THE VANGUARD
MEDICAL GROUP

Syed Quadri, DO
Stephanie M Andree, FNP-BC
Josephine R Chambers, FNP-BC

PATIENT REGISTRATION

Today's Date _____/_____/_____

Patient Name (First, Middle, Last)_____

SSN # _____-_____-_____ Patient Date of Birth _____ /_____/_____

Gender (Circle) F / M / Other: _____ Marital Status: _____

Patient Home Address: _____

City: _____ State: _____ Zip Code: _____

Preferred Phone Number(_____) _____ - _____Home Phone Number (_____) _____ - _____

Employment : _____Work Phone Number (_____) _____ - _____

Email Address: _____

Referring Physician

Practice Name:_____

Physicians Name:_____

City: _____State:_____ Zip: _____

Phone#_____ Fax: _____

Primary Care Physician

Practice Name: _____

Physicians Name:_____

City: _____State _____ Zip: _____

Phone#_____ Fax: _____

Emergency Contact Name: _____

Phone # (_____) _____ - _____ Relationship_____

Patient Information or Guarantor Information if the patient is under the age of 18

Guarantor Name _____Guarantor Date of Birth _____/_____/_____

Home Address:_____State: _____Zip Code: _____

A state-issued photo Identification card and a copy of your license is required. All copayments and outstanding balances are due prior to services being rendered. I hereby authorize payments directly to the physician of medical benefits. I also understand I am responsible for any portion of my bill not covered by my insurance company. I hereby release the information for insurance claim purposes. I have read and understood all of the above and hereby state that the information is correct to the best of my knowledge.

Patient or Guarantor Signature _____ Date _____

THE VANGUARD MEDICAL GROUP

PATIENT INFORMATION QUESTIONNAIRE

Describe your most disabling/severe pain: Circle the number that best describes how severe your pain is:
No pain Mild Discomfort Distress Horrible Worst pain Imaginable

How and when did your pain begin? _____ (month/year) __Work accident ___Following surgery/illness ___Home accident __Other accident ___Auto accidenT __ Unknown __Other:_____

Describe the circumstances around the onset of your pain:_____

Duration of pain
☐ >1 week ☐1-4 wks ☐ 1-3 months
☐ 3-6 month ☐ 6 -12 month ☐ > 1 year

How often does the pain occur?
☐ Continuously ☐ Several times per day
☐ Intermittent ☐Occasionally ☐Less than daily

How has the pain intensity changed since it began?
☐ Increased ☐ Decreased ☐ No change

Select one or more items below to describe the nature of your pain:
☐ Throbbing ☐ Shooting ☐ Sharp ☐ Cramping ☐ Hot/burning ☐ Aching ☐ Stabbing

How do the following factors affect your pain? (check one blank per number)

	Better	Worse	No effect		Better	Worse	No effect
1. Heat	☐	☐	☐	6. Climate	☐	☐	☐
2. Cold	☐	☐	☐	7. Fatigue	☐	☐	☐
3. Lying down	☐	☐	☐	8. Coughing	☐	☐	☐
4. Sitting	☐	☐	☐	9. Massage	☐	☐	☐
5. Walking	☐	☐	☐	10. Alcohol	☐	☐	☐

Which of the following activities are affected by your pain?
☐ Falling asleep ☐ Social Interaction ☐ Household Chores ☐ Leisure
☐ Staying asleep ☐ Sexual Activity ☐ Work/School

Give the dates of the tests you have had to diagnose your pain:
X-rays _____Myelogram _____ CT Scan _____ Nerve conduction/EMG _____ MRI_____Other _____

Do you have any drug allergies? ***No*** known drug allergies ***Yes*** (please list drug and reaction):
_____

List all medications you are currently taking: (Please bring current medications list to each visit)

Medication **Dose**

Past Surgical History: _____

Family History: Please check any of the conditions below that run in your family:
☐ Arthritis ☐ Cancer ☐ Depression ☐ Diabetes ☐Heart disease ☐Lupus ☐Stroke ☐ Other:_____

Which of the following medications have you tried previously for your pain? (Please circle all that apply)
NSAIDs: Tylenol/Acetaminophen | Ibuprofen/Advil/Motrin | Naproxen/Naproxen/Aleve | Meloxicam/Mobic | Diclofenac/Voltaren | Celebrex/Celecoxib | Daypro/Oxaprozin | Indomethacin/Indocin | Etodolac | Piroxicam | Nabumetone | Ketoprofen | Ketorolac/Toradol | Other:

THE VANGUARD MEDICAL GROUP

Max Tolerated Dose:	Why Stopped?
Dates Used:	

Anticonvulsants: Gabapentin/Neurontin | Lyrica/Pregabalin | Other**:**

Max Tolerated Dose:	Why Stopped?
Dates Used:	

Antidepressants: Cymbalta/Duloxetine | Venlafaxine/Effexor | Elavil/Amitriptyline | Pamelor/Nortriptyline | Savella/Milnacipran | Doxepin/Silenor | Other:

Max Tolerated Dose:	Why Stopped?
Dates Used:	

Muscle Relaxers: Tizanidine/Zanaflex | Flexeril/Cyclobenzaprine | Baclofen | Norflex/Orphenadrine | Soma/Carisoprodol | Skelaxin/Metaxalone | Robaxin/Methocarbamol | Other**:**

Max Tolerated Dose:	Why Stopped?
Dates Used:	

OPIOIDS: Tramadol/Ultram | Tylenol with Codeine | Hydrocodone/Vicodin/Norco/Lortab | Oxycodone/Percocet | Morphine | Hydromorphone/Dilaudid | Nucynta/Tapentadol | Fentanyl/Duragesic | Buprenorphine/Butrans/Belbuca | Suboxone | Methadone | Other**:**

Max Tolerated Dose:	Why Stopped?
Dates Used:	

What other therapies have you tried previously for your pain? (Please circle all that apply)

TENS Unit | Physical Therapy/Occupational Therapy | Heat/Ice | Massage | Chiropractor | Pain Psychology/CBT/Biofeedback | Spinal Cord Stimulator | Osteopathic Manipulation/OMT | Acupuncture | Yoga | Tai Chi | Mindfulness/Meditation | Other**:**

Dates Used: _____

THE VANGUARD MEDICAL GROUP

Print Name: _____ Date of Birth: _____

HIPAA Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this
information can and will be used to:

❏ Conduct, plan, and direct my treatment and follow- up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

❏ Obtain payment from third party payers.

❏ Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read, and understand your Notice of Privacy Practices (NPP), containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its NPP from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the NPP.

I understand that I may request in writing that you restrict how my private information is used or
disclosed to carry out treatment, payment, or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Signature_____ Date_____

Prescriber Signature_____ Date_____

Staff Please Note: A copy of this agreement should be provided to the patient upon signing.

PATIENT PORTAL ENROLLMENT FORM

Personal E-mail Address of Patient _____

Patient Portal Guidelines and Security Purpose of this Form

The Patient Portal offers secure viewing and communication as a service to patients and families who wish to view parts of their records and communicate with our staff. When enrolling to access the Patient Portal, you must agree to the conditions in the Enrollment Form and our Patient Portal Terms of Service.

Protecting Your Private Health Information: This method of communication and viewing prevents unauthorized persons from being able to access or read messages while they are in transmission. However, keeping messages secure depends on three important factors:

1. We need you to provide your correct email address and you MUST inform us if it ever changes. Do not use your work email address, as this information might be available to your employer.
2. This provided an email address will be the primary address for your account.
3. You need to keep unauthorized individuals from learning your Patient Portal password. If you think someone has learned your password, you should promptly go to the Patient Portal and change it.

Patient Portal Consent - Please check the appropriate enrollment box: Yes ___ I consent to Patient Portal enrollment. _____ No, I am deferring enrollment at this time.

Patient Signature: _____ Date: _____

THE VANGUARD MEDICAL GROUP

Print Name: _____ Date of Birth: _____

OPIOID (NARCOTIC) CONSENT FORM AND MANAGEMENT AGREEMENT

This consent and agreement for treatment between the undersigned patient and prescribers at **The Vanguard Medical Group** is to establish clear conditions and consent for the prescription and safe use of pain controlling opioid medications or other controlled substances prescribed by a healthcare provider for the patient. These medications are being prescribed only for the purpose of treating pain. Along with medications, other medical care may be prescribed to improve the ability to do daily activities. This may include exercise, use of non-opioid analgesics, physical therapy, psychological evaluation/ counseling, weight management, classes on managing pain, integrative therapies such as acupuncture and Healing Touch, or other beneficial therapies or treatment.

The Patient agrees to and accepts the following conditions for the management of pain medication prescribed by the Physician/Nurse Practitioner for the patient. Failure to comply with the conditions in this agreement may result in these medications being discontinued and **possible termination** of the prescriber/patient relationship.

I understand that a reduction in the intensity of my pain AND improvement in my daily life functions are the goals of this program. Should it become evident that these goals are not being met with the use of pain medications, I understand the medications may be reduced and/or discontinued.

1. I must comply with the following guidelines:
   - **a.** I will only use this medication for purposes of pain control.
   - **b.** I will take the prescribed medication only at the dose and frequency prescribed.
   - **c**. I will not increase or change the dose or frequency without consulting my prescriber first.
   - **d**. If I use my medication at a faster rate than prescribed I will be without medication for a period of time and this could result in dependence withdrawal that is uncomfortable and may include an uneasy feeling, increased pain, irritability, belly pain, diarrhea, sweats, and goose-flesh and/or serious physical or psychological effects.
   - **e.** EARLY refills may not be given.
   - **f.** I will not attempt to get pain medication from any other healthcare provider.
   - **g.** I will inform all other healthcare providers (ER, surgeon, dentist, etc.) that I am receiving pain medications from this prescriber. Should I receive any other prescriptions for pain medication I will inform this provider of the exact medication I received by the next business day.
   - **h.** I am expected to keep scheduled office appointments.
   - **i.** I am required to keep my prescriber up to date on all medications that I am taking especially other sedating medications such as medications for anxiety (Xanax, Valium, Klonopin, Lorazepam, etc.), for depression or other mental health conditions, for allergies (antihistamines that cause drowsiness such as Benadryl), for sleep (Ambien, Restoril, Lunesta, etc.) and over-the-counter (Tylenol PM, etc.), for cough (Tussinex, etc.) and for muscle relaxation (Flexeril, Soma,Zanaflex, etc).
   - **j.** I will consent to random drug screening at the provider's request. Unexpected results may result in changing or discontinuing my medications. I agree to bring my pain medication into the office to be counted if requested.
   - **k.** I will not use this medication with any alcohol containing beverages.
   - **l.** I will not use any illegal substances including cocaine, methamphetamines, etc.
   - **m**. I will not attempt to forge or call in a prescription for myself or any other individual. I will not attempt to alter the prescription in any way written by the prescriber. I understand that these are prosecutable offenses and may be reported to the authorities.
   - **n.** If I am arrested or incarcerated related to legal or illegal drugs my medications may be discontinued.
   - **o**. I will not share, trade or sell my medication for money, goods or services. I understand that these are prosecutable offenses and may be reported to the authorities.
   - **p.** I am responsible for the protection and security of my medications. I will keep them in my possession or in a secure place at all times not allowing anyone else, including family, friends, children and at-risk adults, access to these medications.
   - **q.** If my medications are lost or stolen a re-evaluation of my competence to continue on these medications may be performed. Replacement scripts will **NOT** be provided

2. I understand refills of my prescriptions should be addressed in person at scheduled office visits. I will not stop by the office without an appointment and I understand I will not be seen and refills will not be addressed without an appointment. Refills may not be made nights, weekends or holidays.

3. I agree to be evaluated by a psychiatric specialist, psychologist and/or addiction specialist at any time during my treatment at my doctor's request. I agree to the release of those records and reports to my prescriber. If in their opinion, I am not a candidate for further opioid treatment, I understand my medications may be weaned and discontinued.

4. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to the prescribing of my pain medications. I authorize the Prescriber and pharmacy to cooperate fully with any city, state, or federal law enforcement agency in the investigation of any possible misuse, sale or other diversions of pain medication. I authorize the Prescriber to provide a copy of this agreement to my pharmacy and my other healthcare providers.

THE VANGUARD MEDICAL GROUP

5. I understand that it is my responsibility to keep others and myself from harm, including the safety of my driving. If there is any question of impairment in my ability to safely perform any activity, I agree not to attempt to perform such activity until I have discussed this with my provider.

6. I further accept full responsibility for any sickness, injury or untoward event which may happen to anyone else as a result of my taking any of the medications prescribed by this provider.

7. I understand that the long-term effects of opioid therapy have yet to scientifically determined and treatment may change throughout my time as a patient. I understand, accept and agree that there may be unknown risks associated with the long-term use of opioids and my doctor will advise me as knowledge and training advance and will make appropriate treatment changes.

8. I understand that all medications have potential side effects. For pain medications, these include but are not limited to: addiction, physical dependence, chemical dependence, constipation which may be severe enough to require medical treatment, difficulty with urination, drowsiness, cognitive impairment, nausea, itching, depressed respiration, reduced sexual function and adverse effects or injury to the organs. A distinct clinical syndrome, “hyperalgesia syndrome”, has been described in the literature and can actually result in increased pain from continual and escalated doses of opioid medication.

9. I understand if I take more medication than prescribed or combine opioids with other sedating medications or alcohol it could result in coma, organ damage, or even death. These interactions are especially dangerous if I have a disease such as COPD or sleep apnea.

10. Women of childbearing age: I understand if I am planning to become pregnant, if I become pregnant or if I am suspicious that I am pregnant, I will notify my prescriber immediately. I further accept that any medication may cause harm to my embryo/fetus/baby and hold the prescriber and all staff harmless for injuries to the embryo/fetus/baby.

I will obtain all medications from one pharmacy. Pharmacy _____ _____Location _____Phone_____

I have read the above and have had all my questions answered. I know that pain can be managed with many types of treatments. If I am receiving pain medications for a trial period, for an expected acute or subacute condition or for a specific time frame such as a work-related injury then this agreement applies to the timeframe that this provider prescribes pain medication.

Opioid medication is only one part of my pain management plan of care. There is limited scientific data to suggest that using opioids over 4-5 months will lower my pain and or improve my daily function. There is some scientific information that suggests using opioids can increase my pain, make me feel less well, and increase my risk of unintentional **death** directly related to the opioid medication. I know that if my provider feels my risk from opioids is greater than my benefit, I may have my opioids compassionately lowered or removed altogether. I understand that no agreement can anticipate all events in medical treatment that may arise and that for myself and my heirs, I will hold harmless the prescriber, the practice, the clinic, its officers, owners, and staff for all resultant problems. By my signature below, I agree to all the above terms both explicit and implicit.

Patient Signature_____ Date_____

Prescriber Signature_____ Date_____

*Witness (receipt of copy of agreement):*_____

THE VANGUARD MEDICAL GROUP

Print Name: _____ Date of Birth: _____

CONSENT TO TREAT

I understand that I require treatment in this facility because of my condition. I permit my physician(s) or his employees, students in training, and all other persons caring for me to treat me in ways they judge are beneficial to me. I understand that this care may include tests, nursing care, examinations, and medical and surgical treatment.

I recognize it is the responsibility of my physician to explain to me the nature of any diagnostic tests and medical and/or surgical procedures judged by him as necessary for my treatment and to advise me of the risks and consequences of such procedures. I acknowledge that no guarantees have been made to me by my physician as to the result of any treatments, examinations, and/or operative procedures performed in the physician's office.

1. A release of Medical Information

I hereby authorize the physician involved with my care to release information from my medical records as may be required to any person, corporation, or agency which is legally responsible or has good cause to believe is legally responsible for processing and/or paying all or any part of the physician's charges and/or professional fees to which any entity designated by me for discharge and planning purposes.

2. Medicare Consent (If applicable)

I certify that the information given by me in applying for payment under title XVIII (Medicare) of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to information to the Social Security Administration or its intermediaries or carriers any information needed for this or a related medical claims. I request that payment of authorized benefits may be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me. The Medicare intermediary advises that the
type of services may no longer qualify as covered under Medicare.

3. Assignment of Benefits/ Financial

I hereby assign payment directly to The Vanguard Medical Group all insurance benefits payments (including any major medical payments) due to me as a result of the named patient's outpatient treatment or service and pursuant to any insurance contract I have which provides for such treatment. I agree to be responsible for any charges incurred that are not paid by insurance or other third party payers.

By signing this document, I acknowledge that I have read and understood this consent. Further, I hereby consent and authorize this facility to use or disclose my Protected Health Information in conjunction with treatment, payment or health care operations in accordance with the terms of consent.

Patient Signature: _____ Date: _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO INDIVIDUALS/FAMILY MEMBERS

In accordance with Federal government privacy rules implemented through the Healthcare Portability Act (HIPAA), in order for your healthcare provider or our staff to discuss your condition with members of your family or other individuals that you designate, we must obtain your authorization prior to doing so. In the event of a critical episode or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived.

_____ I do not authorize The Vanguard Medical Group to release any or all information concerning my medical care to any individual except as set forth above.

_____ I do authorize The Vanguard Medical Group to verbally release any or all information concerning my medical care to the following individuals.

Name: _____Relationship to Patient: _____

Permission to Leave Message:

I give permission to The Vanguard Medical Group leave a message(s) with a person or machine at the designated phone number.

Print Name(s):_____Phone Number:_____-_____-_____

Expiration Date of Authorization:

This authorization is effective until revoked or terminated by the patient or the patient's personal representative.

Right to Terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to The Vanguard Medical Group.

Patient Signature: _____ Date: _____

THE VANGUARD MEDICAL GROUP

Print Name: _____ Date of Birth: _____

APPOINTMENT CANCELLATION POLICY AGREEMENT

The Vanguard Medical Group is committed to providing all of our patients with exceptional care. When a patient cancels without giving enough notice, they prevent another patient from being seen.

All appointment reminders will be sent by email only. This is a courtesy only. **You are responsible to remember and keep your appointment regardless if you receive a reminder or not.** We strongly recommend that you register with our Patient Portal program on https://portal.kareo.com/app/new/login where you can see your upcoming appointments, medication list, and diagnosis history.

Emergency absences will be considered on an individual basis by *The Vanguard Medical Group.* It is mutually understood that if a cancellation is due to circumstances beyond any of our control, such as a power outage, unfortunate incidence, or whether that requires you or us to have to cancel or be closed during regular business hours, we will reschedule your existing appointment and no discount or charges will apply.
Please call us at (219) 809- 9839 by 2:00 p.m. on the day prior to your scheduled appointment to notify us of any changes or cancellations. **To cancel a *Monday* appointment, please call our office by 2:00 p.m. on *Friday*.**

Patients who do not show up for their office appointment without a call to cancel are considered a No-Show and will be subject to a $20.00 No Show fee. Patients who do not show up for their Surgical procedure without a call to cancel are considered a No-Show and will be subject to a $75.00 No Show Fee. This fee will not be submitted to insurance. It is your responsibility and must be paid in full prior to scheduling your next appointment.

Patients who No Show three (3) times may see limitations to access future appointments; i.e. scheduled at the end of the day.

I have read and understand the above policies. By signing, I acknowledge that I will adhere and agree to all office policies. I am willing to continue with my evaluation or treatment.

Patient Signature: _____ Date: _____

Print Name: _____ Date of Birth: _____

THE VANGUARD MEDICAL GROUP

The following are some questions given to all patients at The Vanguard Medical Group who are on or being considered for opioids for their pain. Please answer each question as honestly as possible. This information is for our records and will remain confidential. Your answers alone will not determine your treatment. Thank you

CAGE Questionnaire (Circle Yes or No)

1. Have you ever felt you should cut down on your drinking?	Yes	No
2. Have people annoyed you by criticizing your drinking?	Yes	No
3. Have you ever felt bad or guilty about your drinking?	Yes	No
4. Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover (eye-opener)?	Yes	No

FOR OFFICE CODING: Total Score _____

SOAPP Questionnaire: Please answer the questions below using the following scale:

0 = Never, 1 = Seldom, 2 = Sometimes, 3 = Often, 4 = Very Often

1. How often do you have mood swings? 0 1 2 3 4
2. How often do you smoke a cigarette within an hour after you wake up? 0 1 2 3 4
3. How often have any of your family members, including parents and grandparents, had a problem with alcohol or drugs? 0 1 2 3 4
4. How often have any of your close friends had a problem with alcohol or drugs? 0 1 2 3 4
5. How often have others suggested that you have a drug or alcohol problem? 0 1 2 3 4
6. How often have you attended an AA or NA meeting? 0 1 2 3 4
7. How often have you taken medication other than the way that it was prescribed?..... 0 1 2 3 4
8. How often have you been treated for an alcohol or drug problem? 0 1 2 3 4
9. How often have your medications been lost or stolen? 0 1 2 3 4
10. How often have others expressed concern over your use of medication? 0 1 2 3 4
11. How often have you felt a craving for medication? 0 1 2 3 4
12. How often have you been asked to give a urine screen for substance abuse? 0 1 2 3 4
13. How often have you used illegal drugs (for example, marijuana, cocaine, etc.) in the past five years? 0 1 2 3 4
14. How often, in your lifetime, have you had legal problems or been arrested? 0 1 2 3 4

FOR OFFICE CODING: Total Score _____

PHQ-2 (Depression Screening)

Over the past two weeks, how often have you been bothered by any of the following problems?

0 = Not at all 1 = Several days 2 = More than half the days 3 = Nearly every day

Little interest or pleasure in doing things.....0 1 2 3 4
Feeling down, depressed, or hopeless.....0 1 2 3 4

FOR OFFICE CODING: Total Score _____

Print Name: _____ Date of Birth: _____

THE VANGUARD MEDICAL GROUP

Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle one)

0=Not at all sure 1=Several days 2=Over half the days 3=Nearly every day

1. Feeling nervous, anxious, or on edge..... 0 1 2 3
2. Not being able to stop or control worrying..... 0 1 2 3
3. Worrying too much about different things..... 0 1 2 3
4. Trouble relaxing.....0 1 2 3
5. Being so restless that it's hard to sit still.....0 1 2 3
6. Becoming easily annoyed or irritable..... 0 1 2 3
7. Feeling afraid as if something awful might happen..... 0 1 2 3

FOR OFFICE CODING: Total Score _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

____Not difficult at all ____Somewhat difficult____Very difficult ____Extremely difficult

Suicide Risk Assessment: The SBQ-R Test (Circle one)

Question 1. Have you ever thought about or attempted to kill yourself?
- 1 = Never
- 2 = It was just a brief passing thought
- 3a = I have had a plan at least once to kill myself but did not try to do it
- 3b = I have had a plan at least once to kill myself and really wanted to die
- 4a = I have attempted to kill myself but did not want to die
- 4b = I have attempted to kill myself, and really hoped to die

Question 2. How often have you thought about killing yourself in the past year?
- 1 = Never
- 2 = Rarely (1 time)
- 3 = Sometimes (2 times)
- 4 = Often (3-4 times)
- 5 = Very Often (5 or more times)

Question 3. Have you ever told someone that you were going to commit suicide, or that you might do it?
- 1 = No
- 2a = Yes, at one time, but did not really want to die
- 2b = Yes, at one time, and really wanted to die
- 3a = Yes, more than once, but did not want to do it
- 3b = Yes, more than once, and really wanted to do it

Question 4. How likely is it that you will attempt suicide someday?
- 0 = Never
- 1 = No chance at all
- 2 = Rather unlikely
- 3 = Unlikely
- 4 = Likely
- 5 = Rather likely

FOR OFFICE CODING: Total Score _____

Signature:_____ Date: _____