New York Foot and Ankle

Laurence D. Landau, D.P.M., F.A.P.W.C.A.
Corrine E. Renne, D.P.M., F.A.P.W.C.A.
And Associates

4230 Hempstead Tpke., Ste. 200
Bethpage, NY 11714
(516)470-0996

397 Franklin Avenue
Franklin Square, NY 11010
(516)233-1919

And other locations.

Name:_____ I Prefer to be called:_____ DATE: _____

Address: _____ City:_____ State: _____ Zip:_____

Phone:(____)_____Work Phone: (_____)_____ Cell Phone: (_____)_____

The best time to contact me is :_____ ☐ A.M ☐ P.M. on my ☐ Home Phone ☐ Work Phone ☐ Cell Phone

Date Of Birth:_____ Social Security Number:_____

Check Appropriate Box ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐Divorced

If Student, Name of School: _____ City/State_____ ☐ FT ☐PT

Spouse, or Parent's Name: _____Employer:_____Work Phone (_____) _____

Whom may we thank for referring you? _____

Person to contact of case of emergency _____ Phone: _____

Email Address _____ Would you like to receive our e-newsletter? ☐ Yes ☐ No

Responsible Party

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Name: _____ Relationship to Patient: _____

Address: _____

City: _____ State:_____ Zip:_____ Phone:(_____)_____

Employer:_____ Work Phone(___)_____ SSN:_____

Insurance Information

Name of Insured_____ DOB_____ Relationship to Patient_____

SSN:_____ Name of Employer_____ Work Phone: (_____)_____

Address of Employer:_____City:_____ State:_____ Zip_____

Insurance company_____ Grp #_____ ID#_____

Ins Co. Address_____ Ins Co. Phone (_____) _____

----------DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐YES ☐ NO --- IF YES, COMPLETE THE FOLLOWING ----------

Name of Insured_____ DOB_____ Relationship to Patient_____

SSN:_____ Name of Employer_____ Work Phone: (_____)_____

Address of Employer:_____City:_____ State:_____ Zip_____

Insurance company_____ Grp #_____ ID#_____

Ins Co. Address_____ Ins Co. Phone (_____) _____

IS THIS VISIT DUE TO AN INJURY ON THE JOB OR A MOTER VEHICLE ACCIDENT? ☐ YES* ☐ NO

*IF YES, PLEASE COMPLETE A WORKERS COMPENSATION NO-FAULT FORM

"I verify the accuracy of the above information and hereby assign, transfer, and set over to _____ all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until a written notice is given by me revoking said authorization; I understand that I am financially responsible for all charges whether or not they are covered by insurance.

Patient authorized signature: _____ Date:_____

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I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. I agree that if it is necessary for this office to take legal action to obtain payment for services that were rendered to me, I will be responsible for collection costs and attorney fees associated with the collection of the outstanding costs and attorney fees associated with the collection of the outstanding monies due and payable to this office.

Date: _____ Signature: _____

****

I understand that I am responsible for the fees for service. A service charge of 1.5% per month (18%) per year will be added to any balance due more than 30 days beyond completion of treatment, 33% will be added to your balance to compensate for legal/collection fees.

Patient/Parent/Guardian Signature: _____

Date: _____

****

I hereby authorize my insurance company(s) known by the name(s) of _____ to pay directly to Laurence D. Landau, D.P.M., PC benefits due to me out of indemnity under the terms of my policy. Payment is authorized upon your receipt of their itemized bill. This policy was in full force and effect at the time services were rendered, should it be necessary any and all reasonable collection and/or attorney fees will be added to the patient's bill.

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NO SHOW POLICY

Effective January 1, please be advised that we will require 24 hours cancellation notice prior to your scheduled appointment. Failure to notify our office of a cancellation will result in a $25.00 fee.

Please understand this is to discourage lost time for the doctors and other patients who have scheduled appointments. We appreciate your understanding,

Please sign and date below:

Sign: _____

Date: _____

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Patient Name: _____ Date of Birth: _____

In Case of Emergency, Notify: _____ Telephone: _____

Medications (include Dosage): _____

_____

Pharmacy Name, Town & Telephone: _____

Medical History

	SELF	FAMILY			SELF	FAMILY
HEARING PROBLEMS				HIATUS HERNIA		
DIABETES				LIVER PROBLEMS		
KIDNEY PROBLEMS				ANEMIA		
THYROID DISEASE				BLOOD CLOTS		
EMPHYSEMA				DIZZINESS		
EYE DISORDERS				ARTHRITIS		
MENIGITIS				SWOLLEN LEGS		
HIGH BLOOD PRESSURE				HEART ATTACKS		
CHEST PAIN				STROKE		
BLACKOUTS				SEIZURES		
ASTHMA				NERVOUS DISORDERS		
BACK PROBLEMS				FRACTURES		
HEPATITIS				CANCER		
OTHER						

MALE: Recent Prostate Exam: _____ (DATE IF KNOWN) Recent PSA: _____ (DATE IF KNOWN)

FEMALE LMP: _____ (LAST MENSTRAL PERIOD) Recent Pap Smear: _____ (DATE IF KNOWN) Recent BE: _____ (BREAST EXAMINATION IF KNOWN)

Surgical History: _____

_____

Allergies to Medications/Foods _____

Smoke: Yes____ No ____ If yes, how many ppd: _____

Alcohol: Yes____ No ____ If yes, how many drinks day/week _____

Herbal Meds: Yes____ No ____ If yes, what medications: _____

Prescribed by: _____

_____ _____

PATIENT/AUTHORIZED SIGNATURE DATE

Notice of Privacy Practices

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Notice of Privacy Practices

As required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

This notice describes how health information about you (as a patient of this practice) may be used and disclosed and how you can get access to your individually identifiable health information.

Please review this notice carefully.

A. Our commitment to your privacy:

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (also called *protected* health information, or PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the Notice of Privacy Practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your PHI,
- Your privacy rights in your PHI,
- Our obligations concerning the use and disclosure of your PHI.

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. If you have questions about this Notice, please contact:

Dr. Laurence D. Landau, D.P.M. at (516) 470-0996.

C. We may use and disclose your PHI in the following ways:

The following categories describe the different ways in which we may use and disclose your PHI.

1. Treatment. Our practice may use your PHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your PHI in order to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice – including, but not limited to, our doctors and nurses – may use or disclose your PHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your PHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your PHI to other health care providers for purposes related to your treatment.

2. Payment. Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your PHI to bill you directly for services and items. We may disclose your PHI to other health care providers and entities to assist in their billing and collection efforts.

3. Health care operations. Our practice may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your PHI to other health care providers and entities to assist in their health care operations.

4. Appointment reminders. Our practice may use and disclose your PHI to contact you and remind you of an appointment.

5. Treatment options. Our practice may use and disclose your PHI to inform you of potential treatment options or alternatives.

6. Health-related benefits and services. Our practice may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you.

7. Release of information to family/friends. Our practice may release your PHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a baby sitter take their child to the pediatrician's office for treatment of a cold. In this example, the baby sitter may have access to this child's medical information.

8. Disclosures required by law. Our practice will use and disclose your PHI when we are required to do so by federal, state or local law.

D. Use and disclosure of your PHI in certain special circumstances:

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. Public health risks. Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:

- Maintaining vital records, such as births and deaths,
- Reporting child abuse or neglect,
- Preventing or controlling disease, injury or disability,
- Notifying a person regarding potential exposure to a communicable disease,
- Notifying a person regarding a potential risk for spreading or contracting a disease or condition,
- Reporting reactions to drugs or problems with products or devices,
- Notifying individuals if a product or device they may be using has been recalled,
- Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information,
- Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. Health oversight activities. Our practice may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. Lawsuits and similar proceedings. Our practice may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. Law enforcement. We may release PHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement,
- Concerning a death we believe has resulted from criminal conduct,
- Regarding criminal conduct at our offices,
- In response to a warrant, summons, court order, subpoena or similar legal process,
- To identify/locate a suspect, material witness, fugitive or missing person,
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator).

5. Deceased patients. Our practice may release PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

6. Organ and tissue donation. Our practice may release your PHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

7. Research. Our practice may use and disclose your PHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your PHI for research purposes **except** when an Internal Review Board or Privacy Board has determined that the waiver of your authorization satisfies all of the following conditions:

(A) The use or disclosure involves no more than a minimal risk to your privacy based on the following: (i) an adequate plan to protect the identifiers from improper use and disclosure; (ii) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (iii) adequate written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted;

(B) The research could not practicably be conducted without the waiver,

(C) The research could not practicably be conducted without access to and use of the PHI.

8. Serious threats to health or safety. Our practice may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

9. Military. Our practice may disclose your PHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

10. National security. Our practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the president, other officials or foreign heads of state, or to conduct investigations.

11. Inmates. Our practice may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

12. Workers' compensation. Our practice may release your PHI for workers' compensation and similar programs.

E. Your rights regarding your PHI:

You have the following rights regarding the PHI that we maintain about you:

1. Confidential communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to Dr. Laurence D. Landau, D.P.M. at (516) 470-0996 specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate **reasonable** requests. You do not need to give a reason for your request.

2. Requesting restrictions. You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally,

you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. **We are not required to agree to your request**; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing to Dr. Laurence D. Landau, D.P.M. at (516) 470-0996. Your request must describe in a clear and concise fashion:

- The information you wish restricted,
- Whether you are requesting to limit our practice's use, disclosure or both,
- To whom you want the limits to apply.

3. Inspection and copies. You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Dr. Laurence D. Landau, D.P.M. at (516) 470-0996 in order to inspect and/or obtain a copy of your PHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Dr. Laurence D. Landau, D.P.M. at (516) 470-0996. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the practice; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. Accounting of disclosures. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your PHI for purposes not related to treatment, payment or operations. Use of your PHI as part of the routine patient care in our practice is not required to be documented – for example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to Dr. Laurence D. Landau, D.P.M. at (516) 470-0996. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. Right to a paper copy of this notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time.

To obtain a paper copy of this notice, contact Dr. Laurence D. Landau, D.P.M. at (516) 470-0996.

7. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Dr. Laurence D. Landau, D.P.M. at (516) 470-0996. All complaints must be submitted in writing. **You will not be penalized for filing a complaint**.

8. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time *in writing*. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. *Please note*: we are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact Dr. Laurence D. Landau, D.P.M. at (516) 470-0996.

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Consent to the Use and Disclosure of Private Health Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my healthcare, this office originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many health professionals who contribute to my care
- a means of communication with me to aid in my healthcare
- a source of information for applying my diagnosis and surgical information to my bill
- a means by which a third-party payer can verify that services billed were actually provided
- and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the office reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the office has already taken action in reliance thereon.

I request the following restrictions to the use or disclosure of my health information:

_____

_____

Name of Patient or Legal Representative Witness: _____

Signature_____ Date: _____

THE LOWER EXTREMITY FUNCTIONAL SCALE

We are interested in knowing whether you are having any difficulty at all with the activities listed below because of your lower limb Problem for which you are currently seeking attention. Please provide an answer for **each** activity.

Today, do you or would you have any difficulty at all with:

	Activities	Extreme Difficulty or Unable to Perform Activity	Quite a Bit of Difficulty	Moderate Difficulty	A Little Bit of Difficulty	No Difficulty
1	Any of your usual work, housework, or school activities.	0	1	2	3	4
2	Your usual hobbies, re creational or sporting activities.	0	1	2	3	4
3	Getting into or out of the bath.	0	1	2	3	4
4	Walking between rooms.	0	1	2	3	4
5	Putting on your shoes or socks.	0	1	2	3	4
6	Squatting.	0	1	2	3	4
7	Lifting an object, like a bag of groceries from the floor.	0	1	2	3	4
8	Performing light activities around your home.	0	1	2	3	4
9	Performing heavy activities around your home.	0	1	2	3	4
10	Getting into or out of a car.	0	1	2	3	4
11	Walking 2 blocks.	0	1	2	3	4
12	Walking a mile.	0	1	2	3	4
13	Going up or down 10 stairs (about 1 flight of stairs).	0	1	2	3	4
14	Standing for 1 hour.	0	1	2	3	4
15	Sitting for 1 hour.	0	1	2	3	4
16	Running on even ground.	0	1	2	3	4
17	Running on uneven ground.	0	1	2	3	4
18	Making sharp turns while running fast.	0	1	2	3	4
19	Hopping.	0	1	2	3	4
20	Rolling over in bed.	0	1	2	3	4
	Column Totals:					

Minimum Level of Detectable Change (90% Confidence): 9 points

SCORE: _____ / 80

Please submit the sum of responses.

Reprinted from Binkley, J., Stratford, P., Lott, S., Riddle, D., & The North American Orthopaedic Rehabilitation Research Network, The Lower Extremity Functional Scale: Scale development, measurement properties, and clinical application, Physical Therapy, 1999, 79, 4371-383, with permission of the American Physical Therapy Association.

Do I Need a Test for PAD?

Peripheral Arterial Disease (PAD) is a serious circulatory problem in which the blood vessels that carry blood to your arms, legs, brain, or kidneys, become narrowed or clogged. It affects over 8 million Americans, most over the age of 50. It may result in leg discomfort with walking, poor healing of leg sores/ulcers, difficult to control blood pressure, or symptoms of stroke. People with PAD are at significantly increased risk for stroke and heart attack. Answers to these questions will determine if you are at risk for PAD and if a vascular exam will help us better assess your vascular health status.

Name:_____ Date:_____

Circle "Yes" or "No":

				Test for PAD
1.	Do you have foot, calf, buttock, hip or thigh discomfort (aching, fatigue, tingling, cramping or pain) when you walk which is relieved by rest?	Yes	No	☐
2.	Do you experience any pain at rest in your lower leg(s) or feet?	Yes	No	☐
3.	Do you experience foot or toe pain that often disturbs your sleep?	Yes	No	☐
4.	Are your toes or feet pale, discolored, or bluish?	Yes	No	☐
5.	Do you have skin wounds or ulcers on your feet or toes that are slow to heal (8-12 weeks)?	Yes	No	☐
6.	Has your doctor ever told you that you have diminished or absent pedal (foot) pulses?	Yes	No	☐
7.	Have you suffered a severe injury to the leg(s) or feet?	Yes	No	☐
8.	Do you have an infection of the leg(s) or feet that may be gangrenous (black skin tissue)?	Yes	No	☐

Patient Signature:_____

Physician Signature:_____ Date :_____

Do I Need a Test for CVI?

Chronic Venous Insufficiency (CVI) is a serious circulatory problem in which the leg veins cannot pump enough blood back to your heart. It affects over 2.5 million Americans, most over the age of 40. Symptoms of CVI include varicose veins, skin problems, leg and ankle swelling, tight calves, and legs that feel heavy, tired, restless, or achy. Factors that can increase the risk of CVI include pregnancy, obesity, smoking, standing or sitting for long periods of time and not getting enough exercise. Answers to these questions will help determine if you are at risk for CVI and if a vascular exam will help us better assess your vascular health status.

Name: _____ **Date:** _____

		Circle Yes or No		Test
1.	Are your legs swollen, painful, red or warm to the touch?	Yes	No	☐
2.	Have you had a blood clot in a vein that caused inflammation, pain or irritation?	Yes	No	☐
3.	Do you have varicose veins (veins that are enlarged or swollen and raised above the surface of the skin) in the legs?	Yes	No	☐
4.	Have you had a Deep Vein Thrombosis (DVT) in the past and are experiencing pain, swelling, changes in skin color, cellulites, or non-healing ulcers?	Yes	No	☐
5.	Do your legs feel heavy, tired, restless or achy?	Yes	No	☐
6.	If you push on your swollen foot, ankle or leg for 10 seconds and release, does your fingerprint leave a dimple?	Yes	No	☐
7.	If your feet, ankles and legs are swollen, does the skin look stretched or shiny?	Yes	No	☐
8.	Do you have an ulcer on the inside of your ankle?	Yes	No	☐

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____

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CREDIT CARD AUTHORIZATION FORM

I, _____, authorize Dr. Landau, to keep my signature on file and to charge my credit card as outlined above. I understand that this form is valid for one year unless I cancel through written notice to the health care provider.

_____
Patient Name

_____
Cardholder Name

_____
Billing Address

_____
City, State & Zip code

_____
Circle Credit Card Type – Mastercard – Visa - AMEX

_____
Credit Card Number

_____
Expiration Date---V Code

_____
Cardholder Signature

_____
Todays Date