

**PATIENT MEDICAL HISTORY FORM**

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Dear Patient,

Please return completed packet with signature pages to the front desk.

**Patient Name:** \_\_\_\_\_

**DOB:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Age:** \_\_\_\_\_  Male  Female **SS#:** \_\_\_\_\_

**Primary Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Home Phone:**  Preferred (\_\_\_\_\_) \_\_\_\_\_

**Cell Phone:**  Preferred (\_\_\_\_\_) \_\_\_\_\_

**Secondary Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**May we leave a message on your answering machine / voicemail?**  Yes  No

**Email Address:** \_\_\_\_\_ **May we email you?**  Yes  No

**Preferred Language:** \_\_\_\_\_

**Ethnicity:**  Hispanic/Latino  Non-Hispanic/Latino

**Race:**  Native American or Alaska Native  Asian  Black or African American  Native Hawaiian or  
Other Pacific Islander  White  Other

**Pharmacy Name:** \_\_\_\_\_

**Pharmacy Phone # and Cross Streets:** \_\_\_\_\_

*(Internal Use Only)*

**MRN#:** \_\_\_\_\_



**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Primary Care Physician:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Referring Physician (if different):** \_\_\_\_\_ **Phone:** \_\_\_\_\_

Please list any additional Physicians you see: (Include Phone #):

\_\_\_\_\_ **Phone:** \_\_\_\_\_

\_\_\_\_\_ **Phone:** \_\_\_\_\_

\_\_\_\_\_ **Phone:** \_\_\_\_\_

\_\_\_\_\_ **Phone:** \_\_\_\_\_

**Emergency Contact Name:**

\_\_\_\_\_

**Relationship:** \_\_\_\_\_ **Phone: (\_\_\_\_\_)** \_\_\_\_\_

**Employment Status:**

Employed/Self Employed     Unemployed     Retired     Disabled

**Occupation (or Former Occupation):** \_\_\_\_\_

**Name of Employer:** \_\_\_\_\_ **Work Phone: (\_\_\_\_\_)** \_\_\_\_\_

**Advanced Directives:**

**Living Will**     Yes     No     Unknown

**Durable Power of Attorney**     Yes     No     Unknown

**DNR**     Yes     No     Unknown



# LOW COUNTRY CANCER CARE

A DIVISION OF AMERICAN ONCOLOGY PARTNERS, P.A.

**Hematology • Oncology**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Reason for this Visit: \_\_\_\_\_

**Medical History:** Check the items that apply to you (current or past)

- |                                      |                          |                                   |                          |                            |                          |
|--------------------------------------|--------------------------|-----------------------------------|--------------------------|----------------------------|--------------------------|
| None                                 | <input type="checkbox"/> | Enlarged Prostate                 | <input type="checkbox"/> | Leukemia                   | <input type="checkbox"/> |
| Asthma                               | <input type="checkbox"/> | Peripheral Vascular Disease (PVD) | <input type="checkbox"/> | Anxiety                    | <input type="checkbox"/> |
| Chronic Lung (COPD)                  | <input type="checkbox"/> | Diabetes                          | <input type="checkbox"/> | Problems with Anesthesia   | <input type="checkbox"/> |
| Pneumonia/Bronchitis                 | <input type="checkbox"/> | Lupus-Autoimmune                  | <input type="checkbox"/> | Thyroid Disease            | <input type="checkbox"/> |
| TB (Tuberculosis)                    | <input type="checkbox"/> | Reynaud's Syndrome                | <input type="checkbox"/> | High Blood Pressure        | <input type="checkbox"/> |
| Sleep Apnea                          | <input type="checkbox"/> | Rheumatoid Arthritis              | <input type="checkbox"/> | High Cholesterol           | <input type="checkbox"/> |
| Colon Polyps                         | <input type="checkbox"/> | Osteoarthritis                    | <input type="checkbox"/> | Atrial Fibrillation (Afib) | <input type="checkbox"/> |
| Crohn's Disease                      | <input type="checkbox"/> | Chronic Back Pain                 | <input type="checkbox"/> | Congestive Heart Failure   | <input type="checkbox"/> |
| Diverticulitis                       | <input type="checkbox"/> | Osteoporosis                      | <input type="checkbox"/> | Heart Attack-MI            | <input type="checkbox"/> |
| Irritable Bowel Syndrome (IBS)       | <input type="checkbox"/> | Fracture                          | <input type="checkbox"/> | Heart Disease              | <input type="checkbox"/> |
| Ulcerative Colitis                   | <input type="checkbox"/> | Stroke                            | <input type="checkbox"/> | Rheumatic Fever            | <input type="checkbox"/> |
| Stomach Ulcers                       | <input type="checkbox"/> | Neuropathy                        | <input type="checkbox"/> | Heartburn/Reflux           | <input type="checkbox"/> |
| GERD/Heartburn                       | <input type="checkbox"/> | Parkinson's Disease               | <input type="checkbox"/> | Heart Murmur               | <input type="checkbox"/> |
| Hiatal Hernia                        | <input type="checkbox"/> | Paralysis                         | <input type="checkbox"/> | Irregular Heart Beat       | <input type="checkbox"/> |
| Gallstones                           | <input type="checkbox"/> | Seizures                          | <input type="checkbox"/> | Frequent Infections        | <input type="checkbox"/> |
| Cirrhosis of Liver                   | <input type="checkbox"/> | Migraines                         | <input type="checkbox"/> | Blood Disorder             | <input type="checkbox"/> |
| Hepatitis A/ B/ C                    | <input type="checkbox"/> | Shingles                          | <input type="checkbox"/> | Blood Clots                | <input type="checkbox"/> |
| Pancreatitis                         | <input type="checkbox"/> | Glaucoma/Cataracts                | <input type="checkbox"/> | Anemia                     | <input type="checkbox"/> |
| Kidney Stone                         | <input type="checkbox"/> | Hearing Loss                      | <input type="checkbox"/> | Bleeding Disorder          | <input type="checkbox"/> |
| Kidney Disease/Failure               | <input type="checkbox"/> | Cancer                            | <input type="checkbox"/> | Drug Use                   | <input type="checkbox"/> |
| Freq. Urinary Tract Infections (UTI) | <input type="checkbox"/> | Lymphoma                          | <input type="checkbox"/> | Depression                 | <input type="checkbox"/> |

Other Medical History: \_\_\_\_\_

**Cancer History:**

Type: \_\_\_\_\_ Date diagnosed \_\_\_\_\_

Treatment: (type, date, and location of treatment) \_\_\_\_\_

Treating Physician: \_\_\_\_\_



# LOW COUNTRY CANCER CARE

A DIVISION OF AMERICAN ONCOLOGY PARTNERS, P.A.

**Hematology • Oncology**

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Past Surgical History:** *(Please circle and date any of the surgeries and/or procedures that you have undergone)*

Coronary Bypass	Date: _____	Knee Replacement	Date: _____
Angioplasty	Date: _____	Rotator Cuff Repair	Date: _____
Pacemaker	Date: _____	Cataract	Date: _____
Cardiac Valve Surgery	Date: _____	Gallbladder Surgery	Date: _____
Hemorrhoidectomy	Date: _____	Hysterectomy	Date: _____
Prostate Operation	Date: _____	Prostatectomy	Date: _____
Hernia Repair	Date: _____	Appendectomy	Date: _____
Tonsillectomy	Date: _____	Hip Replacement	Date: _____
Mastectomy	Date: _____	Lumpectomy	Date: _____
Other Operations: _____			

**Social History:**

**Tobacco Use:** *(Present and/or Past):*

- Never Smoked
- Quit smoking When? \_\_\_\_\_ How many years did you smoke? \_\_\_\_\_yr(s)  
How many packs? \_\_\_\_\_/day
- Currently Smoke  Cigarettes  Pipe  Cigars How many packs? \_\_\_\_\_/day  
How many years? \_\_\_\_\_
- Chewing Tobacco

**Alcohol History:** *(Present and/or Past):*

- Non Drinker
- Beer number of bottles \_\_\_\_\_per  Day  Week  Month
- Wine number of glasses \_\_\_\_\_per  Day  Week  Month
- Liquor number of glasses \_\_\_\_\_per  Day  Week  Month

**Marital Status:**  Married  Single  Widowed  Divorced  Other

**Household Status:**  Lives Alone  Lives with Family  Lives in Nursing Home

Winter Resident  Year-Round Resident

**Children:**  Yes  No Number \_\_\_\_\_

**Health Maintenance:**

Sigmoidoscopy / Colonoscopy: Yes No Date: \_\_\_\_\_

Findings: \_\_\_\_\_

Last Mammogram: Date: \_\_\_\_\_ Last Bone Density: Date: \_\_\_\_\_ Last Pelvic Exam: Date: \_\_\_\_\_

Influenza (Flu) Shot: Date: \_\_\_\_\_ Pneumococcal Shot: Date: \_\_\_\_\_ Last Shingles Shot: Date: \_\_\_\_\_

Last EGD: Date: \_\_\_\_\_ Last Colonoscopy: Date: \_\_\_\_\_ Last Prostate Exam: Date: \_\_\_\_\_



# LOW COUNTRY CANCER CARE

A DIVISION OF AMERICAN ONCOLOGY PARTNERS, P.A.

**Hematology • Oncology**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**Review of Symptoms:** (Please check any **current** symptoms you have.)

**General:**

- Weight Loss  
How much \_\_\_\_\_  
Over what time period \_\_\_\_\_
- Fevers
- Max temp \_\_\_\_\_
- Chills
- Night sweats
- Fatigue

**Eyes:**

- Wear Glasses/Contact Lenses
- Blurred Vision
- Double Vision

**Ears, Nose, Throat:**

- Hard of Hearing or Deaf
- Ringing in Ears
- Enlarged Lymph nodes
- Chronic Sinus Problems
- Sore Throat
- Mouth Pain/Sores

**Changes/Difficulty In:**

- Taste
- Smell

**Cardiovascular:**

- Chest Pain/Angina Pectoris
- Palpitations/Heart Murmur
- Irregular Heart Beat/Pressure

**Respiratory:**

- Chronic or Frequent Cough
- Bloody Sputum
- Shortness of Breath

**Skin:**

- Rashes or Itching
- Change in Skin Color or Moles
- Varicose Veins
- Skin Cancer

**Gastrointestinal:**

- Difficult or Painful Swallowing
- Abdominal Pain
- Nausea
- Vomiting
- Heartburn
- Indigestion
- Lump or Sensation in Throat
- Food Sticking
- Bloating
- Belching
- Diarrhea
- Constipation
- Rectal Bleeding
- Black or Tarry Stool
- Hidden Blood in Stool
- Excessive Rectal Gas/Flatus
- Loss of Stool/Fecal Accident
- Poor Appetite
- Jaundice

**Genitourinary:**

- Kidney Stones
- Pelvic Pain
- Incontinence
- Burning or Pain on Urination
- Blood in Urine
- Difficult Urination
- Men: Prostate Problems

**Musculoskeletal:**

- Joint Pain/Arthritis
- Muscle or Joint Weakness
- Back Pain
- Bone Pain
- Muscle Aches

**Neurological:**

- Numbness/Tingling
- Arm or Leg Weakness
- Light-Headed/Dizzy/Fainting Spells
- Tremors/Headaches

**Psychiatric:**

- Anxiety/Agitation
- Depression
- Crying for No Reason
- Insomnia
- Alcoholism
- Drug Problem

**Hematologic:**

- Easy Bruising
- Gum or Nose Bleeding
- Blood Transfusions

**Endocrine:**

- Heat or Cold Intolerance
- Excessive Skin Dryness
- Excessive Thirst
- Excessive Urination
- Weight Problem
- Hot Flashes

**Breast:**

- Rashes or Itching
- Changing in Skin Color
- Varicose Veins
- Skin Cancer
- Breast Pain/Lump
- Breast Discharge
- Breast Rash

**Allergies/Immunology:**

- History of Allergies
- Chronic Infections



Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

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**Family Medical History:** Indicate any family members with cancer, blood disease or other disease.

	Age	Disease	If deceased, cause of death
Father:	_____	_____	_____
Mother:	_____	_____	_____
Siblings:	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

**MEDICATION LIST**

Your treatment can be affected by any medication that you take, and it is important that your physician has updated and correct information.

**Drug Allergies:** List all medication allergies

Medication: _____	Reaction: _____
Medication: _____	Reaction: _____
Medication: _____	Reaction: _____
Medication: _____	Reaction: _____

**Are you allergic to:**

- Iodine    Latex    Shellfish    CT Scan Dye / IV Contrast    Eggs    Peanuts

Other: \_\_\_\_\_

Type of Reaction: \_\_\_\_\_



Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

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### CURRENT MEDICATION LIST

List all medications (including non-prescription) that you are currently taking:

Medication	Dose	Frequency	Ordering Physician



**AUTHORIZATION AND RELEASE TO BE PHOTOGRAPHED  
FOR ELECTRONIC MEDICAL RECORDS**

I authorize Low Country Cancer Care (LCCC/AOP), a division of American Oncology Partners, P.A. (LCCC/AOP), to take my photograph (digital camera/video may be used). These photos may then be placed in my LCCC/AOP electronic medical record for identification purposes and/or medical documentation.

By signing this, I verify that I have received a copy of this authorization form for my records.

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Patient Name (Print)

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Patient or Guarantor (Signature)

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Date





## REQUEST FOR RELEASE OF RECORDS

I, \_\_\_\_\_, request a copy of my complete medical record from the office of:

\_\_\_\_\_

Name and address of practitioner

**To be sent to Low Country Cancer Care:** *(Internal use)*

\_\_\_\_\_

Address, City, State, Zip Code

\_\_\_\_\_

Fax/Telephone Number

\_\_\_\_\_ I give permission to release my medical records to the above listed person, company or medical facility. I understand that my records will be sent via telephone communication.

It is my understanding that by signing this authorization for release of my records, I am giving permission for Low Country Cancer Care (LCCC/AOP) to receive copies of any medical, psychiatric, AIDS, AIDS-related syndromes, HIV testing, alcohol and/or drug abuse related information for the above listed person(s) or organization. I also understand that this authorization may be revoked at any time except to the extent action has been taken prior to revocation. This consent is valid indefinitely until there is written communication received to revoke.

\_\_\_\_\_DISCLAIMER: Not signing does not prevent me from receiving care.

\_\_\_\_\_

Patient Name (Print)

\_\_\_\_\_

Date

\_\_\_\_\_

Patient Date of Birth

\_\_\_\_\_

Patient or Guarantor (Signature)

\_\_\_\_\_

Date



**CONSENT TO DISCLOSE MEDICAL INFORMATION**

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

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Please check one of the following:

\_\_\_\_\_ I give permission to the employees of Low Country Cancer Care (LCCC/AOP), a division of American Oncology Partners, P.A. to disclose my Protected Health Information to me and the following individual(s):

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

\_\_\_\_\_ I request that all my Protected Health Information be disclosed ONLY to me and no other **individual(s)**.

I understand that I may revoke or change this Consent at any time by filling out another Consent form to replace this one.

\_\_\_\_\_  
Patient Name (Print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient or Guarantor (Signature)



**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

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**INSURANCE INFORMATION**

**Primary Insurance Carrier:** \_\_\_\_\_

Name of primary policy holder: \_\_\_\_\_

Policy#/Group ID: \_\_\_\_\_

Policy holder's date of birth: \_\_\_\_\_ Policy holder's SS#: \_\_\_\_\_

Policy holder's employer: \_\_\_\_\_

Does plan have prescription coverage?  Yes  No

**Secondary Insurance Carrier:** \_\_\_\_\_

Name of secondary policy holder: \_\_\_\_\_

Policy#/Group ID: \_\_\_\_\_

Policy holder's date of birth: \_\_\_\_\_ Policy holder's SS#: \_\_\_\_\_

Policy holder's employer: \_\_\_\_\_

Does plan have prescription coverage?  Yes  No

**Pharmacy Insurance Carrier:** \_\_\_\_\_

Name of pharmacy policy holder: \_\_\_\_\_

Policy#/Bin# \_\_\_\_\_

I certify that the information provided is accurate. I will notify Low Country Cancer Care (LCCC/AOP), a division of American Oncology Partners, P.A. of any changes as soon as they become available. I understand that it is my responsibility to update us of any changes to my insurance plan or I may be held liable for the full balance of my treatment.

\_\_\_\_\_  
Patient Name (Print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient or Guarantor (Signature)



## FINANCIAL POLICIES AGREEMENT

Dear Valued Patient,

**Thank you for choosing Low Country Cancer Care, a division of American Oncology Partners, P.A. (LCCC/AOP), as your health care provider.** Our physicians are committed to providing you with the highest quality care.

Prior to receiving treatment, please read and acknowledge our patient financial policies:

- You agree to provide LCCC/AOP with current and accurate insurance, health care benefits program and/or other payer information, and to immediately notify us if your coverage changes.
- You agree that these policies apply to you, and may change from time to time without notice.
- You acknowledge that LCCC/AOP will bill your insurance plan or program for services provided by LCCC/AOP and you agree you are assigning your right to receive payment or benefits from such insurer or program to LCCC/AOP and you are authorizing payment to be made directly to LCCC/AOP.
- You agree you are responsible for payment to LCCC/AOP of all co-pays, deductibles and co-insurance applicable under your insurance policy, plan or program. You understand that payment of such amounts is due at the time of service.
- Depending on your insurer, plan or program, some services may not be covered. If your insurance does not authorize or cover a service or treatment and you nevertheless decide to receive such service or treatment, you agree that you are responsible for payment. This applies to all payers in accordance with all applicable law and regulation and payer requirements (including any “advance beneficiary notice” (ABN) which may be applicable under Medicare).
- To facilitate payment of claims, to perform internal operations and to coordinate your care with other health care providers, LCCC/AOP will use your personal health information internally and will share such information with your insurance policy and certain business associates of LCCC/AOP in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other applicable federal and state law and regulation.
- LCCC/AOP owns and operates AON Pharmacy, LLC, a specialty pharmacy that provides certain pharmaceuticals that may be prescribed by your LCCC/AOP physician and may be covered under your medical or pharmacy benefits plan or program (such as Medicare Part B or Part D). You are not obligated to use AON Pharmacy, LLC and may have your prescriptions filled wherever you choose. However, if you select AON Pharmacy, LLC to fill LCCC/AOP-issued prescriptions, then this policy and all other LCCC/AOP patient financial responsibility policies will also apply to the items and services provided to you by AON Pharmacy, LLC.
- You acknowledge that laboratory and/or radiology services may be necessary as part of your care and treatment which may be performed by LCCC/AOP clinicians at LCCC/AOP’s own facilities. In some cases, services may be provided by outside facilities, in which case, you understand that you may receive a separate bill directly from the outside provider.
- If you make a payment to LCCC/AOP that results in a surplus on your account (i.e., a credit balance), LCCC/AOP may hold that amount as a deposit against charges that are subject to ongoing claims processing or charges for scheduled future services, and LCCC/AOP may apply the surplus against such pending or future scheduled charges. If a surplus still remains after applying all credits, or if at the conclusion of your care a credit balance remains which is not subject to return to your insurer or other payer, LCCC/AOP will refund the credit balance to you. However, you agree that any refund under \$10.00 will be made only if you make a written request and, in any event, any credit balance under \$10.00 will be forfeited if a refund request is not received within five (5) years after the conclusion of your care.



**LOW COUNTRY  
CANCER CARE**

A DIVISION OF AMERICAN ONCOLOGY PARTNERS, P.A.

***Hematology • Oncology***

**I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE PATIENT FINANCIAL POLICIES.  
A COPY IS AVAILABLE TO THE PATIENT UPON REQUEST**

\_\_\_\_\_  
Patient Name (Print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient or Guarantor (Signature)

**For office use:**

\_\_\_\_\_  
Name (Print)

\_\_\_\_\_  
LCCC/AOP Employee (Signature)



**MEDIGAP**

*Only applicable for patients with secondary insurance to Medicare*

**Name of Beneficiary:** \_\_\_\_\_

**Health Insurance Claim Number:** \_\_\_\_\_

**Medicare Beneficiary Identifier:** \_\_\_\_\_

**Medigap Policy Number:** \_\_\_\_\_

I request that payment of authorized Medigap benefits be made on my behalf to Low Country Cancer Care, a division of American Oncology Partners, P.A., (LCCC/AOP) or AON Pharmacy, LLC for any services furnished by \_\_\_\_\_  
\_\_\_\_\_. I authorize any holder of medical information about me to release to \_\_\_\_\_  
Physician Name any information concerning this Medicare claim, because my signing this  
Insurance Name authorization will cause Medicare payment information to cross over automatically.

\_\_\_\_\_  
Patient Name (Print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient or Guarantor (Signature)



**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

By signing this form, you acknowledge that you have received or have been informed that you have the right to receive a copy of the Low Country Cancer Care, a division of American Oncology Partners, P.A., (LCCC/AOP) Notice of Privacy Practices.

This notice is available in hard copy by verbally requesting a copy at the front desk of any Low Country Cancer Care, a division of American Oncology Partners, P.A., (LCCC/AOP) facility or by submitting a request in writing to the corporate office at Low Country Cancer Care, a division of American Oncology Partners, P.A., (LCCC/AOP), Forum Corporate Parkway, Suite 350, Fort Myers, FL 33905.

You may also view and/or print a copy of the Notice of Privacy Practices by visiting [AONcology.com/policies/LCCC\\_NPP.pdf](http://AONcology.com/policies/LCCC_NPP.pdf)

Date: \_\_\_\_\_

\_\_\_\_\_  
Patient Name (Print)

\_\_\_\_\_  
DOB

\_\_\_\_\_  
Patient (Signature)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient or Guarantor (Signature)

\_\_\_\_\_  
Date



By signing below, I authorize Low Country Cancer Care, a division of American Oncology Partners, P.A., (LCCC/AOP) its affiliate and subsidiary entities, and AON Pharmacy, LLC (and any authorized LCCC/AOP texting service vendor) to contact me by SMS text message for health-related notifications, including appointment reminders and billing communications.

I understand that message/data rates may apply to messages sent by LCCC/AOP under my cell phone plan.

I know that I am under no obligation to authorize LCCC/AOP to send me text messages. I may opt-out of receiving these communications at any time by responding with "STOP".

I understand that text messages are not a substitute for professional or medical attention.

By signing below, I indicate I am the person legally responsible for all use of mobile accounts, that I am at least 18 years of age, and that I agree to all terms and conditions of use for the text messaging services.

PLEASE MARK THE FOLLOWING:

- I consent to receiving information via text. I understand I can withdraw my consent at any time.  
Text Cell # \_\_\_\_\_
- I do not consent to receiving any information via text. I understand that I can change my mind and provide consent later.

\_\_\_\_\_  
Patient Name (Print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient (Signature)