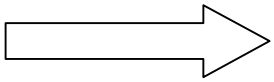
- While our computer generated forms will be applicable for almost all school and daycare forms there are some school, daycare and organizations that require their own custom forms to be filled out. The fee for custom forms is $5 per form, $1 additional if mailed to your home. This fee applies for custom forms done at any time whether done in the office at your child's physical exam or not.

Turn around time

- Although we usually accomplish these in a shorter time frame, please allow a turn around time of up to 2 business days for forms. In addition to the $5 form fee if the form is needed within 24 hour time period there will an additional fee of $5 per item. There is a fee of $ 1.00 for mailing the forms.

Form release

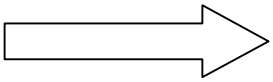
- Due to the Health Insurance Portability and Accountability Act ("HIPAA") regulations, forms will be released to parents or guardians only, unless a 3rd party release form is submitted or on file. We will mail forms to the home address on file at your request, subject to the above fees. All forms must be paid for before they are released.



*Initial _____

Vaccine compliance policy

- **Four Seasons Pediatrics has an office wide policy that requires the vaccination schedule recommended by the American of Pediatrics (AAP) and The Center for Disease Control (CDC). This policy requires pediatric and adolescent vaccination compliance for all patients. This policy is in effect to protect patients in the practice who have Immune Deficiency, those who have had Bone Marrow Transplants, those being treated with chemotherapy, and Newborns too young to be vaccinated. I understand that failure to follow the Vaccine Schedule within 2 weeks of notification will result in discharge from the practice. This policy does not apply to the flu vaccine nor the HPV vaccine, though the practice strongly recommends both of these vaccines.**



*Initial _____

I have ☐ **received a copy (please request copy)** ☐ **read and declined a copy** of the Four Seasons Pediatrics Patient consent for Treatment, Payment and Healthcare Operations, and understand the responsibilities of me and Four Seasons Pediatrics, LLC. **This is also sent to you through our patient portal when you a web enabled as well as being available on our web site, fourseasonspediatrics.com.**

I may revoke my consent in writing except to the extent that the practice has already made disclosures or provided services in reliance upon my prior consent. If I do not sign this consent, I understand that Four Seasons Pediatrics is under no obligation to provide treatment to me.

I authorize the use of my signature for all my insurance submissions and to carry out activities related to treatment, payment and healthcare operations with all my insurance companies. I understand that I am responsible for any fees not covered by my insurance company, unless my insurance company prohibits billing for such services. I authorize payment directly to my doctor. I permit a copy of this authorization to be used in place of the original. The individual signing below will be responsible for all financial and billing activities.

_____ _____ _____

Printed Name **Signature** **Date**

Race and Ethnicity Questionnaire

Four Seasons Pediatrics participates in federal survey programs that report on quality of healthcare at the national level. As such, we are required to ask about information regarding your child. This information is not reported individually to any other organizations outside of Four Seasons Pediatrics. Your response to these questions is not required.

Please answer the following questions about the patient:

1. Race:

   ☐ American Indian or Alaska Native
   ☐ Black or African American
   ☐ White
   ☐ Other _____
   ☐ Unknown
   ☐ I do not wish to answer

2. Ethnicity:

   ☐ Hispanic
   ☐ Non – Hispanic
   ☐ Unknown
   ☐ I do not wish to answer

3. Primary Language:

   ☐ English
   ☐ Other _____ Do you need an interpreter? ___Yes ____No
   ☐ I do not wish to Answer

4. May the doctors have your permission to view prescriptions prescribed outside this office by other locations?

   ☐ Yes
   ☐ No

Patient Name _____

DOB _____

Guardian Name _____

Signature _____

Date _____

Hixny

Hixny Electronic Data Access Consent Form
Four Seasons Pediatrics, LLC

In this Consent Form, you can choose whether to allow Four Seasons Pediatrics, LLC to obtain access to your medical records through a computer network operated by the Healthcare Information Xchange of New York (Hixny), which is part of a statewide computer network. This can help collect the medical records you have in different places where you get health care, and make them available electronically to our office.

You may use this Consent Form to decide whether or not to allow Four Seasons Pediatrics, LLC to see and obtain access to your electronic health records in this way. You can give consent or deny consent, and this form may be filled out now or at a later date. **Your choice will not affect your ability to get medical care or health insurance coverage. Your choice to give or to deny consent may not be the basis for denial of health services.**

If you check the **"I GIVE CONSENT"** box below, you are saying "Yes, Four Seasons Pediatrics, LLC's staff involved in my care may see and get access to all of my medical records through Hixny."

If you check the **"I DENY CONSENT"** box below, you are saying "No, Four Seasons Pediatrics, LLC may not be given access to my medical records through Hixny for any purpose."

Hixny is a not-for-profit organization. It shares information about people's health electronically and securely to improve the quality of health care services.

Please carefully read the information on both pages of this form before making your decision.
You have two choices:

☐ **I GIVE CONSENT for Four Seasons Pediatrics, LLC to access ALL of** my medical records through Hixny in connection with providing me any health care services, including emergency care.

☐ **I DENY CONSENT for Four Seasons Pediatrics, LLC to access** my medical records through Hixny for any purpose, *even in a medical emergency*. Unless you check this box, New York State law allows medical providers treating you in an emergency to get access to your medical records, including records that are available through Hixny.

_____ _____ _____
Print Name of Patient Date of Birth Date

_____ _____
Signature of Patient or Patient's Legal Representative Print Name of Legal Representative (if applicable)

_____
Relationship of Legal Representative to Patient (if applicable)

Details about patient information in HIXNY and the consent process:

1. **How Your Information Will be Used**. Your electronic health information will be used by Four Seasons Pediatrics, LLC **only** to:

- Provide you with medical treatment and related services
- Check whether you have health insurance and what it covers
- Evaluate and improve the quality of medical care provided to all patients.

NOTE: The choice you make in this Consent Form does NOT allow health insurers to have access to your information for the purpose of deciding whether to give you health insurance or pay your bills. You can make that choice in a separate Consent Form that health insurers must use.

2. **What Types of Information about You Are Included**. If you give consent, Four Seasons Pediatrics, LLC may access ALL of your electronic health information available through HIXNY. This includes information created before and after the date of this Consent Form. Your health records may include a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), and lists of medicines you have taken. This information may relate to sensitive health conditions, including but not limited to:

- Alcohol or drug use problems
- Birth control and abortion (family planning)
- Genetic (inherited) diseases or tests
- HIV/AIDS
- Mental health conditions
- Sexually transmitted diseases

3. **Where Health Information About You Comes From**. Information about you comes from places that have provided you with medical care or health insurance ("Information Sources"). These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid program, and other ehealth organizations that exchange health information electronically. A complete list of current Information Sources is available from Four Seasons Pediatrics, LLC. You can obtain an updated list of Information Sources at any time by checking the HIXNY website: www.hixny.org.

4. **Who May Access Information About You, If You Give Consent.** Only these people may access information about you: doctors and other health care providers who serve on Four Seasons Pediatrics, LLC's medical staff who are involved in your medical care; health care providers who are covering or on call for Four Seasons Pediatrics, LLC's doctors; and staff members who carry out activities permitted by this Consent Form as described above in paragraph one.

5. **Penalties for Improper Access to or Use of Your Information.** There are penalties for inappropriate access to or use of your electronic health information. If at any time you suspect that someone who should not have seen or gotten access to information about you has done so, call Four Seasons Pediatrics, LLC at: 518-383-2425; or call HIXNY at (518) 357-3690; or call the NYS Department of Health at (877) 690-2211.

6. **Re-disclosure of Information.** Any electronic health information about you may be re-disclosed by Four Seasons Pediatrics, LLC to others only to the extent permitted by state and federal laws and regulations. This is also true for health information about you that exists in a paper form. Some state and federal laws provide special protections for some kinds of sensitive health information, including HIV/AIDS and drug and alcohol treatment. Their special requirements must be followed whenever people receive these kinds of sensitive health information. HIXNY and persons who access this information through the HIXNY must comply with these requirements.

7. **Effective Period**. This Consent Form will remain in effect until the day you withdraw your consent.

8. **Withdrawing Your Consent**. You can withdraw your consent at any time by signing a Withdrawal of Consent Form and giving it to (Name of Provider Organization). You can also change your consent choices by signing a new Consent Form at any time. You can get these forms from any HIXNY provider, from the HIXNY website at www.hixny.org, or by calling (518) 357-3690. **Note: Organizations that access your health information through HIXNY while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to withdraw your consent, they are not required to return it or remove it from their records.**

9. **Copy of Form**. You are entitled to get a copy of this Consent Form after you sign it**.**

Four Seasons Pediatrics

Parent or Legal Guardian Designation to Permit Another Individual to Consent for Health Care

I (we) appoint the following person:_____ ("other adult") as my (our) proxy decision maker for consenting to non-emergent medical care for my (our) children listed below. I (we) have the legal right to delegate such consent to the proxy decision maker, who is an adult and legally and medically competent to exercise the authority so delegated. I am advised that protected patient health information may be shared with the proxy to facilitate informed decision-making.

_____	_____
Patient Name	**DOB**
_____	_____
Patient Name	**DOB**
_____	_____
Patient Name	**DOB**
_____	_____
Patient Name	**DOB**

"Other Adult's" Information (please enter all information if known):

Name: _____
Phone number: _____
Relation: _____
Address and/or DOB (if known): _____
_____

(optional)"Other Adult's" Information (please enter all information if known:

Name: _____
Phone number: _____
Relation: _____
Address and/or DOB (if known): _____
_____

(optional)"Other Adult's" Information (please enter all information if known:

Name: _____
Phone number: _____
Relation: _____
Address and/or DOB (if known): _____
_____

LIMITATIONS

This consent shall be valid until and including this date _____, (or) it is terminated by one of the individuals signing the authorization below, (or) it is revoked for a reason listed below.

As to the above named child(ren), the "other adult" is authorized to consent to:

- Yearly check-ups - which may include but are not limited to physical examination, evaluation or screening tools, lab work, routine testing, developmental assessment, medication administration
- Acute and Chronic "sick" visits and follow up appointments, such as strep throat or ear rechecks, and medication administration if needed
- Mental or behavioral health examination visits, such as ADHD, depression, anxiety initial or follow up care
- Influenza vaccination appointments (as getting the influenza vaccine is the sole reason for the appointment)

FOR PROCEDURES OR IMMUNIZATIONS, the parent or legal guardian will need to be contacted directly by clinical staff to obtain informed consent before any action is done. The designee above can not consent to these.

Revocation: I understand that this designation shall be revoked by any of the following:

a. A parent may revoke a designation by notifying the health care provider **either orally or in writing, or by any other act evidencing a specific intent to revoke the designation, or by executing a subsequent designation.**
b. If both parents have signed this designation, and either of the parents revokes it, the authority of the designee is revoked.
c. A designee must notify all appropriate health care providers of any revocation of his/her authority.
d. If the parent who signed a designation becomes incapacitated or dies, the designation is revoked.

CONTACT INFORMATION

If the nature of the medical care is not routine or further informed consent is needed, please try to contact me (us) regarding the health of my (our) children at the following telephone number (s). If you are unable for any reason to contact me (us), you may rely on the proxy decision maker for consent.

If a court has ordered that both parents must agree on health care decisions, both parents must sign this designation

Contact Information

Parent's Name:	_____	Parent's Name:	_____
Relationship:	_____	Relationship:	_____
Daytime Phone:	_____	Daytime Phone:	_____
Evening Phone:	_____	Evening Phone:	_____
Cell Phone:	_____	Cell Phone:	_____
Signature:	_____	Signature:	_____