



Highland, IL
 1210 WASHINGTON STREET
 618-654-4520

Lebanon, IL
 110 W ST. LOUIS STREET
 618-537-4407

GENERAL INFORMATION:

PATIENT NAME:		NICKNAME:	
SEX: M / F	GENDER: M / F / OTHER	DATE OF BIRTH:	SOCIAL SECURITY #:
MAILING ADDRESS:		CITY:	STATE: ZIP CODE:
EMAIL ADDRESS:			
MOBILE PHONE #:		SECONDARY PHONE #:	YOUR PRIMARY DOCTOR'S NAME:
EMPLOYER:		OCCUPATION:	
HAVE YOU EVER BEEN TO A CHIROPRACTOR ? Y / N			
NUMBER OF CHILDREN:		MARITAL STATUS: S / M / D / W	

IN CASE OF EMERGENCY:

CONTACT NAME:		
RELATIONSHIP:	ADDRESS:	
HOME PHONE:	CELL PHONE:	WORK PHONE:

HOW DID YOU HEAR ABOUT OUR OFFICE?

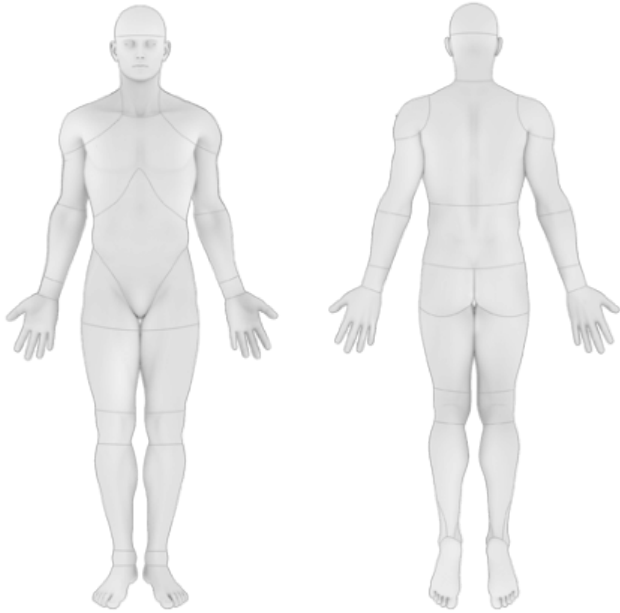
INSURANCE INFORMATION (CAN SKIP IF INSURANCE CARD PRESENT)

PRIMARY INSURANCE COMPANY NAME:			
ID#:	GROUP #:	SUBSCRIBER NAME:	SUBSCRIBER SSN:

SECONDARY INSURANCE COMPANY NAME:			
ID#:	GROUP #:	SUBSCRIBER NAME:	SUBSCRIBER SSN:

Today's Visit

REASON FOR TODAY'S VISIT:		
WHAT CAUSED YOUR ISSUE?		HOW LONG HAVE YOU HAD THIS PROBLEM?
WHAT MAKES IT BETTER:	WHAT MAKES IT WORSE:	RATE THE PAIN : _____ 0 = NOTHING, 10 = WORST IMAGINABLE



PLEASE MARK THE AREAS WHERE YOU FEEL SYMPTOMS ON THE BODY DIAGRAM.

PLEASE LIST ALL SYMPTOMS YOU HAVE EXPERIENCED RECENTLY AND DESCRIBE THEM (SHARP, DULL, BURNING, FREQUENCY, ETC) :

PLEASE CIRCLE YES OR NO:

ANY LOSS OF BLADDER OR BOWEL CONTROL?	YES	NO
ANY UNEXPLAINED WEIGHT LOSS RECENTLY?	YES	NO
ANY PAIN THAT WAKES YOU AT NIGHT OR DOES NOT IMPROVE WITH REST?	YES	NO
PERSONAL HISTORY OF CANCER? IF YES, WHAT KIND? :	YES	NO
CURRENTLY TAKING STEROIDS OR IMMUNOSUPPRESSANT MEDICATION?	YES	NO
DO YOU EXPERIENCE DIZZINESS, FAINTING, OR VISUAL DISTURBANCES?	YES	NO
EXPERIENCING A NEW OR UNUSUALLY SEVERE HEADACHE?	YES	NO

WHAT ACTIVITIES ARE CURRENTLY AFFECTED BY YOUR CONDITION? (CIRCLE ALL THAT APPLY) :

BENDING	LIFTING	STANDING
WALKING	SITTING	DRIVING
EXERCISE	HOUSEHOLD CHORES	SLEEPING
RECREATIONAL ACTIVITIES	CARING FOR CHILDREN	GETTING DRESSED
WORKING	SIT TO STAND	NONE OF THE ABOVE
OTHER:		

PLEASE LIST ANY CURRENT OR PAST MEDICAL CONDITIONS YOU HAVE BEEN DIAGNOSED WITH (EXAMPLES: HIGH BLOOD PRESSURE, DIABETES, THYROID PROBLEMS, ARTHRITIS, ANXIETY, EDS ETC.)

PLEASE INDICATE ANY FAMILY HISTORY OF THE FOLLOWING CONDITIONS (PARENTS, SIBLINGS, GRANDPARENTS, ETC) :

BLEEDING DISORDER	CORONARY ARTERY DISEASE	STROKE	CANCER
HEART DISEASE / ATTACKS	SEIZURES	DIABETES	ARTHRITIS
NEUROLOGICAL DISORDERS	AUTOIMMUNE DISORDERS	SCOLIOSIS	ASTHMA
OTHER:			

PLEASE LIST ANY SURGERY YOU MAY HAVE HAD IN THE PAST WITH APPROXIMATE DATES:

PLEASE LIST ANY MEDICATIONS, VITAMINS, OR SUPPLEMENTS YOU ARE CURRENTLY TAKING:

PLEASE LIST ANYTHING YOU MAY HAVE AN ALLERGIC REACTION FROM:

PLEASE LIST ANY SPORTS, EXERCISE, OR PHYSICAL ACTIVITIES YOU CURRENTLY PARTICIPATE IN:

NOTICE OF NON-PAYABLE SERVICES
(SERVICES NOT COVERED BY YOUR INSURANCE)

SOME INSURANCE COMPANIES DO NOT COVER ALL SERVICES OR THERAPIES RENDERED IN OUR OFFICE. MEDICARE PLANS ONLY COVER SPINAL ADJUSTMENTS (TREATMENT FROM NECK TO LOWER BACK), ANY OTHER SERVICES RENDERED OUTSIDE OF MEDICARE GUIDELINES ARE LEFT TO PATIENT RESPONSIBILITY. INSURANCE COMPANIES WE ARE OUT-OF-NETWORK WITH (CIGNA, TRICARE, AETNA BETTER HEALTH, MEDICAID, MERIDIAN, BCBS WITH MEMBER ID THAT STARTS WITH QM). THE SERVICES LISTED BELOW ARE SERVICES YOU COULD END UP PAYING OUT OF POCKET FOR.

ADVANCED THERAPIES USUALLY NOT COVERED BY COMMERCIAL INSURANCE OR MEDICARE :

TREATMENT	SINGLE VISIT	WITH ADJUSTMENT	PACKAGE OPTIONS
LASER THERAPY	\$55	\$45	6 TREATMENTS : \$240 12 TREATMENTS : \$420
DRY NEEDLING / ACUPUNCTURE	\$60	\$50	3 TREATMENTS : \$135
SHOCKWAVE	\$100	\$90	4 TREATMENTS : \$340 6 TREATMENTS : \$480

ADDITIONAL SERVICES NOT COVERED BY MEDICARE / ESSENCE :

SERVICES	NEW PATIENT EVALUATION	PROGRESS EXAM	SOFT TISSUE, MUSCLE TREATMENT, EXTREMITY ADJUSTMENTS	ELECTRIC STIMULATION
PRICE	\$90	\$70	\$35	\$13

PATIENT ACKNOWLEDGEMENT :

I ACKNOWLEDGE THAT I HAVE BEEN TOLD IN ADVANCE THAT THE SERVICES AND ITEMS LISTED ABOVE ARE NON-PAYABLE BY MEDICARE / INSURANCE AND I AGREE TO PAY FOR THESE SERVICES AND ITEMS AT THE TIME THE SERVICE OR ITEM IS PROVIDED. I HAVE HAD AMPLE OPPORTUNITY TO ASK QUESTIONS ABOUT MY FINANCIAL OBLIGATION AND OTHER TREATMENT OPTIONS. I ALSO ACKNOWLEDGE THAT AT ANY TIME I CAN ASK ALVARADO HEALTHCARE FOR MY COST ESTIMATES BEFORE SERVICES ARE RENDERED. I ACKNOWLEDGE THAT I AM SIGNING THIS NOTICE VOLUNTARILY AND THAT IT IS NOT BEING SIGNED AFTER THE PRODUCTS OR SERVICES HAVE BEEN PROVIDED. I UNDERSTAND THAT I HAVE THE RIGHT TO REFUSE CARE AND THAT BY SIGNING THIS FORM I AM FULLY RESPONSIBLE FOR ALL NON-COVERED SERVICES AND PRODUCTS.

PATIENT NAME (PRINT): _____

PATIENT SIGNATURE: _____

DATE: _____

WITNESS SIGNATURE: _____

DATE: _____

TIME: _____

CONSENT TO TREAT

WE'RE HONORED THAT YOU'VE CHOSEN US TO BE PART OF YOUR HEALTHCARE TEAM. BEFORE BEGINNING TREATMENT, WE WANT YOU TO FEEL FULLY INFORMED, COMFORTABLE, AND CONFIDENT. THIS CONSENT EXPLAINS WHAT CHIROPRACTIC CARE INVOLVES, THE BENEFITS YOU MAY EXPERIENCE, AND THE RARE BUT POSSIBLE RISKS.

WHAT CHIROPRACTIC CARE INVOLVES

- HANDS-ON OR INSTRUMENT-ASSISTED ADJUSTMENTS TO IMPROVE JOINT MOTION
- MUSCLE OR SOFT TISSUE TECHNIQUES
- GENTLE STRETCHING OR MOBILITY WORK
- RECOMMENDATIONS TO SUPPORT YOUR RECOVERY (EXERCISES, LIFESTYLE TIPS, ETC.)
- ADJUSTMENTS HELP RESTORE NORMAL MOTION TO RESTRICTED JOINTS, REDUCE PAIN, CALM IRRITATED NERVES, AND IMPROVE FUNCTION. MANY PATIENTS NOTICE IMPROVEMENTS QUICKLY; OTHERS PROGRESS GRADUALLY.

BENEFITS

- LESS PAIN
- IMPROVED MOVEMENT
- BETTER POSTURE
- FEWER FLARE-UPS
- IMPROVED DAILY FUNCTION
- AN OVERALL SENSE OF "I CAN MOVE LIKE A HUMAN AGAIN"

WHILE WE CANNOT PROMISE RESULTS (EVERY BODY IS UNIQUE), OUR GOAL IS ALWAYS TO HELP YOU FEEL AND FUNCTION YOUR BEST.

POSSIBLE RISKS

- TEMPORARY SORENESS OR STIFFNESS
- MUSCLE SPASMS
- MILD INCREASE IN SYMPTOMS
- SPRAIN OR STRAIN
- DISC IRRITATION
- RIB OR BONE INJURY (RARE)
- STROKE FROM ARTERIAL INJURY (EXTREMELY RARE. THERE IS AN EXTREMELY RARE RISK OF ARTERIAL INJURY ASSOCIATED WITH NECK PAIN AND HEADACHE IN GENERAL. RESEARCH SHOWS THE OCCURRENCE OF SERIOUS COMPLICATIONS, SUCH AS ARTERIAL DISSECTION LEADING TO STROKE, IS ESTIMATED AT BETWEEN 1 IN 1,000,000 TO 1 IN 2,000,000 CERVICAL ADJUSTMENTS. CURRENT SCIENTIFIC EVIDENCE DOES NOT SHOW THAT CHIROPRACTIC ADJUSTMENTS CAUSE ARTERIAL DISSECTIONS IN HEALTHY ARTERIES).

IF ANYTHING FEELS UNCOMFORTABLE DURING YOUR CARE, PLEASE TELL US. WE ADJUST TREATMENT TO YOUR COMFORT LEVEL!

ALTERNATIVES TO CHIROPRACTIC CARE

- DOING NOTHING
- SELF-CARE AT HOME
- OVER-THE-COUNTER OR PRESCRIPTION MEDICATION
- PHYSICAL THERAPY
- INJECTIONS
- SURGICAL EVALUATION (IN SEVERE CASES)

YOU MAY SEEK A SECOND OPINION AT ANY TIME. **WE** GENUINELY SUPPORT WHATEVER HELPS YOU FEEL CONFIDENT IN YOUR CARE.

YOUR PARTICIPATION MATTERS

TO GET THE BEST RESULTS, PLEASE:

- TELL US HOW YOU'RE FEELING
- ASK QUESTIONS WHEN YOU HAVE THEM
- FOLLOW TREATMENT RECOMMENDATIONS AS APPROPRIATE
- LET US KNOW IF ANYTHING CHANGES (NEW SYMPTOMS, PREGNANCY, INJURIES, ETC.)

INFORMED CONSENT

BY SIGNING BELOW, YOU AGREE THAT:

- YOU HAVE READ, OR HAD EXPLAINED TO YOU, THE INFORMATION ABOVE
- YOU UNDERSTAND THE NATURE OF CHIROPRACTIC CARE AND THE POTENTIAL RISKS
- YOU HAVE HAD THE CHANCE TO ASK QUESTIONS
- YOU UNDERSTAND THAT RESULTS ARE NOT GUARANTEED
- YOU CONSENT TO CHIROPRACTIC CARE AND RELATED PROCEDURES AS RECOMMENDED BY YOUR PROVIDER

THIS CONSENT APPLIES TO YOUR CURRENT CONDITION AND ANY FUTURE CONDITIONS FOR WHICH YOU SEEK CARE AT ALVARADO HEALTHCARE.

WE WILL ALWAYS PUT YOUR SAFETY, COMFORT, AND WELL-BEING FIRST. **WE** ARE VERY GRATEFUL FOR YOUR TRUST!

PATIENT NAME (PRINT): _____

PATIENT SIGNATURE: _____

DATE: _____

WITNESS SIGNATURE: _____

DATE: _____

TIME: _____

PATIENT POLICY SUMMARY

INSURANCE AUTHORIZATION & ASSIGNMENT OF BENEFITS

I AUTHORIZE ALVARADO HEALTHCARE TO BILL MY INSURANCE ON MY BEHALF, RELEASE MEDICAL OR BILLING INFORMATION NEEDED TO PROCESS CLAIMS, COMMUNICATE WITH MY INSURANCE COMPANY OR CLAIMS ADMINISTRATOR AS NEEDED, AND RECEIVE PAYMENT OF BENEFITS DIRECTLY FROM MY INSURANCE COMPANY.

FINANCIAL RESPONSIBILITY

I UNDERSTAND THAT INSURANCE VERIFICATION IS NOT A GUARANTEE OF PAYMENT. I AM RESPONSIBLE FOR ANY COPAYS, DEDUCTIBLES, COINSURANCE, NON-COVERED SERVICES, DENIED CLAIMS, AND ANY BALANCE NOT PAID BY MY INSURANCE PLAN. MEDICARE AND OTHER INSURANCE PLANS MAY NOT COVER EXAMS, THERAPIES, EXTREMITY ADJUSTMENTS, LASER THERAPY, DRY NEEDLING, REHAB, OR OTHER SERVICES.

CARD ON FILE AUTHORIZATION

I AUTHORIZE ALVARADO HEALTHCARE TO SECURELY STORE MY DEBIT, CREDIT, OR HSA CARD THROUGH ITS ENCRYPTED PAYMENT PROCESSOR. MY CARD MAY BE CHARGED FOR COPAYS, DEDUCTIBLES, COINSURANCE, NON-COVERED SERVICES, INSURANCE BALANCES, AND APPLICABLE MISSED APPOINTMENT FEES. I WILL BE NOTIFIED BEFORE ANY UNUSUAL OR UNEXPECTED CHARGE IS PROCESSED.

CANCELLATION / NO-SHOW POLICY

IF I NEED TO CANCEL OR RESCHEDULE, I AGREE TO GIVE AT LEAST 24 HOURS NOTICE WHEN POSSIBLE. A SAME-DAY CANCELLATION OR MISSED APPOINTMENT MAY RESULT IN A \$20 FEE. IF I ARRIVE LATE, MY VISIT MAY BE SHORTENED OR RESCHEDULED. EXCEPTIONS MAY BE MADE FOR EMERGENCIES, SEVERE WEATHER, OR OTHER SIGNIFICANT CIRCUMSTANCES.

HIPAA / PRIVACY ACKNOWLEDGMENT

I UNDERSTAND THAT ALVARADO HEALTHCARE MAY USE AND DISCLOSE MY HEALTH INFORMATION FOR TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS AS PERMITTED BY LAW. I UNDERSTAND THAT I MAY REQUEST ACCESS TO MY RECORDS, REQUEST CORRECTIONS, REQUEST CERTAIN LIMITS ON USE OR DISCLOSURE, REQUEST CONFIDENTIAL COMMUNICATIONS, AND RECEIVE A FULL COPY OF THE NOTICE OF PRIVACY PRACTICES.

SOCIAL MEDIA CONSENT (OPTIONAL)

I UNDERSTAND THAT PHOTOS, VIDEOS, OR TESTIMONIALS MAY ONLY BE USED FOR EDUCATIONAL OR PROMOTIONAL PURPOSES WITH MY PERMISSION. THIS IS OPTIONAL, MAY BE WITHDRAWN AT ANY TIME, AND WILL NOT AFFECT MY CARE. SOCIAL MEDIA SELECTION:

- YES, I GIVE PERMISSION FOR ALVARADO HEALTHCARE TO USE PHOTOS, VIDEOS, OR TESTIMONIALS OF ME FOR EDUCATIONAL OR PROMOTIONAL PURPOSES.
- NO, I DO NOT GIVE PERMISSION FOR ALVARADO HEALTHCARE TO USE MY IMAGE, VIDEO, OR STORY.

FULL COPIES OF ANY POLICY OR CONSENT FORM ARE AVAILABLE UPON REQUEST AT THE CLINIC AND MAY ALSO BE AVAILABLE ON THE CLINIC'S WEBSITE.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THAT INFORMATION. PLEASE REVIEW IT CAREFULLY.

OUR COMMITMENT TO YOUR PRIVACY

ALVARADO HEALTHCARE IS REQUIRED BY LAW TO PROTECT THE PRIVACY OF YOUR PROTECTED HEALTH INFORMATION, PROVIDE YOU WITH THIS NOTICE OF OUR PRIVACY PRACTICES, AND FOLLOW THE TERMS OF THE NOTICE CURRENTLY IN EFFECT.

HOW WE MAY USE AND DISCLOSE YOUR INFORMATION

WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS. THIS INCLUDES PROVIDING AND COORDINATING YOUR CARE, BILLING AND COLLECTING PAYMENT, COMMUNICATING WITH OTHER PROVIDERS INVOLVED IN YOUR CARE, CONTACTING YOU ABOUT APPOINTMENTS OR FOLLOW-UP, AND OPERATING AND IMPROVING OUR PRACTICE.

OTHER USES AND DISCLOSURES ALLOWED OR REQUIRED BY LAW

WE MAY ALSO USE OR DISCLOSE YOUR INFORMATION WHEN PERMITTED OR REQUIRED BY LAW, INCLUDING FOR PUBLIC HEALTH AND SAFETY ACTIVITIES, HEALTH OVERSIGHT, ABUSE OR NEGLECT REPORTING, LAW ENFORCEMENT, JUDICIAL OR ADMINISTRATIVE PROCEEDINGS, WORKERS' COMPENSATION CLAIMS, RESEARCH WHEN ALLOWED BY LAW, CORONER OR FUNERAL DIRECTOR DUTIES, CERTAIN GOVERNMENT FUNCTIONS, AND COMPLIANCE WITH FEDERAL OR STATE LAW.

USES REQUIRING YOUR WRITTEN AUTHORIZATION

WE WILL NOT USE OR DISCLOSE YOUR INFORMATION FOR MARKETING, THE SALE OF YOUR INFORMATION, OR OTHER USES REQUIRING AUTHORIZATION WITHOUT YOUR WRITTEN PERMISSION, EXCEPT AS OTHERWISE PERMITTED BY LAW. YOU MAY REVOKE YOUR AUTHORIZATION IN WRITING AT ANY TIME, EXCEPT TO THE EXTENT WE HAVE ALREADY ACTED ON IT.

YOUR RIGHTS

YOU HAVE THE RIGHT TO INSPECT OR RECEIVE A COPY OF YOUR RECORDS, REQUEST A CORRECTION TO YOUR RECORDS, REQUEST CONFIDENTIAL COMMUNICATIONS, REQUEST CERTAIN RESTRICTIONS ON USE OR DISCLOSURE, RECEIVE AN ACCOUNTING OF CERTAIN DISCLOSURES, REQUEST A PAPER COPY OF THIS NOTICE, AND FILE A COMPLAINT IF YOU BELIEVE YOUR PRIVACY RIGHTS HAVE BEEN VIOLATED.

OUR RESPONSIBILITIES

WE ARE REQUIRED BY LAW TO MAINTAIN THE PRIVACY AND SECURITY OF YOUR PROTECTED HEALTH INFORMATION, NOTIFY YOU FOLLOWING A BREACH OF UNSECURED PROTECTED HEALTH INFORMATION WHEN REQUIRED, PROVIDE YOU WITH THIS NOTICE, AND FOLLOW THE PRIVACY PRACTICES DESCRIBED IN THIS NOTICE.

QUESTIONS OR COMPLAINTS

IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, WANT TO EXERCISE YOUR PRIVACY RIGHTS, OR WANT TO FILE A COMPLAINT, PLEASE CONTACT:

ALVARADO HEALTHCARE

PHONE: 618-654-4520 | 618-537-4407

YOU MAY ALSO FILE A COMPLAINT WITH THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES OFFICE FOR CIVIL RIGHTS. YOU WILL NOT BE RETALIATED AGAINST FOR FILING A COMPLAINT.

PATIENT ACKNOWLEDGMENT & CONSENT:

BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE BEEN PROVIDED ACCESS TO, AND HAD THE OPPORTUNITY TO REVIEW, THE CONSENT FORMS AND POLICIES PRESENTED IN THIS INTAKE PACKET, INCLUDING ALVARADO HEALTHCARE'S NOTICE OF PRIVACY PRACTICES, PRIOR TO SIGNING.

I UNDERSTAND THAT I MAY REQUEST FULL COPIES OF ANY POLICY, CONSENT FORM, OR THE NOTICE OF PRIVACY PRACTICES FROM THE CLINIC AT ANY TIME, AND THAT COPIES MAY ALSO BE AVAILABLE ON THE CLINIC'S WEBSITE.

I ACKNOWLEDGE THAT I HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS, THAT MY QUESTIONS HAVE BEEN ANSWERED TO MY SATISFACTION, AND THAT I UNDERSTAND, ACKNOWLEDGE RECEIPT OF, AND AGREE TO THE TERMS, POLICIES, AND CONSENTS DESCRIBED IN THIS INTAKE PACKET.

MY SIGNATURE APPLIES TO ALL DOCUMENTS PRESENTED IN THIS INTAKE PACKET.

PRINTED NAME (PATIENT)

PATIENT SIGNATURE OR LEGAL REPRESENTATIVE

WITNESS SIGNATURE: _____

DATE: _____

TIME: _____

YOU FINISHED!



FOR TREATMENT OF A MINOR

I HEREBY REQUEST AND AUTHORIZE THE MEDICAL PROVIDERS OF ALVARADO HEALTHCARE AND WHOMEVER HE/SHE MAY DESIGNATE AS HIS/HER ASSISTANT OR AUTHORIZED REPRESENTATIVE, TO ADMINISTER CHIROPRACTIC AND RELATED CARE AS HE/SHE DEEMS NECESSARY TO MY DEPENDENT MINOR CHILD. THIS AUTHORIZATION ALSO EXTENDS TO INCLUDE DIAGNOSTIC IMAGING, LABORATORY AND OTHER TESTING AT THE DOCTOR'S DISCRETION. THIS CONSENT IS EFFECTIVE AS OF THE DATE EXECUTED BELOW AND WILL CONTINUE IN EFFECT UNTIL REVOKED BY THE GUARDIAN OR WHEN THE MINOR BECOMES OF LEGAL AGE. ALSO GIVES THIS OFFICE THE RIGHT TO TREAT THE MINOR FOR CHIROPRACTIC CARE AND RELATED CARE AS HE/SHE DEEMS NECESSARY IF A GUARDIAN IS NOT PRESENT.

MINOR/CHILD'S NAME: _____

YOUR RELATIONSHIP TO MINOR/CHILD: _____

AS OF TODAY'S DATE, I HAVE THE LEGAL RIGHT TO SELECT AND AUTHORIZE HEALTH CARE SERVICE FOR THE MINOR CHILD NAMED ABOVE. IF APPLICABLE, UNDER THE TERMS AND CONDITIONS OF A DIVORCE/SEPARATION OR OTHER LEGAL AUTHORIZATION, THE CONSENT OF A SPOUSE, FORMER SPOUSE, OR OTHER PARENT IS NOT REQUIRED. IF MY AUTHORITY TO SO SELECT AND AUTHORIZE THIS CARE SHOULD BE REVOKED OR MODIFIED IN ANY WAY, I WILL IMMEDIATELY NOTIFY THIS OFFICE.

I CERTIFY BY MY SIGNATURE THAT I UNDERSTAND THE NATURE OF THIS CONSENT AND VOLUNTARILY AGREE TO ITS PROVISIONS. I UNDERSTAND I CAN WITHDRAW MY PERMISSION IN WRITING AT ANY TIME.

PRINTED NAME OF PARENT/GUARDIAN: _____

ADDRESS: _____

PHONE: _____

SIGNATURE PARENT/GUARDIAN: _____ **TODAY'S DATE:** _____

WITNESS SIGNATURE: _____

DATE: _____

TIME: _____