ETERNA M.D.
MEDICAL REJUVENATION CENTER

1307 S. International Pkwy, Suite 2091
Lake Mary, FL 32746
eternamd.com | 407-771-0404

Eterna MD New Patient Intake Form

Today's Date: ____________________ **Birth Date:** ____________________

Male/Female: ____________________ ____________________

First Name: ____________________ **Last Name:** ____________________

Home Address: ____

____

City **State** **Zip**

Email Address: ____

Instagram: ____________________ **Cell Phone:** ____________________

Work Phone: ____________________ **Occupation:** ____________________

____________________ **Driver's License #:** ____________________

Emergency Contact Person: ____

Name: ____

First **Last**

Phone Number: ____

How did you hear about us?

Telemundo	☐	**Facebook**	☐	**Seminar**	☐
Google	☐	**Instagram**	☐	**Press Release**	☐
www.eternamd.com	☐	**LinkedIn**	☐	**Realself**	☐
www.trainnowmd.com	☐	**Twitter**	☐	**Television**	☐
Physician	☐	**YouTube**	☐	**Employee**	☐
Friend:	☐	**Yelp**	☐	**Other**	☐

Referred By: ____

Consent to Communicate Test Results and Other Medical Records Information

	Use Pt ID	**OK to leave Voicemail**	**Ok to leave message with another person**	**Preferred Method**
☐ **Call Work Number**	☐	☐	☐	☐
☐ **Call Cell Number**	☐	☐	☐	☐
☐ **Call Home Number**	☐	☐	☐	☐
☐ **Send Email**	☐	☐ **OK for appt reminder?**	☐ **Ok for Newsletters and monthly specials?**	☐
☐ **Send Regular Mail**	☐	**Mail to:** ☐ **Present** ☐ **Permanent** ☐ **Employer** ☐ **Responsible Party**		

BODY JET MEDICAL INTAKE FORM

Today's Date: ____________________

Patient Name: _______________________________ Date of Birth: ___________________

E-mail____

CELL PHONE___________________________________

REASON FOR VISIT TODAY: FAT DEPOSITS

FAT TRANSFER

Outer Legs		Lower Abdomen		Buttocks	
Inner Legs		Upper Abdomen		Face	
Chin		Love Handles		Hands	
Sacrum		Back Rolls		Breast	
Arms		Axillary (Pre,Mid,Post)		None	

==

Office use Only

CC:

PMH:

PSH:

==

FAMILY HISTORY:

Patient Name: ________________________________ Date of Birth: ____________________

Have you previously had liposuction before?	N	Y
If yes, what parts of your body?		
Do you have any allergies to any medication	N	Y
If yes, list:		
Are you pregnant?	N	Y
Do you smoke?	N	Y
Do you have heart disease?	N	Y
Do you have blood clotting disorders?	N	Y
Do you have a history of heavy bleeding during or after surgery or dental work?	N	Y
Do you have a history of blood clots in your legs?	N	Y
Do you have hepatitis or HIV?	N	Y
Have you had surgery in the area(s) for which you are seeking treatment?	N	Y
Are you taking Coumadin, aspirin or other blood-thinning agents?	N	Y
Any Complications with previous surgeries?	N	Y
Abdominal or Inguinal Hernias?	N	Y
Asthma or Lung problems?	N	Y
Previous Back Injury or nerve injuries?	N	Y
History of a Chronic viral infection?	N	Y
History of seizures, neurologic or psychiatric problems?	N	Y
Diabetes or a Kidney infection?	N	Y
Are you taking Birth control pills?	N	Y

LAST MENSTRUAL PERIOD: ________________

	YES	**NO**	**How much?**
SMOKE			
ALCOHOL			
LIVES ALONE			
SINGLE			
MARRIED			
DIVORCED			

LIST ALL YOUR CURRENT MEDICATIONS with DOSAGES:

MEDICATION	**DOSAGE**	**FREQUENCY**

ANY ALLERGIES: _________________________________
ANY ALLERGIES TO LIDOCAINE? Ex: dental block ______________________

Patient Name: _________________________________ **Date of Birth:** ____________________

PROCEDURE	DATE	Not Applicable	RESULTS
MAMMOGRAM			
PAP TEST			
COLONOSCOPY			
RECTAL EXAM			
PELVIC EXAM			
FLU VACCINE			
PNEUMONIA VACCINE			
DEXA SCAN			

==
Office use Only

PHYSICAL EXAM:

VITAL SIGNS

LMP:

A:

AREAS FOR LIPO____

Outer Legs	
Inner Legs	
Chin	
Sacrum	
Arms	

Lower Abdomen	
Upper Abdomen	
Love Handles	
Back Rolls	
Axillary (Pre,Mid,Post)	

FAT TRANSFER

Buttocks	
Face	
Hands	
Breast	
None	

POST- LIPO PROGRAM:
P:
Advise to follow-up in:

Patient Name: _________________________________ Date of Birth: ____________________

OPIOID RISK TOOL (ORT) FOR NARCOTIC ABUSE

Please place an "X" to indicate your selection for the following statements.

STATEMENT	YES	NO
Between ages 16-45		
History of preadolescent sexual abuse		
History of depression		
History of ADD, OCD, bipolar disorder, or schizophrenia		
Personal history of alcohol abuse		
Personal history of illegal drug abuse		
Personal history of prescription drug abuse		
Family history of alcohol abuse		
Family history of illegal drug abuse		
Family history of prescription drug abuse		

CAGE QUESTIONAIRE

Please place an "X" to indicate your selection for the following questions.

QUESTION	YES	NO
Have you ever felt you needed to cut down on your drinking?		
Have people annoyed you by criticizing your drinking?		
Have you ever felt guilty about drinking?		
Have you ever felt you needed a drink first thing in the morning to steady your nerves or to get rid of a hangover?		

Medical History

Name: ______________________________ **Date:** ______________________________

Do you have a history of?

- ☐ Heart Disease
- ☐ Diabetes
- ☐ Herpes Sores
- ☐ Bleeding Disorders
- ☐ Bruising
- ☐ Dark Spots after pregnancy
- ☐ Skin Injury
- ☐ Skin Cancer or suspicious moles
- ☐ Vitiligo
- ☐ Thyroid Disease

Do you have any skin related allergies? ☐ Yes ☐ No

If yes, please specify: ______________________________

Do you have any allergies to medication? ☐ Yes ☐ No

If yes, please specify: ______________________________

Do you take any medications?

- ☐ Aspirin
- ☐ Anti-coagulants (blood thinners)
- ☐ Hormones/Contraceptives
- ☐ Appetite depressant (diet pills)
- ☐ Thyroid Medication
- ☐ Insulin
- ☐ Sedatives
- ☐ Tranquilizers
- ☐ Cortisone
- ☐ Other (please specify) __________
- ☐ Accutane

____

Are you taking any herbal preparations? ☐ Yes ☐ No

If yes, list: ______________________________

What is your daily consumption of alcohol? ______________________________

Do you wear contact lenses? ☐ Yes ☐ No

Have you had cold sores or fever blisters? ☐ Yes ☐ No

Do you use chemical sun tanning lotions? ☐ Yes ☐ No

Are planning a holiday in the sun? ☐ Yes ☐ No

Have you ever had skin resurfacing or rejuvenation or chemical peels? ☐ Yes ☐ No

Have you ever had treatments for pigmented lesions? ☐ Yes ☐ No

Prior treatment (if any) ______________________________

AGREEMENT AS TO RESOLUTION OF CONCERNS

"I, Patient/Guardian" shall be understood to mean ____
"Physician" shall be understood to mean **Dr. De La Vega and Dr. Mercado** of Eterna MD Medical Rejuvenation Center.

I understand that I am entering into a contractual relationship with the physician for professional care. I further understand that meritless and frivolous claims for medical malpractice have an adverse effect upon the cost and availability of medical care to patients and may result in irreparable harm to a medical provider. As additional consideration for professional care provided to me by the physician, I, the Patient/Guardian, agree not to initiate or advance, directly or indirectly, any meritless or frivolous claims of medical malpractice against the Physician.

Should I initiate or pursue a meritorious medical malpractice claim against Physician, I agree to use as expert witnesses (with respect to issues concerning the standard of care) only physicians who are board certified by the American Board of Medical Specialties in the same specialty as the Physician. Further, I agree that these physicians retained by me or on my behalf to be expert witnesses will be members in good standing of the Board of Family Medicine.

I agree the expert will be obligated to adhere to the guidelines or code of conduct defined by the ABFP.

I agree to require any attorney I hire and any physician hired by me or on my behalf as an expert witness to agree to these provisions.

In further consideration Physician also agrees to exactly the same above referenced stipulations.

Each party agrees that a conclusion by a specialty society affording due process to an expert will be treated as supporting or refuting evidence of a frivolous or meritless claim.

Patient/Guardian and Physician agree that this Agreement is binding upon them individually and their respective successors, assigns representatives, personal representatives, spouses and other dependents.

Physician and Patient/Guardian agree that these provisions apply to any claim for medical malpractice whether based on a theory of contract, negligence, battery or any other theory of recovery.

Patient/Guardian acknowledges that he/she has been given ample opportunity to read this agreement and to ask questions about it.

____

Physician   Patient/Guardian Signature

____

Effective from Date of Treatment   Date of Signature

Patient Name: ______________________________ Date of Birth: ____________________

Consent to Photograph for Medical Documentation

I hereby authorize Dr Carlos Mercado MD, to photograph or video record or permit others to photograph or video record while under the care of the above physician and agree that he will use the material for medical documentation purposes.

Patient Signature	Print Name	Date
Witness Signature	Print Name	Date

Consent to Photograph for Marketing/Public Relations

I hereby authorize Dr Carlos Mercado MD, to photograph or video record or permit others to photograph or video record while under the care of the above physician and agree that he will use the material for Digital Marketing Purposes.

Patient Signature	Print Name	Date
Witness Signature	Print Name	Date

.

ETERNA MD CANCELLATION, NO SHOW AND REFUND POLICY

TREATMENTS: All treatments, procedures, and pre-paid packages are non-refundable. Packages are non-transferable and must be used within one year from the date of purchase. Credit from pre-paid treatments, procedures, and packages may be applied towards other forms of treatment(s) or product(s) only at management's discretion. **NO REFUNDS, EXCHANGES ONLY.**

CANCELLATIONS and No Shows: We understand that emergencies do arise, however, we do request at least 24 hours notice for rescheduling or canceling all appointments. Failure to do so will result in a $50 charge in order to re book your appointment. All procedures/treatments that require over an hour appointment will also be secured with a credit card.

ARRIVALS: Please arrive for your appointment at least 15 minutes earlier or on time. By arriving on time will ensure that you will receive the required amount of time you deserve for your treatment and helps us not to intrude on the following patient's reserved time.

CONSENT FOR EVALUATION AND COMMUNICATION

I hereby give my consent to ETERNA MD and their physicians to perform this evaluation that might include medical history, physical examination, lifestyle questions and others that are pertinent to my consultation. I understand they will be assisted by other health professionals, as necessary, and agree to their participation in my evaluation day. I certify that I am under the regular care of another physician for all other medical conditions. I will consult my physician(s) for any other medical services I may require. I understand that ETERNA MD is a specialized practice dealing exclusively in Age Management Medicine and Aesthetic procedures. I also understand that I will continue under the care of my other physician(s) for any on-going medical condition as well as for any medical consultation that I may need. I also give permission to communicate after the consultation with me either via e-mail to send patient care plans with pictures of myself, before and after pictures or other pertinent information such as articles that are educational and provide information regarding my requested services. My physician might communicate with me after my consultation, via phone, mail, electronic communications (e-mails) fax as well as his personnel to follow-up appointments, follow-up consultations, quotes or other information related to the services consulted.

By signing below, I agree to EternaMD's company terms and conditions.
To attest to my consent to this evaluation, I hereby affix my signature to this authorization to evaluation.

__________________________ __________________________ _____________

Patient Name Signature Date

__________________________ __________________________ _____________

Witness Name (please print) Signature Date

Patient Name: ________________________________ Date of Birth: ____________________

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

This notice of Privacy Practices describes the practices for safeguarding your personal health information. The terms of this Notice apply to patients and dependents for medical treatment.

We are required by law to maintain the privacy of our patient's personal health information and to provide the notice of our legal duties and privacy practices with respect to personal health information (PHI). We are required to abide by the terms of this notice as long as it remains in effect. We reserve the right to change the terms of this Notice as necessary as rules of law dictate and to make the new Notice effective for all personal health information (PHI) maintained. Copies of the revised Notices will be mailed to our patients. You have a right to request a copy of the Notice.

Uses and Disclosure of Your Personal Health Information (PHI)

Authorization: Except as explained below, we will not use or disclose your personal health information (PHI) for any purposes unless you have signed a form (Authorization Form) allowing a use of disclosure. Unless we have taken any action in reliance on the authorization, you have the right to revoke an authorization if the request for revocation is in writing and sent to our office of record.

Disclosures for Treatment: We may disclose your personal health information as necessary for your treatment. For example, a doctor or healthcare facility involved in your care from a referral may need your personal health information in our possession to provide care for you.

Uses and Disclosures for Payment: We will use and disclose your personal health information (PHI) as necessary for payment purposes. For example: We may use your personal health information (PHI) to process insurance claims, including Medicare and commercial carriers.

Uses and Disclosures for Health Care Operations: We will use and disclose your personal health information (PHI) as necessary for health care operations. For examples: we may use or disclose your personal health information (PHI) to healthcare facilities or for diagnostic testing, such as; MRI's, CT scans, radiology or laboratory testing.

Practices Uses and disclosures: We may contact you with reminders of an upcoming appointment, information about other treatment options, or health related products, programs or services that may be available to you.

Outside Business Consultants: Some aspects of our services are sometimes performed by persons outside of our organization and are here under contract or agreements. It may be necessary for us to disclose your personal health information to these outside contractors or organization that perform services for us. We require them to safeguard the privacy of your personal health information (PHI) and we require them to be HIPAA compliant.

Family, Friends and Personal Representatives: with your approval, we may disclose to family members, close personal friends or other persons that you may identify, your personal health information (PHI) relevant to their involvement with your care. If you are unavailable, incapacitated or involved in an emergency, and we determine that a limited disclosure is necessary to provide you care/treatment, we may disclose your personal health information (PHI) without your approval.

Other uses and Disclosures: We are permitted or required under HIPAA or State law to use or disclose your personal health information (PHI) without your Authorization, in the following situation:

For any purpose required by Law. For public health requests: such as: Death, Injury, or suspected child abuse or neglect. To a government authority if we believe an individual is a victim of abuse, domestic violence, neglect or for health oversight actions (such as inspections, licensure actions, civil or administrative or criminal proceedings). For administrative or judicial proceedings such as: Subpoena, court orders or a discovery request. For Law Enforcement purposes: such as: Reporting injuries, wounds, or for locating or identifying suspects, missing persons or witnesses. To medical examiners, coroners and funeral directors. 1/2

For procuring, banking or transplants of organs, eye or tissue donations. For certain research projects. To avoid a serious threat to health or safety under certain instances. For intelligence or national security issues, members of the armed forces for military activities, or information about an inmate or an individual being held at a correctional institution or a law enforcement agency having custody. To be compliant with workers compensation programs or requests.

We will follow all state and federal laws or regulations that provide additional privacy protections. We will only release or disclose AIDS/HIV related information, any information relating to your mental status, genetic testing information or any substance abuse issues as permitted by state and federal law or regulations.

Your Rights:

Restrictions on Use and Disclosure of Your Personal Health Information (PHI). You have the right to request restrictions on how we use or disclose your personal health information (PHI) for treatment, healthcare operations or payment (Commercial Insurance Carriers and Medicare/Medicaid). You have the right to restrict disclosures to family members or others who are not involved in your care or who are not financially responsible for your care. To request restrictions on certain individuals, send a written request to our office to Attention: Privacy Officer.

We are not required to always agree with your request for a restriction but, if we do grant your request, you will receive a written acceptance of your request.

Receipt of Confidential Communications of your personal health information (PHI). You have the right to request communications relating to your personal health information (PHI) by alternative means such as by: Fax (with a secure cover sheet) or at an alternative location. We will accommodate any reasonable requests. To request a confidential communication, please send a written request to our office: Attention: Privacy Officer.

Access to your Personal Health Information (PHI). You have the right to inspect and or obtain copies of your personal health information that we maintain in your designated personal records, with one or two exceptions. To request access to your information, you must send a written request to our office, Attention: Privacy Officer. A medical records release form can be obtained at our office.

Amendment of your Personal Health Information (PHI). You have the right to request an amendment to your personal health information (PHI) to correct any errors or omissions. To request an amendment to your personal health information, you must send a written request to our office: Attention: Privacy Officer. We are not required to grant the request in certain instances.

Accounting of Disclosures of your Personal Health Information (PHI). You have the right to receive an accounting of certain disclosures made by us of your personal health information. To request an accounting, you must send a written request. Attn: Privacy Officer.

Complaints: If you believe your privacy rights have been violated, you can send a written complaint to our office. Please send to the attention of: Privacy Officer.

If you have any questions or need any assistance regarding this Privacy Notice of your privacy rights, please contact our office.

I acknowledge that I have received a copy of the Privacy Practices for Protected Health Information effective today. 2/2

Name : ____ DOB:_______________

Signature:______________________________

Date:_______________________

Patient Name: ________________________________ Date of Birth: ____________________

Skin Typing Matrix

Question	Answer		Score
My ethnic origin is closest to:	Very fair (Celtic and Scandinavian)	☐	0
	Fair-skinned Caucasians with light hair and light eyes	☐	1
	Pale-skinned Caucasians with dark hair and dark eyes	☐	2
	Olive-skinned (Mediterranean, some Asian, some Hispanic)	☐	3
	Dark-skinned (Middle Eastern, Hispanic, Asians, some Africans)	☐	4
	Very dark-skinned (African)	☐	5
My eye color is:	Light blue	☐	0
	Blue / Green	☐	1
	Green / Gray / Golden	☐	2
	Hazel / Light brown	☐	3
	Brown	☐	4
My natural hair color at age 18 was:	Red	☐	0
	Blonde	☐	1
	Light brown	☐	2
	Dark brown	☐	3
	Black	☐	4
The color of my skin that is not normally exposed to sun is:	Pink to reddish	☐	0
	Very Pale	☐	1
	Pale with a beige tan	☐	2
	Light brown	☐	3
	Medium to dark brown	☐	4
	Dark brown - black	☐	5
If I go out in the sun for an hour or so without sunscreen and have not been out in the sun for weeks, my skin will:	Burn, blister and peel	☐	0
	Burn, then when the burn resolves there is little or no color change	☐	1
	Burn, but then turns to tan in a few days	☐	2
	Burn, but then turns to tan quickly	☐	3
	Just tan	☐	4
	Just gets darker	☐	5
	My skin color is so dark that I can't tell	☐	6
When was the last time the area to be treated was exposed to natural sunlight, tanning booths or artificial tanning cream?	Longer than one month ago	☐	0
	Within the past month	☐	1
	Within the past two weeks	☐	2
	Within the past week	☐	3

Total Score: ________

If your score is:	Your skin type is:
0 – 3	1
4 – 7	2
8 – 11	3
12 – 15	4
16 – 19	5
20 – 24	6

CONSENT FOR ELECTRONIC COMMUNICATION
Eterna MD Medical Rejuvenation Center
1307 South International Pkwy Suite 2091, Lake Mary Fl 32746
Phone 4077710404 | Fax 4077710405| info@eternamd.com | www.eternamd.com

Dr. Carlos Mercado MD has offered to communicate using the following means of electronic communication ("the Services") [check all that apply]:

__X___Email

__X___Videoconferencing

__X___Text messaging (including instant messaging)

__X___Website/Portal Social media

_____Other (specify): _________________

PATIENT ACKNOWLEDGMENT AND AGREEMENT:

I acknowledge that I have read and fully understand the risks, limitations, conditions of use, and instructions for use of the selected electronic communication Services more fully described in the Appendix to this consent form. I understand and accept the risks outlined in the Appendix to this consent form, associated with the use of the Services in communications with the Physician and the Physician's staff. I consent to the conditions and will follow the instructions outlined in the Appendix, as well as any other conditions that the Physician may impose on communications with patients using the Services.

I acknowledge and understand that despite recommendations that encryption software be used as a security mechanism for electronic communications, it is possible that communications with the Physician or the Physician's staff using the Services may not be encrypted. Despite this, I agree to communicate with the Physician or the Physician's staff using these Services with a full understanding of the risk.

I acknowledge that either I or the Physician may, at any time, withdraw the option of communicating electronically through the Services upon providing written notice. Any questions I had have been answered.

1- APPENDIX

Risks of using electronic communication

The Physician will use reasonable means to protect the security and confidentiality of information sent and received using the Services ("Services" is defined in the attached Consent to us e

electronic communications). However, because of the risks outlined below, the Physician cannot guarantee the security and confidentiality of electronic communications:

Patient Name: ________________________________ **Date of Birth:** ____________________

- • Use of electronic communications to discuss sensitive information can increase the risk of such information being disclosed to third parties.
- • Despite reasonable efforts to protect the privacy and security of electronic communication, it is not possible to completely secure the information.
- • Employers and online services may have a legal right to inspect and keep electronic communications that pass through their system.
- • Electronic communications can introduce malware into a computer system, and potentially damage or disrupt the computer, networks, and security settings.
- • Electronic communications can be forwarded, intercepted, circulated, stored, or even changed without the knowledge or permission of the Physician or the patient.
- • Even after the sender and recipient have deleted copies of electronic communications, back-up copies may exist on a computer system.
- • Electronic communications may be disclosed in accordance with a duty to report or a court order.
- • Videoconferencing using services such as Skype or FaceTime may be more open to interception than other forms of videoconferencing.
- • If the email or text is used as an e-communication tool, the following are additional risks: Email, text messages, and instant messages can more easily be misdirected, resulting in increased risk of being received by unintended and unknown recipients.
- • Email, text messages, and instant messages can be easier to falsify than handwritten or signed hard copies. It is not feasible to verify the identity of the sender, or to ensure that only the recipient can read the message once it has been sent.

2- APPENDIX CONTINUED

• Conditions of using the Services While the Physician will attempt to review and respond in a

timely fashion to your electronic communication, the Physician cannot guarantee that all electronic communications will be reviewed and responded to within any specific period of

time.

- • The Services will not be used for medical emergencies or other time-sensitive matters.

Patient Name: ________________________________ Date of Birth: ____________________

- • If your electronic communication requires or invites a response from the Physician and you have not received a response within a reasonable time period, it is your responsibility to follow up to determine whether the intended recipient received the electronic communication and when the recipient will respond.

- • Electronic communication is not an appropriate substitute for in-person or over-the-telephone communication or clinical examinations, where appropriate, or for attending the Emergency Department when needed.

- • You are responsible for following up on the Physician’s electronic communication and for scheduling appointments where warranted.

- • Electronic communications concerning diagnosis or treatment may be printed or transcribed in full and made part of your medical record. Other individuals authorized to access the medical record, such as staff and billing personnel, may have access to those communications.

- • The Physician may forward electronic communications to staff and those involved in the delivery and administration of your care.

- • The Physician might use one or more of the Services to communicate with those involved in your care. The Physician will not forward electronic communications to third parties, including family members, without your prior written consent, except as authorized or required by law.

- • You and the Physician will not use the Services to communicate sensitive medical information about matters specified below [check all that apply:

_____Sexually transmitted disease

_____AIDS/HIV

_____Mental health

_____Developmental disability

_____Substance abuse

_____Other (specify):

- • You agree to inform the Physician of any types of information you do not want sent via the Services, in addition to those set out above. You can add to or modify the above list at any time by notifying the Physician in writing.

- • Some Services might not be used for therapeutic purposes or to communicate clinical information. Where applicable, the use of these Services will be limited to education, information, and administrative purposes.

- • The Physician is not responsible for information loss due to technical failures associated with your software or internet service provider.

Patient Name: ________________________________ Date of Birth: ____________________

3- APPENDIX CONTINUED

• • Instructions for communication using the Services To communicate using the Services, you must: Reasonably limit or avoid using an employer's or other third party's computer.

• • Inform the Physician of any changes in the patient's email address, mobile phone number, or other account information necessary to communicate via the Services.

• • If the Services include email, instant messaging and/or text messaging, the following applies:

• • Include in the message's subject line an appropriate description of the nature of the communication (e.g. "prescription renewal"), and your full name in the body of the message.

• • Review all electronic communications to ensure they are clear and that all relevant information is provided before sending to the physician.

• • Ensure the Physician is aware when you receive an electronic communication from the Physician, such as by a reply message or allowing "read receipts" to be sent.

• • Take precautions to preserve the confidentiality of electronic communications, such as using screen savers and safeguarding computer passwords.

• • Withdraw consent only by email or written communication to the Physician.

• • If you require immediate assistance, or if your condition appears serious or rapidly worsens, you should not rely on the Services. Rather, you should call the Physician's office or take other measures as appropriate, such as going to the nearest Emergency Department or urgent care clinic.

• • Other conditions of use in addition to those set out above:

____

I have reviewed and understand all the risks, conditions, and instructions described in this

Patient name: ____________________________________

Patient signature: _________________________________Date: ______________________________

Witness signature: ________________________________Date: ______________________________