LIBERATION
CHIROPRACTIC & WELLNESS

7921 Tanner Williams Road, Ste B
Mobile, AL 36608
Phone 251.607.0040
Fax 251.607.7202

New Patient Action Plan

1. Your first appointment today will consist of **posture images, examination, insight scan, and x-rays** as the doctor finds necessary. X-rays will then be marked and reviewed by the doctor to review results with you at your second appointment (typically 24 hours turnaround).

2. Your second appointment the doctor will review what was found on your x-rays, you will receive your **first adjustment, and if there are any additional tests or x-rays** needed to determine the best course of care, the doctor will order.

3. Your third appointment is the most important visit you will have; the doctor will go through all of your x-rays, findings, and offer **recommendations on course of care**. There is NO cost for this visit.

If you have insurance, we will verify your coverage for chiropractic care. If your insurance does not cover chiropractic care, we offer ChiroHealth USA**; a medical discount program that saves you 35% off your chiropractic care plus capped family fees for initial exams and x-rays.

The cost of annual membership for ChiroHealth USA is only $49.00 to cover you and your entire family for one year.

First Visits:
First family member 1st visit cap: $100.00 (normal average is $209)
Each additional family member: $60.00

ChiroHealth** Second Visit:	Adjustment: $39.00**	Stress X-ray: $29.25**	Total: $68.25**
Insurance Second Visit:	Adjustment: $60.00	Stress X-ray: $45.00	Total: $105.00

Date: _____ Time: _____

Third Visit: NO COST review of X-rays and Care Plan recommendations

Date: _____ Time: _____

Total Cost: $ _____

Patient Signature: _____ Date: _____

Staff Signature: _____Date: _____

PERSONAL INJURY APPLICATION FOR CARE AT LIBERATION CHIROPRACTIC & WELLNESS, P.C.

TODAY'S DATE:_____

PATIENT DEMOGRAPHICS

Name: _____Birth Date: _____-_____-_____ Age: _____ ☐ Male ☐ Female

Address: _____City: _____ State: _____ Zip: _____

E-mail Address: _____ Home Phone: _____Mobile Phone:_____

Marital Status: ❑ Single ❑ Married Do you have Insurance: ❑ Yes ❑ No Work Phone:_____

Social Security #: _____Driver's License #:_____

Employer: _____ Occupation:_____

Spouse's Name _____Spouse's Employer_____

Number of children and Ages: _____

Name & Number of Emergency Contact: _____Relationship: _____

HISTORY of COMPLAINT

Please identify the condition(s) that brought you to this office: Primary:_____

Secondary: _____ Third: _____ Fourth:_____

On a scale of 1 to 10, with 10 being the worst pain you've ever felt, and zero being no pain, rate your above complaints:

Primary or chief complaint:	0	1	2	3	4	5	6	7	8	9	10
Second complaint:	0	1	2	3	4	5	6	7	8	9	10
Third complaint:	0	1	2	3	4	5	6	7	8	9	10
Fourth complaint:	0	1	2	3	4	5	6	7	8	9	10

When did the problem(s) begin? _____ How did the injury happen?_____

When is the problem at its worst? ☐ AM ☐ PM ☐ mid-day ☐ late

How long does it last? ☐ It is constant ☐ I experience it on and off during the day ☐ It comes and goes throughout week

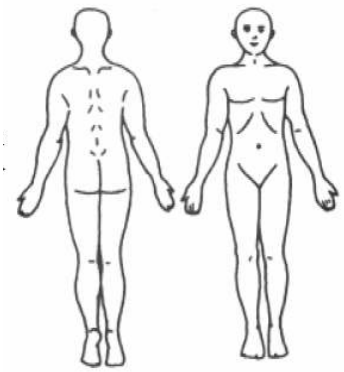
Condition(s) ever been treated by anyone in the past? ☐ No ☐ Yes When: _____

Name of Previous Chiropractor: _____ ☐ I've never seen one

How long were you under care: _____ What were the results?_____

*PLEASE MARK the areas on the Diagram with the following letters to describe your symptoms:

R =Radiating B =Burning D =Dull A =Aching N =Numbness S =Sharp/Stabbing T=Tingling



What relieves your symptoms? _____

What makes them feel worse? _____

How is this most affecting your life and activities? _____

_____

Automobile/Personal Injury Accident or Worker's Compensation Questionnaire

Dear Patient: This information is considered confidential. We need this information because we care enough to want to know and your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form. Thank you.

Please explain in detail how your accident happened: _____

_____

_____

What were the time and date of present injury? _____

Where did you feel pain immediately after the accident? _____

List the extent of your injuries as you know them: _____

_____

Did you require post accident hospitalization? ☐ Yes ☐ No

Check symptoms you have noticed since the accident:

☐ Headaches	☐ Dizziness	☐ Depression	☐ Fatigue
☐ Light Bothers Eyes	☐ Buzzing In Ears	☐ Diarrhea	☐ Neck Pain
☐ Head Seems Too Heavy	☐ Memory Loss	☐ Feet Cold	☐ Neck Stiff
☐ Pins and Needles In Arms	☐ Ears Ring	☐ Hands Cold	☐ Fainting
☐ Sleeping Problems	☐ Back Pain	☐ Face Flushed	☐ Loss of Balance
☐ Constipation	☐ Tension	☐ Nervousness	☐ Numbness in Fingers
☐ Loss of Smell	☐ Fever	☐ Irritability	☐ Numbness in Toes
☐ Loss of Taste	☐ Chest Pain	☐ Cold Sweats	☐ Shortness of Breath
☐ Stomach Upset			

Symptoms other than above:_____

Where were you taken after the accident?_____

Hospitalized? ☐ No ☐ Yes If yes, admitted? _____ How long? _____

Name of Hospital: _____

Name of Doctors: _____

What treatment was given? _____

Was any other doctor consulted after your accident? ☐ Yes ☐ No

If so, what was the doctor's name? _____ D.C., M.D., D.O., D.D.S.

What was the diagnosis? _____

What treatment was given? _____

How often did you see the doctor? _____

How long did you see the doctor? _____

Have you ever had any complaints in the involved area before? ☐ Yes ☐ No

If so, what were the complaints? _____

Before the injury were you capable of working on an equal basis with others your age? ☐ Yes ☐ No

Are your work activities restricted as a result of this accident? ☐ Yes ☐ No

Since this injury are your symptoms: ☐ Improving ☐ Getting worse ☐ Same

Driver of other vehicle (if any)

Name: _____ Insurance Company: _____ Policy No._____

Driver of vehicle in which you were injured (if applicable)

Name: _____ Insurance Company: _____ Policy No._____

Name of your insurance adjustor: _____

Have you retained an attorney? ☐ Yes ☐ No

If so, his/her name and address: _____

You were heading: ☐ North ☐ East ☐ South ☐ West

on what roadway: _____(street or highway)

Other vehicle was heading: ☐ North ☐ East ☐ South ☐ West

on what roadway: _____ (street or highway)

Were police notified? ☐ Yes ☐ No

Were you knocked unconscious? ☐ Yes ☐ No If so, for how long? _____

You were struck from: ☐ Behind ☐ Front ☐ Driver's Side ☐ Passenger's Side

You were: ☐ Driver ☐ Passenger ☐ Front Seat ☐ Back Seat ☐ Using Seat Belts

Patient Signature: _____ Date: _____

Doctor Signature: _____Date: _____

PAST HISTORY

Have you suffered with any of this or a similar problem in the past? ❑ No ❑ Yes

If yes how many times? _____ When was the last episode? _____ How did the injury happen?_____

Other forms of treatment tried: ☐ No ☐ Yes

If yes, please state what type of treatment:_____ How long ago? _____

and who provided it: _____ What were the results? ☐ Favorable ☐ Unfavorable (please below)

_____

Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body:

_____

If you have ever suffered with any of these conditions? Indicate with a P for "In the Past" and C for "Current"

___ Neck Pain	___ Jaw Pain, TMJ	___ Shoulder Pain	___ Upper Back Pain	___ Mid Back Pain
___ Low Back Pain	___ Hip Pain	___ Scoliosis	___ Back Curvature	___ Foot/Knee Problems
___ Broken Bone	___Dislocations	___ Fracture	___ Osteo Arthritis	___ Rheumatoid Arthritis
___ Numb/Tingling arms, hands, fingers		___ Numb/Tingling legs, feet, toes		___ Swollen/Painful Joints
___ Dizziness	___ Fainting	___ Loss of Balance	___ Tremors	___ Convulsions/Epilepsy
___ Cancer	___ Tumors	___ Disability	___ Chest Pain	___ Heart Problem
___ Heart Attack	___ High Blood Pressure	___ Low Blood Pressure	___ Cerebro-Vascular	___ Double Vision
___ Blurred Vision	___ Ringing in Ears	___ Hearing Loss	___ Asthma	___ Lung Problems
___ Difficulty Breathing	___ Painful when Coughing/Sneezing		___ Heartburn	___ Digestive Problems
___ Colon Trouble	___ Gall Bladder Issues	___ Diarrhea	___ Constipation	___ Diabetes
___ Headache	___ Ulcers	___ Prostate Problems	___ Sexual Dysfunction	___ Pregnant(Now)
___ PMS	___ Menstrual Issues	___ Menopausal	___ Frequent Colds/Flu	___ Allergies
___ Sinus Issues	___ Depression	___ Irritable	___ Mood Changes	___ ADD/ADHD
___ Learning Disability	___ Eating Disorder	___ Trouble Sleeping	___ Bed Wetting	___ Kidney Trouble
___ Liver Trouble	___ Hepatitis (A,B,C)	___ Skin Problems		

List ALL Past Injuries:
List ALL Surgeries:
List Other Childhood Illnesses:
List Other Adult Conditions:

SOCIAL HISTORY

Smoking: ❑Cigars ❑Pipe ❑Cigarettes ❑E-cigs How often? ❑Daily ❑Weekends ❑Occasionally ❑Never ❑In the Past

Alcohol Use: ❑Daily ❑Weekends ❑Occasionally ❑Never ❑In the Past

Recreational Drug Use: ❑Daily ❑Weekends ❑Occasionally ❑Never ❑In the Past

FAMILY HISTORY

Does anyone in your family suffer with the same condition(s)? ❑ No ❑ Yes

If yes whom: ❑Grandmother ❑Grandfather ❑Mother ❑Father ❑Sister ❑Brother ❑Son ❑Daughter

Have they ever been treated for their condition? ❑ No ❑ Yes ❑ I don't know

Any other hereditary conditions the doctor should be aware of? _____

DAILY ACTIVITIES: Effects of Current conditions On Performance

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

Bending	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Concentrating	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Doing computer Work	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Gardening	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Playing Sports	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Recreation Activities	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Shoveling	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Sleeping	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Watching TV	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Carrying	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Dancing	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Dressing	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Lifting	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Pushing	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Rolling Over	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Sitting	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Standing	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Working	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Climbing	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Doing Chores	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Driving	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Sexual Activity	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Reading	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Running	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Sitting to Standing	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Walking	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform

List ALL Prescription & Non-Prescription drugs you take:_____

_____

_____

_____

_____

_____

_____

List ALL Nutritional Supplements & Vitamins you take:_____

_____

_____

_____

_____

_____

_____

INITIAL NERVE SYSTEM PROFILE

When was your most recent auto accident? _____ What speed was the collision? _____ mph

Type of impact: Front - Side - Rear Was treatment received? Please describe:_____

Describe your most recent strain/stress at work? _____

If treatment was received, please describe: _____

Does your job require you remain in long term stressful postures? _____

Other spinal traumas in the past? _____

Any collision, quick burst, or repetitive motion sports: football, wrestling, basketball, baseball, soccer, tennis, golf, track and field:_____

Any traumas as a child (fall on your head, impact to your head, concussion, fall onto your back or tailbone, biking accident, etc): _____

Any injuries around the house (lifting, bending, woke up with stiff neck, “back went out”, etc): _____

_____

INITIAL NUTRITIONAL PROFILE

Have you tested with high triglycerides or high cholesterol? ☐ Yes ☐ No Values? _____

If not diabetic, have you been diagnosed as pre-diabetic or with metabolic syndrome? ☐ Yes ☐ No

Do you eat a good healthy breakfast daily from Monday to Friday? ☐ Yes ☐ No

How many days per week do you skip one meal? (0) (1) (2) (3) (4+)

How many fast food, refined foods, or pre-pared meals do you eat per week? (0) (1-3) (4-6) (7+)

How many servings of fruit do you have on a given day? (0-1) (2-3) (4+)

How many servings of vegetables do you have on a given day? (0-1) (2-3) (4-5)

Do you regularly drink (1 or more per day) any of the following? (circle all that apply)

Tap Water Filtered Water Soda Diet Soda Sweet Drinks Coffee Juice Milk Alcohol

INITIAL FITNESS PROFILE

How many times per week do you exercise?

Cardiovascular: _____Hours _____Days/Wk

Weight Training: _____Hours _____Days/Wk

Low Impact (Yoga, etc.)_____Hours _____Days/Wk

_____: _____Hours _____Days/Wk

What is your target weight? _____ lbs

What is your current weight? _____ lbs

How willing are you to change any of these things to reach your health goals? *(On a scale of 1-10)* _____

INITIAL TOXICITY PROFILE

Are you regularly exposed to cleaning products or industrial chemicals?	☐ Yes	☐ No
Have you ever noticed mold growing in your home or your place of work?	☐ Yes	☐ No
Does your home, work, school, or car have damp or mildew smell?	☐ Yes	☐ No
Did you receive the full standard profile of vaccinations?	☐ Yes	☐ No
Do you receive yearly flu shots?	☐ Yes	☐ No
How many flu shots have you received?	_____ (estimate)	
Have you been diagnosed with fibromyalgia, chronic fatigue or multiple chemical sensitivities?	☐ Yes	☐ No
Do you have symptoms of hormonal system imbalance (thyroid, reproductive, adrenal)?	☐ Yes	☐ No

INITIAL STRESS PROFILE

Do you get an average of 8 hours of sleep per night?	☐ Yes	☐ No
Do you average less than 6 hours of sleep per night?	☐ Yes	☐ No
Do you ever take pills to go to sleep or relax?	☐ Yes	☐ No
Do you often feel short on time and procrastinate on projects?	☐ Yes	☐ No
Do you experience feelings of anxiety about completing tasks?	☐ Yes	☐ No
Do you feel like you don't give enough time to important areas in your life (family, hobby, etc)?	☐ Yes	☐ No
Do you rely more on your memory than a planner and action list to get things done?	☐ Yes	☐ No
Do you take time to pray, meditate, or visualize on a regular basis?	☐ Yes	☐ No

Patient Signature: _____ Date: _____

Doctor Signature: _____Date: _____

INFORMED CONSENT AND AUTHORIZATION TO TREAT

I understand that my care plan has been designed to stabilize and correct the spine in order to reduce pressure on the nervous system. This is done per the exam and x-ray findings and our clinical experience with the goal of improving overall structure and function. In addition, I understand that my schedule for care may be increased or decreased by the doctor at any time in order to accomplish this goal. It is further understood that if there are any additional costs associated with a change in my care plan, they will be discussed with me prior to my receiving any additional services.

It has been explained to me and I acknowledge that the care plan I wish to participate in imposes two 'situational restrictions' which could cause my care to be suspended or terminated should either one occur. Both have been explained to me and I understand and agree to immediately notify this practice should the following circumstances arise:

In the event I sustain a new injury or have an accident, I realize that I may experience new symptoms and/or a new problem may arise which could impede recovery from my current condition. In such an instance, I recognize that it is important to evaluate any new symptoms to determine how they may affect my current and future health status and assess whether there is a need to modify my current care plan. Once my new symptoms and condition are diagnosed and/or resolved, my care plan will resume.

In the event I decide to interrupt any payment due this office, either because I wish to discontinue my care or for any other reason, I may not resume care without an additional evaluation from my doctor. If I am making monthly payments at that time, it is possible that I will owe money since there may be more services being rendered in the beginning of my care than my monthly payments cover.

Regarding Chiropractic Adjustments, Modalities, and Therapeutic Procedures: I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risk are most often very minimal; in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and all other procedures provided at Liberation Chiropractic & Wellness P.C. have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

Patient Signature: _____ Date: _____

Staff Signature: _____Date: _____

INFORMED CONSENT REGARDING X-RAYS AND IMAGING STUDIES

FEMALES please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see one of our staff members for further explanation.

The first day of my last menstrual cycle was on _____-_____-20_____

☐ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not currently pregnant.

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

Patient Signature: _____ Date: _____

Staff Signature: _____Date: _____

PAYMENT POLICY AND FINANCIAL AGREEMENT OF UNDERSTANDING

I understand that I am directly and fully responsible to Liberation Chiropractic & Wellness, P.C. for all fees associated with chiropractic care and other services I receive.

I hereby authorize payment to be made directly to Liberation Chiropractic & Wellness, P.C., for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Liberation Chiropractic & Wellness, P.C. for any and all services I receive at this office.

☐ INSURANCE PATIENTS: I have been made aware that most insurance plans impose either a visit or dollar limit and/or restrict chiropractic management approaches by covering only a limited number of treatment types and/or techniques, some of which may be used to treat my condition(s) throughout the clinical course of my care. Further, it has been made clear to me that these limitations are not a consideration in formulating care plans, and that the doctor's recommendations are based solely on achieving my personal goals. With this understood and the realization that full insurance reimbursement is unlikely, I agree to follow the doctor's recommendations for care irrespective of my health plan coverage.

In as much as the doctor has discussed the terms of this 'Agreement of Understanding' and I have conveyed my complete understanding of all payment options available to me, I prefer the office to bill my insurance company and await direct provider reimbursement for all covered services. For this consideration, I will provide any and all assistance, including assigning my benefits, in order to ensure proper reimbursement is made directly to Liberation Chiropractic & Wellness PC and its doctors as expeditiously as possible. I further understand that charges for all services have been reviewed with me in advance and those that my insurance does not cover are my responsibility. I further waive any requirement moving forward to sign a "Non-Covered Services Statement" every visit if required by my insurance.

☐ CASH PATIENTS: I would like to participate in the payment simplification program offered at this office to facilitate effortless payment for a certain portion of the cost of services and procedures I have consented to receive over the course my treatment, and to make monthly payments towards my care plan for the course of my treatment. If for any reason I decide to discontinue my care plan, any unused amount I have overpaid will be refunded to me within 30 days of the practice receiving a written statement from me explaining the reasons for my decision.

Patient Signature: _____ Date: _____

Staff Signature: _____Date: _____

NOTICE OF PRIVACY PRACTICE

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your **P**ersonal **H**ealth **I**nformation. In addition we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as **dictated by our office policy,** we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled **'HIPAA'** on tables in the reception. Once you have read this notice, please sign the last page, and return only the signature page (page 2) to our front desk receptionist. Keep this page for your records.

PERMITTED DISCLOSURES:

1. Treatment purposes- discussion with other health care providers involved in your care
2. Inadvertent disclosures- open treating area mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes- to process a claim or aid in investigation
5. Emergency- in the event of a medical emergency we may notify a family member
6. For Public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement – to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons –discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders -**we may call your home and leave messages** regarding a missed appointment or apprize you of changes in practice hours or upcoming events.
11. Change of ownership- in the event this practice is sold, the new owners would have access to your PHI.

YOUR RIGHTS:

1. To receive an accounting of disclosures
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice
3. To request mailings to an address different than residence
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain **one copy** of your records at no charge, when timely notice is provided (72 hours). **X-rays** are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

COMPLAINTS:
If you wish to make a formal complaint about how we handle your health information, please call Danelle Adair at (251) 607-0040. If she is unavailable, you may make an appointment with our receptionist to see her within 72 hours or 3 working days . If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Ave. SW
Room 509F HHH Building
Washington DC 20201

I have received a copy of Liberation Chiropractic & Wellness, P.C.'s Patient Privacy Notice. I understand my rights as well as the practices duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this 'Notice of Privacy Practice" at a time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this "Notice" is available to me at the request of our staff. At this time, I do not have any questions regarding my rights or any of the information I have received, I do not have any concerns regarding these 'Policies ', and all my questions have been answered by a qualified member of the staff to my complete satisfaction.

Patient Signature: _____ Date: _____

Staff Signature: _____Date: _____