BILLING INFORMATION
Brian J. Williams, M.D., P.C.

PATIENT INFORMATION (Please print clearly)

PATIENT NAME: ____ DATE_______________

DATE OF BIRTH: _______________ SEX: Male /Female SSN: ______________ MARITAL STATUS: Single/Married/Widowed

(Please check appropriate boxes)
LANGUAGE: English/Spanish/Other ETHNICITY: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Refuse to report
RACE: (please select one) ☐African American ☐White ☐Hispanic ☐American Indian ☐Native Hawaiian ☐Pacific Islander ☐Other

PHONE#: Home_______________________ Work: ____________________________ Cell: __________________________

HOME ADDRESS: ____

City_____________________________ State__________ Zip______________ ***Email:** _________________________________

WHO CAN WE CONTACT IN CASE OF AN EMERGENCY? Name: ____

Phone#:___________________________________ Relationship: __________________________________

Do you give our office permission to discuss medical information with emergency contact? ☐Yes ☐No

DO YOU GIVE OUR OFFICE PERMISSION TO DISCUSS YOUR MEDICAL INFORMATION WITH FAMILY MEMBERS?
☐YES ☐NO IF YES, PLEASE PROVIDE THEIR NAMES AND PHONE NUMBERS BELOW.

NAME:___________________________________RELATIONSHIP:___________________PHONE #____________________

NAME:___________________________________RELATIONSHIP:___________________PHONE #____________________

WHO INTRODUCED YOU TO OUR OFFICE? ____

WHO IS YOUR FAMILY PHYSICIAN? (first and last name please)____

B ILLING INFORMATION (**If Patient is over 18 the Patient is the responsible party**)
(Excluding insurance)
RESPONSIBLE PARTY (**Person/Guardian signing paperwork**):____

DATE OF BIRTH:__________________ RELATIONSHIP TO PATIENT: ☐Self ☐ Parent ☐ Spouse ☐ Legal Guardian

MAILING ADDRESS (if different from above):____

City_________________________________State______________Zip_________________

INSURANCE INFORMATION DO YOU HAVE HEALTH INSURANCE? ☐ YES ☐ NO
IF YES, PLEASE PRESENT YOUR PHOTO ID WITH YOUR CARDS TO THE FRONT DESK TO TAKE A COPY. (PLEASE BE AWARE THAT IF WE DO NOT HAVE YOUR CURRENT INSURANCE INFORMATION WE WILL BE UNABLE TO BILL YOUR CLAIM)

PRIMARY INSURANCE: ____**IDENTIFICATION#**_____________________

Is Patient on Hospice ☐ YES ☐ NO

NAME OF INSURED: ____**DATE OF BIRTH**: _______________________

SECONDARY INSURANCE: ____**IDENTIFICATION#** _____________________

NAME OF INSURED: ____**DATE OF BIRTH**: _______________________

PLEASE SEE OTHER SIDE

I understand that I am financially responsible for all charges whether paid or not paid by my insurance. I am aware that if I do not provide current insurance information Dr. Williams' office will be unable to bill my claim.

ANY ACCOUNTS OVER THIRTY DAYS OLD WILL ACCRUE INTEREST OF 1.5% PER MONTH (18% PER YEAR) UNTIL THE ACCOUNT IS PAID IN FULL. In the event that full payment for charges incurred in my medical care is not made, I agree to pay all cost of collection, including 40% Collection Agency Commission and reasonable attorney's fees. I also agree to submit myself to the jurisdiction of the courts of Salt Lake County, Utah.

I understand that if a biopsy or pathology is necessary that unless otherwise specified it will be sent to and read by Dermpath Diagnostics Richfield Laboratory of Dermatology, a division of Ameripath. An administrative fee is added to each specimen. If insured, insurance will cover the fee.

I understand that in the event that I cannot make a scheduled appointment I must cancel 24 hours prior to that appointment time. Failure to do so will result in a $50.00 charge to my account (per incident).

I consent to medical treatment as provided by Brian J. Williams, M.D., P.C.

This agreement will remain in effect until revoked by me in writing. A photocopy of this assignment will be considered as valid as an original.

SIGNATURE:____ DATE:_______________
(Responsible Party)

I have received a copy of the Notice of Privacy Practices for Brian J. Williams, M.D., P.C.

SIGNATURE:____DATE:_________________
(Responsible Party)

OFFICE USE ONLY

SIGNATURE: ____ DATE: ____________________
(Witness)

For Medicare & Medicaid Patients Only

According to the Centers for Medicare and Medicaid Services, a provider is to bill a Medicare beneficiary for his/her yearly deductible and coinsurance. In addition, a provider may bill Medicare beneficiaries for non-covered services and services that are considered to be not medically necessary as long as an Advanced Beneficiary Notice has been signed by the patient.

I agree that I am financially responsible for charges as outlined above. I am aware that if I do not provide current insurance information Dr. Williams' office will be unable to bill my claim.

I understand that in the event that I cannot make a scheduled appointment I must cancel 24 hours prior to that appointment time. Failure to do so will result in a $50.00 charge to my account (per incident). This fee is not billable to Medicare and Medicaid.

In the event that full payment for charges incurred in my medical care is not made, I agree to pay all cost of collection, Collection Agency Commission and reasonable attorney's fees. I also agree to submit myself to the jurisdiction of the courts of Salt Lake County, Utah.

I consent to medical treatment as provided by Brian J. Williams, M.D., P.C.

This agreement will remain in effect until revoked by me in writing. A photocopy of this assignment will be considered as valid as an original.

SIGNATURE:____ DATE:_______________
(Responsible Party)

I have received a copy of the Notice of Privacy Practices for Brian J. Williams, M.D., P.C.

SIGNATURE:____DATE:_________________
(Responsible Party)

OFFICE USE ONLY

SIGNATURE: ____ DATE: __________________
(Witness)

PATIENT HISTORY FORM

Brian J. Williams M.D.
602 E 7200 S 2nd Floor
Midvale, UT 84047
Tel: 801-313-1010 Fax: 801-747-2116

Name: ____
Date: ____
Date of Birth: __________________________________
***Preferred Pharmacy:** ___________________________
(Include Location) ________________________________

Please give thoughtful, brief answers to the following items. Write N/A for those sections not applicable.

Chief **Problem** or symptom briefly stated:____
____

What seemed to cause or lead up to the problem?_______________________________________
____

Date started:___________________ Intermittent or constant:______________________________
Triggered by?__________________ Frequency(# of episodes)?_____________________________

Associated body symptoms:____
____

Treatments you've already tried & their effectiveness:__________________________________
____

Name of doctor who referred you or who has been treating you?__________________________

Anything similar in family members or co-workers? _______________________________________
Family history of these symptoms?____
Any habits that might have contributed to this problem?____________________________________
Anything else you would like to add that you feel might help us understand this problem better?
____
____

Are you **ALLERGIC TO MEDICATIONS** or have you had a bad reaction to any medications, please describe:____
List **CURRENT DRUGS** (blood thinners, steroids, over-the-counter medications, etc.) that you are taking: ____
____

Have you ever had or currently have:
SKIN CANCER (please specify) ☐ Basal Cell ☐ Squamous Cell ☐ Melanoma ☐ None
Please give details: ____

Do you **BLEED ABNORMALLY** for a long time following a cut or do you bleed easily? Please circle: **YES NO**
Does anyone in your immediate family have a bleeding disorder?
Please circle: **YES NO**
Do you have any **ADULT ILLNESS** (high blood pressure, diabetes, heart disease, etc.) please describe:____
____

Do you smoke? Please circle: **YES NO** Do you use alcohol? **YES NO**
If yes, approx. how much:______________________ Approx. how much:_____________________

Continued on the other side

Is there a possibility that you are pregnant? **YES** **NO**

Occupation:_______________________________________

Any unusual **CHILDHOOD DISEASES**, please describe:___________________________________
____

Do you have any **ALLERGIES** such as hay fever, asthma or food allergies? Please describe:____

Please list surgical **PROCEDURES** and **HOSPITALIZATIONS** (place, date, reason):
____
____
____

FAMILY HISTORY: (please check any of the following diseases that seem to run in your family or have occurred in any related family member)

- ☐ Bleeding Disorders
- ☐ Heart disease
- ☐ Eczema
- ☐ Cancer
- ☐ Asthma
- ☐ Miscellaneous
- ☐ Skin Cancer
- ☐ Hay Fever
- ☐ Stroke
- ☐ Diabetes

SYSTEMS REVIEW: (please circle any of the following problems that you have had or currently have)

☐ Check here if none apply

- ☐ Cancer
- ☐ Diabetes
- ☐ Measles
- ☐ Mumps
- ☐ Rheumatic fever
- ☐ Epilepsy
- ☐ Pneumonia
- ☐ Asthma

- ☐ Convulsions
- ☐ Seizures or fits
- ☐ Severe headaches
- ☐ Frequent headaches
- ☐ Dizziness

- ☐ Hearing problems
- ☐ Arthritis
- ☐ Joint Pain or swelling

- ☐ Trouble swallowing
- ☐ Frequent sore throats
- ☐ Swollen neck glands
- ☐ Thyroid problems
- ☐ Hoarseness

- ☐ Recent weight gain
- ☐ Recent weight loss
- ☐ Change in appetite
- ☐ Food Allergies
- ☐ Stomach trouble
- ☐ Ulcers

- ☐ Broken bones
- ☐ Chronic pain

- ☐ Nervous Breakdown
- ☐ Depression
- ☐ Anxiety
- ☐ Seen a psychiatrist

- ☐ Menstrual problems
- ☐ Abnormal vaginal bleeding
- ☐ Venereal disease
- ☐ Syphilis
- ☐ Gonorrhea

- ☐ Poor vision
- ☐ Sore that won't heal
- ☐ Ankle swelling
- ☐ Eczema
- ☐ Hay Fever

- ☐ Trouble breathing
  - ☐ During day
  - ☐ During night
  - ☐ During exercise
- ☐ High blood pressure
- ☐ Heart attack
- ☐ Stroke
- ☐ Heart trouble
- ☐ Coughing blood
- ☐ Blood in urine
- ☐ Kidney stone
- ☐ Painful urination
- ☐ Bladder infection

- ☐ Sinus infection
- ☐ Easy bleeding
- ☐ Easy bruising
- ☐ Anemia

- ☐ Gall bladder trouble
- ☐ Bowel trouble
- ☐ Liver disease
- ☐ Yellow Jaundice
- ☐ Blood in bowel movements

NOTICE OF PRIVACY PRACTICES

This Notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Introduction. Brian J. Williams, M.D., P.C. is a private medical practice with a focus on dermatology, which includes diseases of the skin, hair and nails. Our practice involves diagnosis and treatment of all such diseases, including surgery of the skin and minor cosmetic procedures.

When you become a patient of Brian J. Williams, M.D., P.C. you provide us with information about you and your health, which is used to create a medical record. Your medical record is the information we use to plan your care, provide treatment, and receive payment for our services. It is important for you to understand that your health record contains personal health information that is protected by federal and state laws.

Our responsibilities. Brian J. Williams, M.D., P.C. is required to maintain the privacy of your personal health information and to provide you with a notice about our legal duties and privacy practices with respect to your personal health information. We are also required to accommodate reasonable requests that you make to communicate personal health information by alternative means or at alternative locations. Any time we use or disclose your personal health information, we must follow the terms of this Notice (or Notices as may be in effect at that time)

How We Use And Disclose Your Protected Health Information.

- Uses and Disclosures for Treatment, Payment and Health Care Operations.

After making a good faith effort to provide you with this Notice, we may use your personal health information to provide your treatment, to obtain payment for your treatment, and for our internal health care operations. We may use and disclose your personal health information for such purposes in the following ways:

(1) *For Treatment.* We may use and disclose your personal health information to plan, provide, and coordinate your health care services. For example, we may send a letter or call your primary care physician or referral doctor regarding your diagnosis and treatment.

(2) *For Payment.* We may use and disclose your personal health information to obtain payment for health care services we have provided to you. For example, we will send information regarding your visits to your insurance company for them to determine benefits payable to your claim.

(3) *For Health Care Operations.* We may use or disclose your protected health information for our health care operations. For example, we may use or disclose your personal health information to perform risk assessments and other administrative tasks to monitor the quality of care that we provide.

(4) *For Communications With Patient.* We may use and disclose your personal health information to contact you, leave messages, and remind you of appointments.

- Uses and Disclosures With Authorization. For uses and disclosures of your personal health information not involving treatment, payment or health care operations, we will receive your written authorization prior to using or disclosing any personal health information (unless we are required or permitted by law to use or disclose your information). You have the right to revoke any authorization previously granted.
- Uses and Disclosures Without Authorization: We may use and disclose your personal health information without obtaining your consent or authorization, in the following situations:

(1)*For laboratory services.* When laboratory services such as blood tests or pathology are required, personal information including, but not limited to, your name, address, insurance information if applicable, and diagnosis may be forward to the laboratory.

(2) *For continuity of care.* When you require additional medical care not provided by our office, such as extensive skin surgery, extensive laboratory testing, or physical therapy, we will release your medical record or discuss your case with the physician/facility to which you were referred.

(3) *Notification of Family or Close Friends.* We may use or disclose your personal information to notify a family member, personal representative or another person responsible for your care, if you have given us permission, either verbally, or in writing to do so. If you are unable to agree or object, we may disclose this information as necessary if we determine that it is in your best interest based upon our professional judgment. In all cases, we will only disclose the health information that is directly relevant to that person's involvement with your health care.
(4) *Required by law.* We may use or disclose your personal health information to the extent that we are required by law to do so. An example of this would be if your records were requested by subpoena. This use or disclosure will be made in full compliance with the applicable law governing the disclosure.
(5) *Public Health Activities.* We may disclose your personal health information for public health activities to a public health authority authorized by law to collect or receive information for the purpose of controlling disease, injury or disability. We may also disclose your health information to a public authority authorized to receive reports of child abuse or neglect or to report information about products or services under the jurisdiction of the United States Food and Drug Administration.
(6) *Workers Compensation.* In the case of a worker's compensation claim, we may disclose your personal health information in accordance with worker's compensation laws.

Your Rights. You have the right to do the following:

- Right to Receive Further Information. You have the right to contact our office if you want additional information about our privacy practices, your privacy rights, or disagree about a decision we made about your personal health information, or if you believe that your privacy rights have been violated.
- Right to Inspect and Copy Your Health Information. Upon written request, you have the right to access and obtain a copy of your health information maintained by use.
- Right to Amend Your Health Information. You have the right to request in writing that we amend health information maintained in your health record. We will comply with your request only if we determine the information you wish to amend is false, inaccurate or misleading.
- Right to Request Additional Restrictions on Uses and Disclosures of Your Health Information. You have the right to request in writing that we place additional restrictions on how we use or disclose your personal health information. While we will consider any request for additional restrictions, we are not required to agree to your request.
- Right to Request an Accounting of Disclosures. You have a right to request in writing a record of whom we have released your personal information to. The record will include the date the information was released, to whom, and a brief statement of reason for the disclosure.
- Right to Request Confidentiality in Certain Communications. You have the right to request to receive your health information by alternative means of communication or at alternative locations. We will accommodate any such reasonable written request made on your behalf.
- Right to File a Complaint If you believe your privacy rights have been violated in addition to filing a complaint with us, you have the right to file a written complaint with the Office of Civil Rights of the United States Department of Health and Human Services. Upon request, the Privacy Officer will provide you with the information needed to file your complaint. Under no circumstances will we retaliate against you for filing a complaint with us or the Office of Civil Rights.

Changes to Notice. We reserve the right to change our privacy practices and to alter this Notice according to those changes; we will give you a copy of our revised notice at your next office visit.
Privacy Officer. To contact our Privacy Officer, please address all requests to: Brian J. Williams, M.D., P.C., 6065 S. Fashion Blvd. Murray, UT 84107 ATTN: Privacy Officer. The privacy officer can also be reached by phone at (801) 313-1010. The privacy officer can assist you with any questions or concerns you may have regarding our privacy practices.
Effective Date of this Notice. This Notice is effective as of November 1, 2004. For new patients after November 1, 2004 the effective date is the first date of service as noted in the medical record.

ARBITRATION

As the recent election brought to light, the rising healthcare costs are starting to affect everyone. One of the issues most discussed was the cost of insurance. In an effort to do our part to stem the tide of increasing healthcare costs while increasing our ability to offer excellent service, we are instituting arbitration agreements with our patients. Arbitration agreements are voluntary but it is a good way for you, the patient, to also contribute to bringing and keeping down the cost of healthcare without adverse effect to you. If you are not familiar with these agreements we have included an explanation about arbitration here below. If after reading the agreement you have additional concerns or questions, please read the separate sheet with the frequently asked questions regarding this new and effective way of patient/doctor interaction. Please feel free to ask the doctor any further questions you may have. Thank you for helping us and signing these agreements. Together we can do our part to provide for better healthcare in the future.

WRITTEN EXPLANATION OF BINDING ARBITRATION

A binding arbitration agreement requires a patient to submit all future medical malpractice claims to arbitration instead of having the claim heard in court by a jury.

An arbitrator is a person chosen to resolve disputes after hearing the information presented by both sides. You select an arbitrator, your doctor selects one, and you and the doctor agree on a third arbitrator. In the event we cannot agree, the third arbitrator will be selected by the other two arbitrators from a court-issued list of arbitrators.

You pay for the fees and expenses of your arbitrator, the doctor pays for his or her arbitrator, and the fees and expenses of the third arbitrator are shared equally.

You have the right, at your expense, to be represented in arbitration by an attorney.

By choosing arbitration, you may also have the right to require mediation. Mediation occurs before arbitration. Mediation is a process by which a neutral person tries to help the parties reach a mutually agreeable resolution of their dispute. The cost of mediation is shared equally.

You have the right to decline to enter into the agreement and still receive health care.

You have the right to rescind the agreement within ten (10) days of signing the agreement.

The arbitration agreement is renewed each year unless it has been canceled in writing before the renewal date.

You have the right to have all of your questions about arbitration answered.

ARBITRATION AGREEMENT

Article 1 Dispute Resolution

By signing this Agreement ("Agreement") we are agreeing to resolve any Claim for medical malpractice by the dispute resolution process described in this Agreement. Under this Agreement, you can pursue your Claim and seek damages, but you are waiving your right to have it decided by a judge or jury.

Article 2 Definitions

A. The term "we," "parties" or "us" means you, (the patient), and the provider.

B. The term "Claim" means one or more Malpractice Actions defined in the Utah Health Care Malpractice Act (Utah Code 78-14-3(15)). Each party may use legal process to resolve non-medical malpractice claims.

C. The term "Provider" means the physician, group, or clinic and their employees, partners, associates, agents, successors and estates.

D. The term "Patient" or "you" means:

(1) you and any person who makes a Claim for care given to YOU, such as your heirs, your spouse, children, parents or legal representatives, AND

(2) your unborn child or newborn child for care provided during the 12 months immediately following the date you sign this Agreement, or any person who makes a Claim for care given to that unborn or newborn child.

Article 3 Dispute Resolution Options

A. Methods Available for Dispute Resolution. We agree to resolve any Claim by:

(1) working directly with each other to try and find a solution that resolves the Claim, OR

(2) using non-binding mediation (each will bear one-half of the costs); OR

(3) using binding arbitration as described in this Agreement

You may choose to use any or all of these methods to resolve you Claim.

B. Legal Counsel. Each of us may choose to be represented by legal counsel during any stage of the dispute resolution process, but each of us will pay the fees and costs of our own attorney.

C. Arbitration – Final Resolution If working with the Provider or using non-binding mediation does not resolve your Claim, we agree that your Claim will be resolved through binding arbitration. We both agree that the decision reached in binding arbitration will be final

Article 4 How to Arbitrate a Claim

A. Notice. To make a Claim under this Agreement, mail a written notice to the Provider by certified mail that briefly describes the nature of you Claim (the "Notice"). If the Notice is sent to the Provider by certified mail it will suspend (toll) the applicable statute of limitations during the dispute resolution process described in this Agreement.

B. Arbitrators. Within 30 days of receiving the Notice, the provider will contact you. If you and the Provider cannot resolve the Claim by working together through mediation, we will start the process of choosing arbitrators. There will be three arbitrators, unless we agree that a single arbitrator may resolve the Claim.

(1) Appointed Arbitrators. You will appoint an arbitrator of your choosing and all Providers will jointly appoint an arbitrator of their choosing.

(2) Jointly-Selected Arbitrators. You and the Provider(s) will then jointly appoint an arbitrator (the "Jointly-Selected Arbitrator"). If you and the Provider(s) cannot agree upon a Jointly-Selected Arbitrator, the arbitrators appointed by each of the parties will choose the Jointly-Selected Arbitrator from a list of individuals approved as arbitrators by the state or federal courts of Utah. If the arbitrators cannot agree on a Jointly-Selected Arbitrator, either or both of us may request that a Utah court select an individual from the lists described above. Each party will pay their own fees and costs in such an action. The Jointly-Selected Arbitrator will preside over the arbitration hearing and have all other powers of an arbitrator as set forth in the Utah Uniform Arbitration Act.

C. Arbitration Expenses. You will pay the fees and costs of the arbitrator you appoint and the Provider(s) will pay the fees and costs of arbitrator the Provider(s) appoints.
Each of us will also pay one-half of the fees and expenses of the Jointly-Selected Arbitrator and any other expenses of the arbitration panel.

D. Final and Binding Decision. A majority of the three arbitrators will make a final decision on the Claim. The decision shall be consistent with the Utah Uniform Arbitration Act.

E. All Claims May be Joined. Any person or entity that could be appropriately named in a court proceeding ("Joined Party") is entitled to participate in this arbitration as long as that person or entity agrees to be bound by the arbitration decision. ("Joinder"). Joinder may also include Claims against persons or entities that provided care prior to the signing date of this Agreement. A "Joined Party" does not participate in the selection of the arbitrators but is considered a "Provider" for all other purposes of this Agreement.

Article 5 Liability and Damages May Be Arbitrated Separately

At the request of either party, the issues of liability and damages will be arbitrated separately. If the arbitration panel finds liability, the parties may agree to either continue to arbitrate damages with the initial panel or either party may cause that a second panel be selected for considering damages. However, if a second panel is selected, the Jointly Selected arbitrator will remain the same and will continue to preside over the arbitration unless the parties agree otherwise.

Article 6 Venue/ Governing Law.

The arbitration hearings will be held in a place agreed to by the parties. If the parties cannot agree, the hearings will be held in Salt Lake City, Utah. Arbitration proceedings are private and shall be kept confidential. The provisions of the Utah Uniform Arbitration Act and the Federal Arbitration Act govern this Agreement. We hereby waive the prelitigation panel review requirements. The arbitrators will apportion fault to all persons or entities that contributed to the injury claimed by the Patient, whether or not those persons or entities are parties to the arbitration.

Article 7 Term/ Rescission/ Termination.

A. Term. This agreement is binding on both of us for one year from the date you sign it unless you rescind it. If it is not rescinded, it will automatically renew every year unless either party notifies the other in writing of a decision to terminate it.

B. Rescission. You may rescind this Agreement within 10 days of signing it by sending written notice by registered or certified mail to the Provider. The notice must include your name, birth date, and signature. The effective date of the rescission notice will be the date the rescission is postmarked. If not rescinded, this Agreement will govern all medical services received by the Patient from Provider after the date of signing, except in the case of a Joined party that provided care prior to signing of this agreement (see Article 4(E)).

C. Termination. If the Agreement has not been rescinded, either party may still terminate it at any time, but termination will not take effect until the next anniversary of the signing of the Agreement. To terminate this Agreement, send written notice by registered or certified mail to the Provider. This Agreement applies to any Claim that arises while it is in effect, even if you file a Claim or request arbitration after the Agreement has been terminated.

Article 8 Severability.

If any part of this Agreement is held to be invalid or unenforceable, the remaining provisions will remain in full force and will not be affected by the invalidity of any other provision.

Article 9 Acknowledgement of Written Explanation of Arbitration.

I have received a written explanation of the terms of this Agreement. I have had the right to ask and have my questions answered. I understand that any Claim I might have must be resolved through the dispute resolution process in this Agreement instead of having them heard by a judge or jury. I understand the role of the arbitrators and the manner in which they are selected. I understand the responsibility for arbitration related costs. I understand that this Agreement renews each year unless cancelled before the renewal date. I understand that I can decline to enter into the Agreement and still receive health care. I also understand that the Provider still has the right to chose not to treat a patient for any reason other than refusal to sign this Agreement. I understand that I can rescind this Agreement within 10 days of signing it.

Article 10 Receipt of Copy. I have received a copy of this document.

Dermatology
By:/s/ Brian J. Williams M.D.
Its: President

____
Name of patient (print)

____
Signature of Physician or Authorized Agent

____
Signature of Patient or Patient's Representative (Date)