ISSAM A. HALABY, MD
GENERAL & VASCULAR SURGERY

436 Nokomis Avenue South · Venice, FL 34285 · Office 941-445-5054 · Fax 941-303-6796

www.HalabyMD.com

Welcome!

Issam A. Halaby, M.D. and his staff are dedicated to providing you with the highest quality of care. ***We welcome you to our practice!***

Office Hours

- Monday through Thursday from 8:30 A.M. to 4:30 P.M.
- Fridays, 8:30 A.M. to 3:30 P.M.

For additional information please visit our websites at **venicesurgery.com** and **westcoastveins.com**

Arrival Times

- New patients please arrive 30 minutes prior to your appointments.
- Established patients arrive 15 minutes prior to appointment.

Early arrival allows staff the necessary time to collect the information required for your appointment, and to better assist you.

Bring to Appointment

- State Issued Driver's License, or Identification Card

Please keep this information for future use.

Revised 032322

- Health Insurance card(s)
- List of current medications, and/or supplements

This ensures that we always have the most current information in your Electronic Health Records.

Follow-up Appointments

- Any return visits or testing that your provider orders after your appointment will be made at check-out.

Insurance

- Many insurance companies require an authorization/referral prior to your appointment.
- Referrals come from your Primary Care Physician (PCP).
- It's the patient's responsibility to contact the PCP to request and obtain the authorization.
- Authorizations/referrals must be submitted to our office prior to your appointment.
- We will not be able to honor appointments if the proper documents have not been received at our office.
- Co-pays or co-insurance is required to be paid at the time of your visit.

Medical Record Request

- To release records, you will be asked to sign an Authorization to Release Medical Records form.
- This form will become part of your Electronic Health Records.
- Please allow 10 business days for reproduction of your records.
- You will be called when records are available for you to pick up.

Please keep this information for future use.

Answering Service

- Calls after hours will be answered by our professional answering service.
- The service will gather the necessary information to relay to Dr. Halaby, or his associates.
- Your call will be returned as quickly as possible.
- Be prepared to accurately describe your problem and list the medications you are currently taking.
- Routine questions should be addressed during regular office hours.
- Use your nearest Emergency Room for a true emergency.

Clinical/Nurse Calls

- Dial (941) 584-1002 for clinical and prescription refills
- We strive to answer calls as they come in, however; that is not always possible. If you reach the voice mail please leave your full name, date of birth, return phone number and reason for your call.
- Clinical staff will return calls throughout the day as time allows.
- Emergent issues should not be left on the voicemail. Please dial 941-445-5054 and ask to speak with the nurse.
- Please allow 48 hours for prescription refills.
- The fastest prescription refill is by Electronic Prescription submission through our Electronic Medical Record – please have your prescription number and pharmacy contact information available for when we return your call.

Please feel free to call these departments directly for any questions, concerns or assistance you may need, they will be happy to assist you!

Billing Department – (941) 484-1203

Front Desk – (941) 445-5054

Procedure Scheduling – (941) 485-1384

Please keep this information for future use.

Revised 032322

ISSAM A. HALABY, MD
GENERAL & VASCULAR SURGERY

436 Nokomis Avenue South · Venice, FL 34285 · Office 941-445-5054 · Fax 941-303-6796

Please read and complete the entire form.

Last Name _____First_____ MI __ Date of Birth_____ SS#_____

Address _____ City _____State_____ Zip_____

Northern Address _____ City _____ State _____ Zip_____

Home phone # _____Cell # _____Northern Ph # _____

Circle which phone number should be your PRIMARY contact number>>> Home Cell Work

Employer_____ Employer Phone _____

Email Address _____ May we email regarding cosmetic services we offer? Yes No

Primary Insurance Co: _____ Policy Holder _____ And DOB _____

Secondary Insurance Co: _____ Policy Holder _____ And DOB _____

SS# Primary Policy Holder: _____SS# Secondary Policy Holder: _____

Emergency Contact: _____ Telephone: _____

Authorization for Direct Payment & Release of Information via Auto-Fax

I authorize release of information to my insurance companies, and any holder of Medicare and/or other insurance companies to support reimbursement for services rendered at Surgical Associates of Venice & Englewood. I request that payment of authorized benefits be made on my behalf. I agree to assign benefits payable to the provider or facility furnishing the services. I understand that I am responsible for my bill, including any deductible or portion of my bill not covered or reimbursed by my insurance companies. I authorize Surgical Associates of Venice & Englewood to release information from my medical record to my referring physician, primary care physician, and other provider involved in my treatment for the purpose of continued care.

Financial Agreement

I understand that I am fully responsible, upon receipt of services or billing invoice, for any charges incurred by me for professional services rendered by the providers at Surgical Associates of Venice & Englewood. I understand that I may be required to make a payment at the time of any visit, if an insurance co-payment or deductible payment is required. I will be required to make payment on any past due balances on my account. I understand that if Surgical Associates of Venice & Englewood should file a claim with my medical insurance and/or third party representative, it is for my convenience and does not constitute any guarantee of payment by insurance or representative. If care is required and my insurance plan or contract determines the treatment is a non-covered service, and if the plan refuses payment to the provider, I understand I am responsible for full payment of services prior to, or at, the time of services rendered. I understand that, should the charges incurred be the result of an injury involving a third party and I have involved an attorney for purposes of a liability claim against the third party, I am responsible for all charges at the time services are rendered and not at the time of any liability settlement.

My signature below indicates I have read, understand and agree with the information disclosed in this document. I have also been offered, or received a copy of the Notice of Privacy Practices provided by Issam A. Halaby, M.D. PhD FACS

Patient Acknowledgement _____ ***Date*** _____

ISSAM A. HALABY, MD
GENERAL & VASCULAR SURGERY

436 Nokomis Avenue South · Venice, FL 34285 · Office 941-445-5054 · Fax 941-303-6796

Patient Last Name _____First Name _____MI_____

Consent to Treatment
I am presenting myself for medical and/or surgical treatment to Surgical Associates of Venice & Englewood and I voluntarily consent to the rendering of such care, including diagnostic tests and medical treatment, by authorized agents and employees of Surgical Associates of Venice & Englewood, physicians, or their designees, as may in their professional judgment be deemed necessary or beneficial to my wellbeing.

I understand that when the physicians treat me in the hospital, wound care center, or surgery center that they are functioning as independent contractors and will bill separately from those facilities or from other physicians who treat me in those facilities. I understand that the physicians are not employed by those facilities and that they are independent contractors who have been granted the privilege of using the hospital / medical facilities for the care and treatment of their patients.

I understand that examination and treatment received on an emergency basis is not intended as a substitution or replacement for complete medical care.

Medicare Certification Release
I certify that the information given by me in applying for payment under the Title XVIII and Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf to Surgical Associates of Venice & Englewood.

Insurance Assignment
I hereby assign to and authorize Surgical Associates of Venice & Englewood and its physicians involved in my care during this period of illness and treatment, or their duly authorized assigns to take all necessary steps, without limitations, to insure that any insurance benefits otherwise payable to me or my estate are paid directly to Surgical Associates of Venice & Englewood. This assignment of benefits includes but is not limited to billing insurance, filing petitions, filing suit, in my name or on behalf of the physicians, filing proofs of claim, filing probate claims and filing grievances and all other similar procedures, as may be amended from time to time with the state department of insurance. I also agree to provide and sign any other documents that may be reasonably necessary to accomplish any of the other purposes.

Fraud
Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, or files a statement of claim containing false, incomplete or misleading information may be subject to prosecution under applicable law.

Electronic Prescriptions
I am granting permission to Surgical Associates of Venice & Englewood to submit my prescriptions electronically when applicable and retrieve pharmacy benefits electronically for reconciliation purposes.

_____ _____
Signature of Patient or Legally Authorized Representative ***Printed Name of Person Signing***

Date _____

ISSAM A. HALABY, MD
GENERAL & VASCULAR SURGERY

436 Nokomis Avenue South · Venice, FL 34285 · Office 941-445-5054 · Fax 941-303-6796

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

In response to the Health Insurance Portability and Accountability Act, Surgical Associates of Venice & Englewood would like permission to disclose your confidential information and request that the following determinations are made which give us guidelines as to who you would like to have access to your confidential information.

Please place an X on the line(s) beside each name to advise as to what information we are permitted to share with each individual. If you list a name but no designation, we will assume that any/all types of information may be shared. We do NOT need the names of your physicians or Healthcare facilities, ONLY the names of your family and/or friends.

Name(s)	**Appointment**	**Financial**	**Medical**	**ALL**
_____	____	____	____	____
_____	____	____	____	____
_____	____	____	____	____
_____	____	____	____	____

I understand that the only way to change the permissions given above is to complete and sign a subsequent form. In addition, I agree that Surgical Associates of Venice & Englewood may leave appointment information with others who answer my preferred method of contact, on my answering machine or cell phone.

Patient Signature _____ Date _____

I consent to receiving emails, texts (SMS), auto-dialed and or artificial or pre-recorded messages to my cellular phone or to telephone numbers or email provided by me to Surgical Associates of Venice & Englewood or their agents including, without limitation, any account management companies and independent contractors including debt collectors. I understand that consenting to the above is not required before I receive service.

Patient Signature _____ Date _____

Surgical Associates of Venice & Englewood
Notice of Privacy Practices

This notice describes how medical information about you at Surgical Associates of Venice & Englewood may be used and disclosed, and how you can get access to your health information. Please review this notice carefully.

We are dedicated to maintaining the privacy of your health information. There will be records created each time you visit our providers or receive treatment from us. We may also collect information from others such as medical records from your other physicians and prior test results. These records may contain your symptoms, examination and test results, diagnoses, treatment, a plan for future treatment, and billing-related information. This notice applies to all of the records of your care generated by Surgical Associates of Venice & Englewood.

Our Responsibilities
We are required by law to maintain the privacy of your protected health information, to provide you with this notice of our legal duties and the privacy practices we maintain concerning your protected health information, and to notify any affected individuals following a breach of any unsecured protected health information. We will abide by the terms of the notice currently in effect.

Uses and Disclosures – How we may use and disclose protected health information about you

For Treatment -We may use and disclose protected health information about you to provide you with medical treatment or services. We may disclose protected health information about you to doctors, nurses, technicians and medical students or other personnel who are taking care of you. As an example, we may need to communicate with your primary care doctor to plan your treatment and follow-up care.

For Payment –We may use and disclose your protected health information to bill and collect payment from you, your insurance company, worker's compensation company or a third-party payer. As an example, we may need to provide your insurance company with information about your diagnosis so that it will pay us or reimburse you for the treatment or so we may get approval for payment and or determine if your plan will pay for treatment.

For Healthcare Operations –We may use and disclose your protected health information to run our practice. This may include measuring and improving quality, evaluating the performance of employees, conducting training programs and obtaining accreditation, certificates, licenses and credentials we may need to serve you. We will use these results to continually try to improve the quality of care for all patients that we serve.

Surgical Associates of Venice & Englewood may also use and disclose protected health information:

- To remind you that you have an appointment for medical care
- To determine your satisfaction with our services
- To conduct case management or care coordination activities
- To contact you as part of our fundraising efforts, if any, though you will have the right to opt out of such communications
- To business associates we have contracted with to perform an agreed upon service
- To inform you about health-related benefits or services
- To inform you about possible treatment alternatives
- To inform funeral directors consistent with applicable law
- For population-based activities relating to improving health or reducing healthcare costs
- For conducting training programs or reviewing competence of healthcare professionals

Individuals involved in Your Care or Payment for Your Care: We may release protected health information about you to a friend or family member who is involved in your medical care or who helps pay for your care.

Law Enforcement / Legal Proceedings: We may release protected health information for law enforcement purposes as required by law or in response to a valid subpoena or court order. We also may disclose your information 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.

As Required by Law, we may also disclose information to the following types of entities, included but not limited to:

- Public health or legal authorities charged with preventing or controlling disease, injury, disability or other threat to health or safety
- A funeral director, medical examiner or coroner to identify a deceased individual or to identify the cause of death.
- The U. S. Food and Drug Administration
- Workers' Compensation Agents
- Correctional Institutions (if you are in custody of a correctional institution or law enforcement officer)
- Military command authorities
- Organ and tissue donation organizations
- Health oversight agencies
- National security and intelligence agencies
- Protective services for the president and others

Future Communications: We may communicate with you via newsletters, mailings, or other means regarding treatment options, health-related information, disease management programs, wellness programs, or other community-based initiatives or activities in which our facility is participating.

Changes to This Notice: The terms of this notice applies to all records containing your protected health information created and 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 created or maintained in the past and future. The current notice will be posted in the facility and will include the new effective date. Copies of any revised notices will be available on our website and will be provided to you upon your next visit to our facility after the effective date.

Your Health Information Rights: While your health record is the physical property of the healthcare practitioner or facility that compiled it, you have the right to:

- Inspect and obtain a copy of the protected health information that may be used to make decisions about you, including patient medical records and billing records. You must submit your request to Privacy Officer, 436 Nokomis Avenue South, Venice, FL 34285. You may also request that we send your health information directly to another person based on your signed written instructions. We may deny your request to inspect and copy in certain, very limited circumstances. If you are denied access to protected health information, you may request that the denial be reviewed in some situations. Another licensed healthcare professional chosen by us will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review. Our practice may charge a fee for the cost of copying, mailing, labor and supplies associated with your request.

- Ask to amend your protected health information if you believe it is incorrect or incomplete, and you must request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be submitted in writing to Privacy Officer, 436 Nokomis Avenue South, Venice, FL 34285. You must provide us with reasons that support your request for amendment. Our practice reserves the right to deny your request if you ask us to amend information that is in our opinion, inaccurate and incomplete and not part of the protected health information kept by or for our practice. You will be notified of the reason for the denial.

- Request an "accounting of disclosures". An accounting of disclosures is a list of certain non-routine disclosures our practice has made of your protected health information for purposes other than treatment, payment, healthcare operations, or certain other permitted purposes. Use of your protected health information as part of the routine patient care in our practice is not required to be documented. In order to obtain an accounting of disclosures, you must submit your request in writing to Privacy Officer, 436 Nokomis Avenue South, Venice, FL 34285. All requests for accounting of disclosures must indicate the time period involved.

- Request in writing that we restrict disclosures of protected health information if the disclosure is for payment or healthcare operations, is not required by law, and the protected health information pertains solely to a healthcare item or service for which the individual, or someone on the individual's behalf other than the health plan, has paid Surgical Associates of Venice & Englewood in full. Additionally, you may request restrictions on the protected health information we disclose about you to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had. We are not required to agree to your request, except as described below. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

- Request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For example, you may ask that we contact you at work or by U. S. Mail. In order to request a type of confidential communication, you must make a written request to Privacy Officer, 436 Nokomis Avenue South, Venice, FL 34285. In order to request communication at an alternate location, your request must include a mailing address where you will receive bills for services and related correspondence regarding payment for services. Please realize that we reserve the right to contact you by other means at other locations if you fail to respond to any communication from us that requires a response.

- Receive a paper copy of our Notice of Privacy Practices even if you agreed to receive this notice electronically. You may ask us to give you a copy of this notice at any time. You may obtain a copy of this notice at our website VeniceSurgery.com.

Other Uses of Your Protected Health Information That Require Your Authorization:
Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Examples of these additional authorizations involve the release of psychotherapy notes (if any), marketing, or the sale of your protected health information. Any authorization you provide to us regarding the use and disclosures of your protected health information may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your protected health information for the reasons described in the authorization. You understand that we are unable to take back any disclosures we have already made with your permission and that we are required to remain our records of the care that we provided to you.

Complaints:
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 Privacy Officer, 436 Nokomis Avenue South, Venice, FL 34285 or by calling 941-445-5054. You will not be penalized for filing a complaint.

For further information, please contact our Practice Administrator who serves as our Privacy Officer at 436 Nokomis Avenue South, Venice, FL 34285 or 941-445-5054. Effective Date 09/01/2013

ISSAM A. HALABY, MD
GENERAL & VASCULAR SURGERY

436 Nokomis Avenue South · Venice, FL 34285 · Office 941-445-5054 · Fax 941-303-6796

Patient History Questionnaire - Please complete & bring to your appointment.

PATIENT INFORMATION

Last Name _____First _____MI___ Sex M F Date: _____
Referring physician: _____ Birth date: _____ Age: _____
Primary Dr: _____Cardiologist_____
Other Doctors _____

Race: ***(Circle One)*** White Am. Indian/AK Native Asian Black/African Am. Nat. Hawaiian Other Race Declined

Ethnicity: (***Circle One)*** Hispanic or Latino Non-Hispanic or Latino Declined

HISTORY OF PRESENT ILLNESS

Reason for your visit: _____

♦ Location of Problem: _____Duration: _____
(Where on the body symptom occurs- Right or Left side if applicable) ***(How long have you had symptom? How long does it last?)***

♦ Severity: _____ Quality: _____
(Severe, worse, slightly. Pain scale 1-10) ***(Character of symptom...burning, gnawing, stabbing)***

♦ Timing: _____ Context: _____
(When symptoms occur) ***(Situation associated with symptom)***

♦ Modifying Factors: _____
(Things that make symptoms better or worse)

♦ Associated Signs/Symptoms: _____
(Other things that happen when this symptom occurs)

Medical History: *Please circle **Yes** or **No** if you have the following medical problems& explain below.*

High Blood Pressure . ..Yes No Respiratory Problems . ..Yes No >Type _____
Diabetes ……. .Yes No Bleeding Problems. . . . .Yes No>Type_____
Stroke…… . . . .Yes No Heart Trouble……Yes No> Type_____
Cancer…….. Yes No >> Type_____
Other Problems_____

What is your current weight? _____ Height ____Feet _____Inches
Preferred Pharmacy_____ Location/Phone_____

Current Medications/Dosage:

_____
_____
_____

Drug Allergies: _____
Are you allergic to contrast dye? Yes No

Please Continue to Reverse Side

ISSAM A. HALABY, MD
GENERAL & VASCULAR SURGERY

436 Nokomis Avenue South · Venice, FL 34285 · Office 941-445-5054 · Fax 941-303-6796

Past Hospitalizations/Surgeries/Injuries and Approximate Dates:

_____

_____

_____

Family History: *Please list any medical problems in your relatives.*

Father: _____

Mother: _____

Siblings: _____ Other _____

Social History: Marital Status: ❑Single ❑Married ❑Separated ❑Divorced ❑Widowed

Tobacco Use: ❑Never ❑Quit/ What age? _____ ❑Smoker/ how much?_____

Alcohol Use: ❑Never ❑Rarely ❑Moderate ❑Daily ❑How much?_____

Recreational Drug Use: ❑Never ❑Type and frequency _____

Occupation: _____ Permanent Resident? Yes No

Review of Systems *Please circle **Yes** or **No** if you have any of the following problems.*

Constitutional			**Ears/Nose/Mouth/Throat**			**Eyes**		
Good General Health	Yes	No	Hearing loss or ringing	Yes	No	Wear glasses/contacts	Yes	No
Recent weight change	Yes	No	Sinus problems	Yes	No	Blurred/double vision	Yes	No
Night sweats, fevers	Yes	No	Nose bleeds	Yes	No	Eye disease or injury	Yes	No
Fatigue	Yes	No	Sore throat/voice change	Yes	No	Glaucoma	Yes	No

Cardiovascular			**Respiratory**			**Gastrointestinal**		
Chest pain	Yes	No	Shortness of breath	Yes	No	Nausea/vomiting	Yes	No
Palpitations	Yes	No	Cough	Yes	No	Abdominal pain	Yes	No
Heart trouble	Yes	No	Wheezing/asthma	Yes	No	Rectal bleeding	Yes	No
Swelling hands/feet	Yes	No	Coughing up blood	Yes	No	Bowel problems	Yes	No

Musculoskeletal			**Neurological**			**Integumentary (Skin/Breast)**		
Muscle pain or cramp	Yes	No	Frequent headaches	Yes	No	Change in hair or nails	Yes	No
Stiffness/swelling joints	Yes	No	Paralysis or tremors	Yes	No	Rashes or itching	Yes	No
Joint pain	Yes	No	Convulsions/seizures	Yes	No	Breast lump	Yes	No
Trouble walking	Yes	No	Numbness/tingling	Yes	No	Breast pain/discharge	Yes	No

Endocrine			**Hematologic / Lymphatic**			**Allergic/Immunologic**		
Excessive thirst/urination	Yes	No	Bruise easily	Yes	No	Food allergies	Yes	No
Thyroid disease	Yes	No	Slow to heal	Yes	No	Aspirin allergies	Yes	No
Hormone problem	Yes	No	Enlarged glands	Yes	No	Antibiotic allergies	Yes	No

Genitourinary -Male only			**Genitourinary -Female only**			**Psychiatric**		
Blood in urine	Yes	No	Blood in urine	Yes	No	Insomnia	Yes	No
Kidney stones	Yes	No	Kidney stones	Yes	No	Confusion/memory loss	Yes	No
Sexual problems	Yes	No	Sexual problems	Yes	No	Depression	Yes	No
Testicle pain	Yes	No	Menstrual problems	Yes	No	Other _____		

Patient statement: To the best of my knowledge, the above information is accurate and complete.

Signed _____ Date_____

ISSAM A. HALABY, MD
GENERAL & VASCULAR SURGERY

436 Nokomis Avenue South · Venice, FL 34285 · Office 941-445-5054 · Fax 941-303-6796

Payment Information

Traditional Medicare Only or with a secondary policy:

Patients with *traditional Medicare* only will be asked to pay that amount (20%) at the time of service. We will be pleased to bill any secondary policies that we are contracted with as providers. *Medicare replacement plans* have multiple plans that require co-pays and/or co-insurance amounts. All patients with traditional *Medicare*, or *Medicare replacement plans*, may be asked to pay an additional payment amount if their annual deductible has not been met or they have a co-pay and/or a co-insurance clause.

Managed Care Insurance:

Managed Care insurances (including Medical Replacement Plans) rarely do not have a requirement for a co-pay of co-insurance amount to be paid. We ask that you pay these amounts at the time of service. Authorization or referrals are usually required to see a specialist – especially if it is an HMO plan. Our staff will know in advance if either of these are required and will help secure them.

Commercial Insurances:

Our practice will file a claim for your services, as a courtesy, with any commercial insurance plan. If we are contracted to provide services for your plan, we will only ask for payment of co-pays or co-insurance amounts. If we are not contracted with your plan, we will ask you for payment in full at the time of service.

No Insurance Coverage:

Patients will be expected to pay in full at the time of service. Please ask about our "Prompt Payment Discount" when your services are paid in full, at the time of service and we are not required to file a claim to any plan. We also offer "Payment Plans" when there is a balance of over $500.00.

Non U.S. Residents:

Our practice will be unable to file your claim to any foreign insurance plan that has an address outside the United States. You will be asked to pay in full (in U.S. funds) at the time of service.

Forms of Payment Accepted:

We accept cash, check, Visa, MasterCard, Discover and American Express.

ISSAM A. HALABY, MD
GENERAL & VASCULAR SURGERY

436 Nokomis Avenue South · Venice, FL 34285 · Office 941-445-5054 · Fax 941-303-6796

www.HalabyMD.com

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge:

A copy of Surgical Associates of Venice & Englewood's Notice of Privacy Practices was given/offered to me. If I received healthcare services in an emergency treatment situation, I was given the Notice as soon as reasonably practical after the emergency treatment situation.

_____ _____

Signature of Patient or Representative Date

Staff Use Only

If an acknowledgment is not obtained, please complete the information below:

Patient's name: _____

Date of attempt to obtain acknowledgment: _____

Reason acknowledgment was not obtained:

- Patient/family member received notice but refused to sign acknowledgment
- Emergency treatment situation
- Patient was incapacitated and no family member was present
- Unable to communicate due to language barriers
- Other (as described below)

_____

_____ _____

Staff Signature Date