**MAKE SURE TO FILL OUT EVERYTHING ON**

**ALL PAGES.**

**MAKE SURE TO PUT YOUR NAME ON THE TOP RIGHT CORNER OF EVERY PAGE.**

**IF SOMETHING DOES NOT APPLY PLACE AN “X” IN THE QUESTION AREA OR WRITE IN “N/A”**

**Last Name**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **First Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI\_\_\_\_\_\_\_\_

Social Security#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age \_\_\_\_\_\_\_\_\_\_\_

***Please Circle*** Gender **(male-female)** Martial Status **(single, married, divorced)**

Race **(White, Black, Asian, Hispanic, American Indian, Other)**

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Apt/Unit#\_\_\_\_\_\_\_\_\_\_\_\_

City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_

Home Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email­­: **\_­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

How do you want to be contacted for appointment reminder by Text \_\_\_\_\_ or Phone call \_\_\_\_\_\_\_\_\_\_\_\_\_

Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about us? Personal Reference \_\_\_\_\_\_\_\_\_Internet \_\_\_ Yellow Pages \_\_\_ Other \_\_\_\_\_\_\_\_\_

If a physician referred you to our office please provide the name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Would you like access to the online patient portal? Yes No**

*You will receive an email with instructions on how to create an account on a secured website.*

**EMERGENCY CONTACT**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INSURANCE INFORMATION**

**Primary** Insurance Company Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holders Name *(if other than self)* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy/Member # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer Providing Insurance\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Secondary** Insurance Company Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holders Name *(if other than self)* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy/Member # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer Providing Insurance \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PRIMARY CARE DOCTOR**  **PREFERRED PHARMACY**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date last seen \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The reason for your visit today \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is this related to an accident (circle) YES NO If yes, is it an (circle one) AUTO or Workers Comp

Are you experiencing pain (circle) Yes No Level of pain (1-10) \_\_\_Where is Pain Located\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Shoe Size \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Weight \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Height\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tobacco use\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alcohol use \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Latest A1c**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If Diabetic when was you last eye exam**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Eye Doctor Name**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| **Current Medications Please List** | **Past Surgical History Please List** | **Medication Allergies Please List** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  | **Immunization History** | **No Known Medication Allergies** |
|  | **Tetanus Yes No** | **Date: Month/Year** |
|  |  |  |
|  | **Flu Shot Yes No** | **Date: Month/Year** |
|  |  |  |
|  | **Pneumonia Yes No** | **Date: Month/Year** |
|  |  |  |
|  | **COVID Yes No** | **Date/Month/Year/Type** |
|  |  |  |

### patient and family history

Please circle **P** for patient history and **F** for family history

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| AIDS/HIV | P F | Diabetes | P F | Heart Disease | P F |
| Anemia | P F | Dizzy Spells | P F | Hepatitis | P F |
| Arthritis | P F | Epilepsy | P F | High Blood Pressure | P F |
| Asthma | P F | Fainting | P F | High Cholesterol | P F |
| Bleeding Disorder | P F | Fibromyalgia | P F | Kidney condition | P F |
| Cancer | P F | Gastro-intestinal Disorders | P F | Neuropathy | P F |
| Chest Pain | P F | Glaucoma | P F | Varicose Veins | P F |
| Circulation condition | P F | Gout | P F | Tuberculosis | P F |

**Do you have an Advance Direct Yes\_\_\_\_N0\_\_\_\_ Living will\_\_\_\_\_\_ Medical Durable power of attorney \_\_\_**

**Advance Directive date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**List any other medical conditions for the patient:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**If diabetic please provide the date you were last seen by your primary care doctor and the results of your A1C:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Also, please list the name and phone number of your optometrist or ophthalmologist:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PROTECTED HEALTH INFORMATION DISCLOSURE**

We cannot discuss your Protected Health Information (PHI) with anyone than yourself unless you authorize us to do so. Please list below the name(s) of the individual(s) you authorize our office to discuss your care with. Your PHI will be disclosed to the individual(s) listed below until you notify us otherwise in writing.

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This authorization will remain in effect for one year unless otherwise specified. I understand this authorization extends to all or any part of my medical records. I expressly consent to the release of information as designated above. I understand that this authorization is revocable upon written notice to the office where the original authorization is retained.

**INSURANCE AUTHORIZATION, RELEASE AND ASSIGNMENT OF BENEFITS**

I hereby authorize Ankle & Foot Associates to furnish and/or release any information necessary to insurance carriers concerning my illness and treatments, and I hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. It may be used to process my insurance claim acquired in the course of my examination or treatment, to allow a photocopy of my signature to be used to process my insurance claim for the period of a lifetime. This order will remain in effect until revoked by me in writing.

I have requested the medical service of Ankle & Foot Associates on behalf of myself and/or dependents, and I understand by making this request, I become fully financially responsible for any and all charges occurred in the course of the treatment authorized. I further understand that fees are due and payable on the date services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original. I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s) including Medicare, Medigap, Medicaid, private insurance and any other health/medical plan to issue payment directly to Ankle & Foot Associates, for medical service rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand I am responsible for any amount not covered by insurance, regardless of insurance coverage.  **INITIAL**\_\_\_\_\_\_\_\_\_\_\_\_\_

**NOTICE OF PRIVACY**

I acknowledge that upon request I received a copy of the Ankle & Foot Associates “Notice of Privacy Practices”. I have read and understand all of the above and agree to comply. **INITIAL**\_\_\_\_\_\_\_\_\_\_\_\_

**CONSENT TO TREAT**

The purpose of medical care is to facilitate the treatment of disease, injury and disability. Medical services are provided through examination, testing and use of procedures to the aid of diagnosis or treatment of a medical condition. I request authorize Ankle & Foot Associates to provide me with medical services as described above. I agree to cooperate fully and to participate in all medical procedures and to comply with the plan of medical care/services that is established. **INITIAL**\_\_\_\_\_\_\_\_\_\_\_\_\_

**RESPONSIBLE PARTY – Adult present signing consent to treat if patient is a minor or Power of Attorney is necessary**

Patient Relationship to Responsible Party \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI \_\_\_\_\_\_\_

Social Security# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Apt/Unit# \_\_\_\_\_\_\_\_\_\_\_\_City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_Zip \_\_\_\_\_\_

Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medication Policy**

Any medication request will take up to 72 hours to be processed. If the medication is a narcotic it **cannot** be called into the pharmacy so the patient will have to pick up prescription in the office once processed. If you have not been seen in the past 3 months form time of refill request the patient will need to call the office to make an appointment to see the doctor before any refills will be given. Initialing here indicates that you understand this policy. **INITIAL**\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FINANCIAL POLICY**

The doctors and staff at Ankle & Foot Associates would like to welcome you to our practice. We strive to provide you with excellent medical care and our goal is to make your visits as convenient as possible.

**By signing below you confirm that you have read this policy and understand that:**

* It is your responsibility to inform our office of any address or telephone number changes.

Your account is to be kept current----accordingly, all self pay or insurance co-payments, co-insurance and deductibles will be collected **at the time of services.** Payable by: cash, check, Visa, MasterCard, Discover or American Express.

* If you do not have payment(s), your appointment may be rescheduled.
* A returned check will result in a $25 service charge **and** all future payment being required in the form of cash or credit card.
* There is a $25 charge for the completion of paperwork (ex: disability, FMLA, etc)
* Any unpaid balances older than 30 days may be subject to 1.5% interest per month
* If your account is turned over to collection agency, you will be responsible for any costs incurred in collection of said balance, which may include collection agency fees up to 35% of your outstanding balance, court cost and attorney fees.
* If unable to keep your appointment, please notify us in advance so that we may offer that time to another patient. A pattern of repetitive **“No show” or late cancellations may regretfully result in an assessment of a cancellation/no show fee.**

**If you have health insurance coverage**

We will submit your claims, however ***we must emphasize that as medical providers, our relationship is with you, not your insurance company.***

Although we attempt to verify your benefits with your insurance policy, please be advised this is only an estimate of your coverage based on the information given to us at the time of inquiry.

**By signing below you confirm that you understand:**

It is your responsibility to inform us of any changes to your insurance policy so that your coverage can be re-verified prior to your appointment.

* If your insurance policy requires a referral from your primary care physician, it is your responsibility to have that referral faxed to our office prior to your appointment.
* Not all services are covered benefits with all insurance plans.
* It is your responsibility to be aware of what service(s) is being provided to you and if it is a covered benefit under your insurance policy.
* You are responsible for any non-covered charges not payable by your insurance policy.
* Although filing your insurance claims is a courtesy extended to you, all charges are always your responsibility from the date services are rendered.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we urge you to contact us promptly for assistance in the management of your account. If you have any questions about the above information, *please* do not hesitate to ask us. **We are here to help you.**

**I have read and understand the above Financial Policy and agree to meet all financial obligations.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Patient Signature Responsible Party Signature (if other than patient)

Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Late Cancellations / No Show Appointments**

In order to avoid late cancellations and no show appointments, we will be charging the following fee for no show cancellation.

$30 Office Visit

$250 for Surgery

We kindly request a minimum of 24 hour notice if you need to reschedule or cancel your appointment.

**Payments**

Co-payments, Co-insurance, Deductible and Self pay rates are due in **FULL** on the day that the services are rendered, unless prior financial arrangements have been made with the office. We do accept cash, check, credit cards and debit cards.

**Referrals**

If you have an insurance that requires an Authorization or Referral, it must be on file before you are seen. You will be asked to reschedule your appointment if your referrals is not on file by 3pm the day before. As a courtesy, we do send a notice to your primary care physician that one is needed, but it is **the patient’s responsibility** to assure that the referral is obtained prior to the visit.

By signing below you agree to abide by our policies. Your understanding and compliance with these policies is greatly appreciated. We thank you for your business.

Sincerely,

Ankle & Foot Associates

David Auguste, DPM

Stanley S Shama, DPM

Michael Birau, DPM

Patient Name (Print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employee Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_