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Patient Information Sheet

***Please present ALL Insurance cards and Drivers License at time of visit.**
COMPLETE ALL FIELDS as best as possible.

Name: (First) _____ (MI) _____ (Last) _____

Date of Birth: _____ Age: _____ Sex: ☐ Male ☐ Female Height: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow Weight: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____ Social Security Number: _____

Home Phone: _____ Cell: _____ Email address: _____

Occupation: _____ Employer: _____ Work Phone: _____

Employer Address: _____

Pharmacy Name: _____ Town: _____ Phone: _____

Primary Care Physician: _____ Town: _____ Phone: _____

Referring Physician: _____ Town: _____ Phone: _____

Emergency Contact Name: _____ Relationship: _____ Phone: _____

Primary Insurance Plan: _____ ID#: _____

Address: _____

Primary Insurance Plan Holder's Name: _____ DOB: _____

Relationship to patient: _____

Mailing Address of Plan Holder (if different from patient): _____

Home Phone of Plan Holder: _____ Cell phone of Plan Holder: _____

Secondary Insurance Plan: _____ ID#: _____

Address: _____

Secondary Insurance Plan Holder's Name: _____ DOB: _____

Relationship to patient: _____

Patient Release: MUST BE SIGNED BY PATIENT: I understand that Nu-Spine, LLC will prepare any necessary paperwork needed to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Nu-Spine, LLC will be credited to my account.
I understand that any person who knowingly files a statement of claim containing any false or misleading information or knowingly presents any fraudulent information such as personal identification or invalid insurance information is subject to civil and criminal penalties.
I understand and agree that all services rendered to me will be billed to my insurance and that I am responsible for payment. I also hereby authorize Nu-Spine, LLC staff to release any information pertinent to my case concerning illness, condition, or disability and treatment thereof, to any insurance company, adjuster, or attorney involved in this case. I also give permission to leave messages at the insurance companies' and/or attorneys' phone numbers regarding my file AND at the above home or work phone numbers regarding scheduling of appointments and care.

Patient Signature: _____ **Date:** _____

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If you are being seen as the result of an Auto Accident or Worker's Compensation case,
COMPLETE ALL Fields as best as possible

Auto Accident / Workers Comp

Name: (First)_____ (MI)_____ (Last)_____

Were you in an accident: ☐ Motor Vehicle ☐ Workers Comp ☐ Fall ☐ Lifting ☐ Other:_____

Date of Accident/Injury _____ **Location of Accident/Injury** _____

Were you the: ☐ Driver ☐ Passenger ☐ Pedestrian ☐ Other:_____

ATTORNEY INFORMATION

Attorney's Name:_____ **Attorney Phone #:**_____

Attorney's Firm:_____

INSURANCE INFORMATION

Insurance Company:_____

Claim #: _____ **Policy #:** _____

Insurance Co. Billing Address: _____

Insurance Co. City: _____ **City:** _____ **State:**_____ **Zip:**_____

Claims Rep Name: _____

Claims Rep Phone#:_____

Case Manager:_____ **Case Manager Phone:**_____

Patient Release: MUST BE SIGNED BY PATIENT : I understand that Nu-Spine, LLC will prepare any necessary paperwork needed to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Nu-Spine, LLC will be credited to my account.

I understand that any person who knowingly files a statement of claim containing any false or misleading information or knowingly presents any fraudulent information such as personal identification or invalid insurance information is subject to civil and criminal penalties.

I understand and agree that all services rendered to me will be billed to my insurance and that I am responsible for payment. I also hereby authorize Nu-Spine, LLC staff to release any information pertinent to my case concerning illness, condition, or disability and treatment thereof, to any insurance company, adjuster, or attorney involved in this case. I also give permission to leave messages at the insurance companies' and/or attorneys' phone numbers regarding my file AND at the above home or work phone numbers regarding scheduling of appointments and care.

Patient Signature: _____ **Date:** _____

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Chief Complaint

Please describe the reason(s) for your visit today: _____

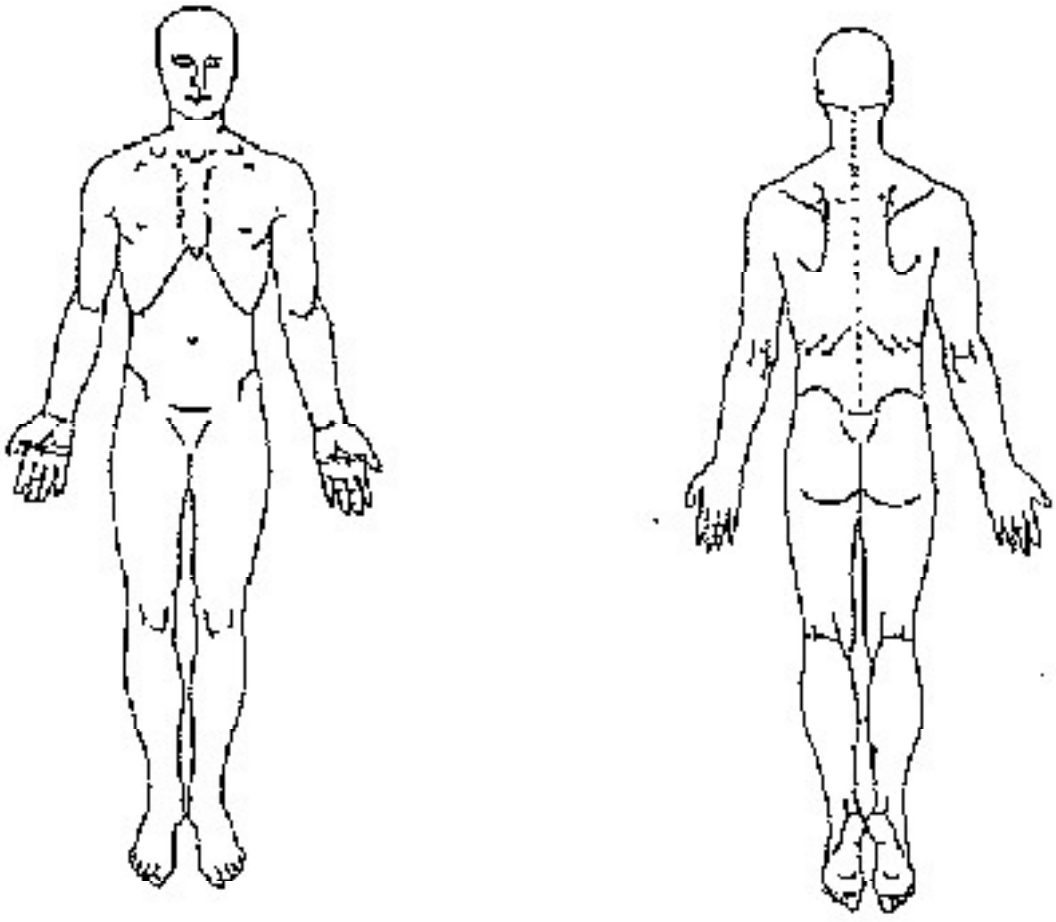
_____

_____

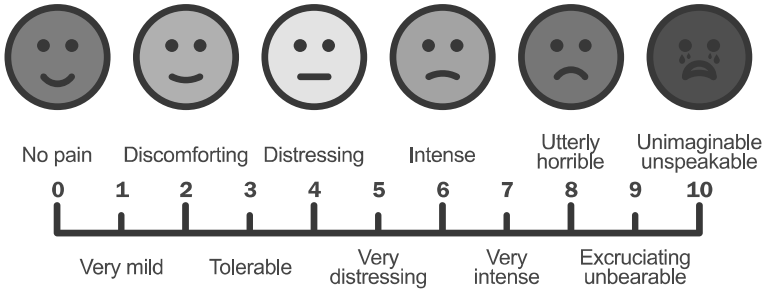
_____

Where are you experiencing pain?

- Please indicate **P** for pain, **N** for numbness, and **T** for tingling in each area. Shade area as needed to show full area of pain.
- If multiple locations please indicate where pain is most severe.



Please Indicate Pain Level



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Past Medical History

Please mark your past medical history (Illnesses, Injuries, Hospitalizations, etc.)

☐ Arthritis	☐ Diabetes	☐ Heart Disease	☐ Osteoporosis
☐ Asthma/Lung Disease	☐ Gastritis or Ulcers	☐ High Blood Pressure	☐ Seizures
☐ Blood Clots	☐ Headaches	☐ High Cholesterol	☐ Stroke
☐ Cancer	☐ Head Injury/Concussion	☐ Kidney or Liver Disease	☐ Thyroid Problems

☐ Other _____

Past Surgical History

Surgery: _____ Date: _____

Surgery: _____ Date: _____

Surgery: _____ Date: _____

Allergies to medication or foods (Please list all) _____

_____

_____

Please list your history of motor vehicle accidents, back injuries, etc. (Date, Did symptoms resolve?, Duration of symptoms) _____

_____

_____

Medications (Please list all medications, over the counter drugs, vitamins and any herbal remedies)

Medication: _____ Dosage: _____ Frequency: _____ Date: _____

Medication: _____ Dosage: _____ Frequency: _____ Date: _____

Medication: _____ Dosage: _____ Frequency: _____ Date: _____

Medication: _____ Dosage: _____ Frequency: _____ Date: _____

Medication: _____ Dosage: _____ Frequency: _____ Date: _____

Medication: _____ Dosage: _____ Frequency: _____ Date: _____

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Conservative Treatment Prior to Office Visit Today

	Successful (Yes/No)	Did you experience temporary relief?	Comments (Last Visit)
Bed Rest			
Cervical Collar			
Analgesics			
Physical Therapy			
Chiropractic Therapy Name of Chiropractor: _____			
Pain Management Name of Dr. _____			
Epidural Steroid Injection			

Have you had any of the following imaging done? ☐ X-ray ☐ MRI ☐ CT Scan

Date: _____ Location: _____

Review of Systems

Please circle all that apply to your current state of health.

General	Weight loss or gain	Fatigue	Fever or chills	Weakness	Trouble sleeping	Change in appetite
Skin	Rashes	Lumps	Itching	Dryness	Color changes	Hair and nails changes
Head/Neck	Head Injury	Headache	Neck lumps	Neck pain	Neck stiffness	Swollen glands
Ears	Decreased hearing	Ringing in ears (tinnitus)	Earache	Drainage		
Eyes	Glaucoma	Cataracts	Flashing lights	Specks/Floaters		
Nose	Stuffiness	Discharge	Itching	Hay fever	Nosebleeds	Sinus pain
Throat	Sore throat	Hoarseness	Mouth sores	Dentures	Sore tongue	Dry mouth
Cardiovascular	Chest pain	Leg edema (swelling)	Palpitations	Loss of consciousness		
Gastrointestinal	Abdominal pain	Nausea/Vomiting	Diarrhea/ Constipation	Bright red blood per rectum	Dark, black tarry stool	
Endocrine	Diabetes	Hyperthyroid	Hypothyroid	Sweating		
Respiratory	Cough (dry or wet, productive)	Sputum (color and amount) _____	Coughing up blood	Shortness of breath	Wheezing	Painful breathing
Neuro	Numbness / Tingling	Bowel / Bladder Incontinence	Seizures	Groin Numbness	Tremors	
Musculoskeletal	Hip pain	Knee pain	Shoulder pain	Back pain	Joint pain	

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Social History

	Never*	Occasionally	Frequently	Daily
Alcohol Use				
Tobacco Specify: _____				
Cigars				
Illicit Drugs Specify: _____				
Vape				

*If you have quit indicate when.

Is your visit today related to a Auto Accident/Workers' Comp injury? _____

*** If yes, please fill out the Auto Accident/Workers' Comp form as well.**

Patient Signature: _____ **Date:** _____

New Jersey Department of Banking and Insurance

CONSENT TO REPRESENTATION IN APPEALS OF UTILIZATION MANAGEMENT DETERMINATIONS AND AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS IN UM APPEALS AND INDEPENDENT ARBITRATION OF CLAIMS

APPEALS OF UTILIZATION MANAGEMENT DETERMINATIONS

You have the right to ask your insurer, HMO or other company providing your health benefits (carrier) to change its utilization management (UM) decision if the carrier determines that a service or treatment covered under your health benefits plan is or was not medically necessary.* This is called a UM appeal. You also have the right to allow a doctor, hospital or other health care provider to make a UM appeal for you.

There are three appeal stages if you are covered under a health benefits plan issued in New Jersey. Stage 1: the carrier reviews your case using a different health care professional from the one who first reviewed your case. Stage 2: the carrier reviews your case using a panel that includes medical professionals trained in cases like yours. Stage 3: your case will be reviewed through the Independent Health Care Appeals Program of the New Jersey Department of Banking and Insurance (DOBI) using an Independent Utilization Review Organization (IURO) that contracts with medical professionals whose practices include cases like yours. The health care provider is required to attempt to send you a letter telling you it intends to file an appeal before filing at each stage.

At Stage 3, the health care provider will share your personal and medical information with DOBI, the IURO, and the IURO's contracted medical professionals. Everyone is required by law to keep your information confidential. DOBI must report data about IURO decisions, but no personal information is ever included in these reports.

You have the right to cancel (revoke) your consent at any time. Your financial obligation, IF ANY, does not change because you choose to give consent to representation, or later revoke your consent. Your consent to representation and release of information for appeal of a UM determination will end 24 months after the date you sign the consent.

INDEPENDENT ARBITRATION OF CLAIMS

Your health care provider has the right to take certain claims to an independent claims arbitration process through the DOBI. To arbitrate the claim(s), the health care provider may share some of your personal and medical information with the DOBI, the arbitration organization, and the arbitration professional(s). Everyone is required to keep your information confidential. The DOBI reports data about the arbitration outcomes, but no personal information will be in the reports. Your consent to the release of information for the arbitration process will end 24 months after the date you sign the consent.

CONSENT TO REPRESENTATION IN UM APPEALS AND AUTHORIZATION TO RELEASE OF INFORMATION IN UM APPEALS AND ARBITRATION OF CLAIMS

I, _____, by marking [√] (or [x]) and signing below, agree to:

☑ representation by NU Spine LLC in an appeal of an adverse UM determination as allowed by N.J.S.A. 26:2S-11, and release of personal health information to DOBI, its contractors for the Independent Health Care Appeals Program, and independent contractors reviewing the appeal. My consent to representation and authorization of release of information expires in 24 months, but I may revoke both sooner.

☑ release of personal health information to DOBI, its contractors for the Independent Claims Arbitration Program or the Chapter 32 Independent Arbitration System, and any independent contractors that may be required to perform the arbitration process. My authorization of release of information for purposes of claims arbitration will expire in 24 months.

Signature: _____ Ins. ID#:_____ Date: _____

Relationship to Patient: ☐ I am the Patient ☐ I am the Personal Representative (provide contact information on back)

* If the patient is a minor, or unable to read and complete this form due to mental or physical incapacity, a personal representative of the patient may complete the form.

Health Care Provider: The Patient or his or her Personal Representative MUST receive a copy of both sides/pages of this document AFTER PAGE 1 has been completed, signed and dated.

New Jersey Department of Banking and Insurance

NOTICE OF REVOCATION OF CONSENT TO REPRESENTATION IN APPEALS OF UTILIZATION MANAGEMENT DETERMINATIONS AND OF AUTHORIZATION TO RELEASE OF MEDICAL RECORDS

You may, at any time, revoke the consent you gave allowing a health care provider to represent you in an appeal of a UM determination and allowing the release of your medical records to the DOBI, the IURO and medical professionals that contract with the IURO. You may use this form to revoke your consent, or you may submit some other written evidence of your intent to revoke consent, if you prefer. Either way, if you have not yet received a Stage 2 UM determination from the carrier, send the written and signed revocation to the carrier at the address indicated in the carrier's written notice to you regarding the carrier's initial UM determination. If you have received a Stage 2 UM determination, then your revocation should be sent to:

New Jersey Department of Banking and Insurance
Consumer Protection Services
Office of Managed Care – Attn: IHCAP
P.O. Box 329
Trenton, NJ 08625-0329
OR for courier service to: 20 West State Street OR by fax to: (609) 633-0807

You may also want to send a copy of your notice of revocation to the health care provider.

ONLY COMPLETE AND SEND THIS IN WHEN AND IF YOU WISH TO REVOKE YOUR CONSENT!

REVOCATION OF CONSENT TO REPRESENTATION AND RELEASE OF MEDICAL RECORDS IN UM DETERMINATION APPEALS

☐ I hereby revoke my consent to representation by ☐ and my authorization to the release of medical information in an appeal of an adverse UM determination. I understand that by revoking consent, the UM appeal may not be pursued further by my health care provider. I understand that this revocation may occur after my personal and medical information has already been shared with the DOBI, the IUROs and medical professionals with whom the IUROs contract, but that no further distribution of records in this matter will occur based on my authorization, and that all of my medical and personal information is required to be maintained as confidential by all parties.

Signature: _____ Ins. ID#_____ Date:_____
Relationship to Patient: ☐ I am the Patient ☐ I am the Personal Representative

Contact Information of Personal Representative

Please provide the following contact information IF it is different from the patient's contact information:

PRINT NAME: _____

ADDRESS:_____

_____

PHONE: _____ FAX: _____ EMAIL: _____

Health Care Provider: The Patient or his or her Personal Representative MUST receive a copy of both sides/pages of this document AFTER PAGE 1 has been completed, signed and dated.

NU SPINE

ASSIGNMENT OF BENEFITS: I, _____, irrevocably assign to NU SPINE (aka provider) all of my rights and benefits under my insurance contract for payment for services rendered to me. I authorize the provider to file insurance claims on my behalf for services rendered to me, which authorization specifically includes but is not limited to appealing, filing arbitration/litigation in provider's name on my behalf against any third-party payer, including but not limited to PIP/No-Fault/auto, Workers' Compensation, Commercial Health and other carriers. I authorize provider to retain an attorney of their choice on for collection of provider bills. I direct that all payments for medical services go directly to my medical provider and/or their attorney. I authorize and consent to my provider and his designees acting on my behalf in this regard and in regard to my general health insurance coverage pursuant to the "benefit denial appeals process" as set forth in the NJ Administrative Code.

LIMITED POWER OF ATTORNEY: In the event the insurance carrier responsible for making medical payments in this matter does not accept my assignment, or my assignment is challenged or deemed invalid, I execute this limited /special power of attorney and appoint and authorize provider and/or their attorney as my agent to collect, in my name, payment for provider's medical services from the carrier in this case. This includes, but is not limited to filing an appeal, arbitration demand or lawsuit. I specifically authorize provider and/or their attorney to file directly against that carrier in my name or in provider's name as a medical provider rendering services to me and designate provider and/or attorney as my attorney-in-fact. I further grant limited power of attorney to provider as my medical provider to receive and collect directly from the insurance carrier money due to provider for services rendered to me, and hereby instruct the insurance carrier to pay provider directly. I authorize provider and/or their attorney to receive from my insurer, immediately upon request, all information regarding my claim, including, but not limited to last payment date, balance of benefits remaining, and summary plan description.

AUTHORIZATION TO RELEASE INFORMATION. I authorize provider and/or their attorney to obtain medical information regarding my physical condition from any other healthcare provider, including but not limited to hospitals, diagnostic centers, and surgeons. I further authorize such health care provider(s) to release all information to provider about me/my treatment, including, but not limited to, medical reports, X-ray reports, narrative reports, and any other report or information regarding my current or past physical condition(s).

DESIGNATION AS AUTHORIZED REPRESENTATIVE. I further authorize provider and/or their attorney to file appeals, review requests, etc. as my designated authorized representative. I authorize provider and/or their attorney to act as my designated authorized representative to all applicable insurance carriers and/or employee health care benefits plans. The provider and/or their attorney is appointed as my representative to act on my behalf in connection with any claim, right or course of action that I have under such insurance policy and/or plan, including the right and ability to act as my Authorized Representative to pursue such claim, right or cause of action in connection with said insurance policy and/or plan, including the right to act as my Authorized Representative with respect to any plan covered by ERISA with respect to any expense incurred for services I received from Provider and to the extent legally permissible to claim on my behalf, such reimbursement and any other applicable fines or remedies. I hereby authorize provider and/or their attorney to appeal my insurance carrier's determination concerning any of my medical claim(s) on my behalf, as my Designated Representative and as part of the appeal, I hereby authorize my insurance carrier in its decision letter and in connection with the processing of my appeal, to communicate with the provider and/or their attorney concerning all medical and financial information contained in my insurance file, including but not limited to treatment for venereal disease, alcoholism and drug abuse, abortion, mental disorder and HIV status relating to my examination, treatment and hospital confinement in connection with the determination which is being appealed. I understand this information is privileged and confidential and will only be released to my designated representative per this member authorization.

I confirm that I have read and fully understand the above. I acknowledge that the authorizations granted above do not expire

Patient Name (printed): _____

Signature*: _____

Date: _____

*If signing on behalf of patient, indicate relationship, and/or why patient cannot sign themselves.

NU·Spine The Minimally Invasive Spine Surgery Institute

NU • SPINE LLC P.O. Box 11 Middletown NJ 07748

OFFICE PHONE: (732) 640-8203 info@nu-spine.com

BILLING PHONE: (732) 441-7177 Billing FAX: (732) 441-7165

Major Medical Out of Network Liability Acknowledgement

I, _____ have been informed by NU SPINE LLC that they are not participating with my health insurance carrier and therefore are out of network.

I understand that since NU SPINE LLC is a non-participating provider that all treatment rendered will apply to my out of network benefits and that I may have additional out of pocket costs such as non-covered services, deductible and/or co-insurance responsibility.

I also understand that any payments from my insurance made out in my or subscriber's name and/or sent to my address shall be immediately given to NU SPINE LLC with the appropriate endorsements and a copy of the explanation of benefits (EOB).

I furthermore understand that any payments from the insurance company deposited by me into my personal bank account with no corresponding prompt payment made by me to NU SPINE LLC can be considered theft of services, which could result in my account being referred to collections and possibly being held personally liable in a competent New Jersey court of law.

Lastly, I shall provide NU SPINE LLC with any secondary insurance coverage to cover some if not all of the balance due. If no secondary insurance is provided, I understand that I will be 100% liable for outstanding balances and agree to pay and/or negotiate the balance due.

_____ _____

(Patient/Parent/Guardian signature) (Date)

_____ _____

(Witness) (Date)

HIPAA COMPLIANT AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION PURSUANT TO 45 CFR 164.508

TO: _____

Name of Healthcare Provider/Physician/Facility/Medicare Contractor

_____

Street Address

_____

City, State and Zip Code

RE: Patient Name: _____

Date of Birth: _____ Social Security Number: _____ _

I authorize and request the disclosure of all protected information for the purpose of review and evaluation in connection with a legal claim. I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following:

☐ All medical records, meaning every page in my record, including but not limited to: office notes, face sheets, history and physical, consultation notes, inpatient, outpatient and emergency room treatment, all clinical charts, r ports, order sheets, progress notes, nurse's notes, social worker records, clinic records, treatment plans, admission records, discharge summaries, requests for and reports of consultations, documents, correspondence, test results, statements, questionnaires/histories, correspondence, photographs, videotapes, telephone messages, and records received by other medical providers.

☐ All physical, occupational and rehab requests, consultations and progress notes.

☐ All disability, Medicaid or Medicare records including claim forms and record of denial of benefits.

☐ All employment, personnel or wage records.

☐ All autopsy, laboratory, histology, cytology, pathology, immunohistochemistry records and specimens; radiology records and films including CT scan, MRI, MRA, EMG, bone scan, myleogram; nerve conduction study, echocardiogram and cardiac catheterization results, videos/CDs/films/reels and reports.

☐ All pharmacy/prescription records including NDC numbers and drug information handouts/monographs.

☐ All billing records including all statements, insurance claim forms, itemized bills, and records of billing to third party payers and payment or denial of benefits for the period _____ to _____ _ .

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human

immunodeficiency virus (HIV), and alcohol and drug abuse. I authorize the release or disclosure of this type of information.

This protected health information is disclosed for the following purposes: _____

This authorization is given in compliance with the federal consent requirements for release of alcohol or substance abuse records of 42 CFR 2.31, the restrictions of which have been specifically considered and expressly waived.

You are authorized to release the above records to the following representatives of defendants in the above-entitled matter who have agreed to pay reasonable charges made by you to supply copies of such records:

Nu-Spine, Dr. Branko Skovrlj Fax: 732-640-8203

Name of Representative

treating provider

Representative Capacity (e.g. attorney, records requestor, agent, etc.)

107 Tindall Road Suite 1

Street Address

Middletown, NJ 08859

City, State and Zip Code

I understand the following: See CFR §164.S08(c)(2)(i-iii)

a. I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.
b. The information released in response to this authorization may be re-disclosed to other parties.
c. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until two years from date of execution at which time this authorization expires.

Signature of Patient or Legally Authorized Representative Date
(See 4SCFR § 164.S0S(c)(l)(vi))

Name and Relationship of Legally Authorized Representative to Patient
(See 4SCFR §164.508(c)(1)(iv))

Witness Signature Date

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Assignment of Benefits and Authorization

Patient:_____ Ins. Company_____

ID# / Claim #_____

In consideration of the professional services rendered by the Nu Spine LLC, and its affiliated health care providers ("Healthcare Providers"), I hereby irrevocably direct, authorize, assign, and consent to the following:

1. The assignment of my rights to bill, collect, appeal, and/or arbitrate my claims for health insurance benefits with regard to the above-captioned claim to Healthcare Providers, including but not limited to surgical facility fees, supplies, primary physician, assistant, anesthesia, and any other fees related to my claim, pursuant to my rights under state and/or federal law including but not limited to the federal ERISA statutes, New Jersey Health Claims Authorization, Processing and Payment Act (HCAPPA), and New Jersey Healthcare Quality Act.

2. The authorization of Healthcare Providers to act as my agent-in-fact with regard to all aspects regarding my claim and to receive all communications regarding the claim and any appeals or arbitration of the denial of my claim as a substitute beneficiary under my policy of health insurance whether fully funded or self-funded.

3. The authorization of Healthcare Providers to initiate, prosecute, and resolve any and all appeals and/or arbitrations and/or legal action on the denial of my claim, including but not limited to internal appeals with the insurer, outside reviewing entities or agencies as well as arbitrations and litigation matters in state or federal court including but not limited to claim under the federal ERISA statutes, New Jersey Health Claims Authorization, Processing and Payment Act (HCAPPA), New Jersey Healthcare Quality Act (HCQA) and personal injury claims under the New Jersey Personal Injury Protection (PIP)/No Fault statute N.J.S.A 39:6A.

4. The authorization of Healthcare Providers to obtain and/or disclose any Private Health Information as contemplated by HIPAA limited to my claim for insurance benefits and any appeal there from. I have signed a separate HIPAA authorization in this regard.

5. The authorization of Healthcare Providers to file a complaint with regard to any denial of my claim(s) with the New Jersey Department of Health and Senior Services, the New Jersey Department of Banking and Insurance, the Federal Department of Labor, as it relates to ERISA plan, as well as any other governmental agency with jurisdiction over my claim and/or the insurer.

6. The authorization for payment of any and all insurance benefits made directly to Healthcare Providers to which I might be entitled under my claims.

7. I hereby further assign to **Nu Spine LLC** all of my rights under my insurance contract, including all of my rights governed by the statutes and regulations of the Employee Retirement Income Security Act (ERISA), including, without any limitation whatsoever, my rights to "recover benefits" under ERISA Section 502(a)(1)(B), my rights to recover civil statutory penalties under ERISA Section 502(c)(1)(B); and my rights to pursue breach of fiduciary claims under ERISA Sections 502(a)(2) and 502(a)(3)

Patient Name (print) : _____ Patient Signature:_____ Date: _____

Witness Name (print): _____Witness Signature: _____ Date: _____