



Name: _____

Person#: _____

Date: _____

RevBy: _____

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____ Suffix: _____

Home Phone: _(____)_____ Work: _(____)_____ Cell: (____)_____

Preferred Contact#: Home Work Cell Marital Status: Sing Mar Div Wid Sep

SSN: _____ DOB: _____ Sex: M F

Preferred Language: English Spanish Other _____

Street Address/City/State/Zip: _____

Billing Address: _____

Email Address: _____ Employer/Occupation: _____

Full Time Resident? Y N If No, Other Address: _____

Primary Care Physician: _____ Address: _____

Who Can We Thank For Referring You To Our Practice:

- Eye Doctor: _____ Other Doctor: _____
- Family/Friend Insurance Employer Website TV Magazine Newspaper Internet Billboard
- Yellow Pages MFE Bus Seminar/Health Fair Other _____

GUARANTOR OR RESPONSIBLE PARTY: Self (Patient) Other (If Patient Is Minor)

If Other, Last Name: _____ First Name: _____ MI: _____ Suffix: _____

Home Phone: _(____)_____ Work: _(____)_____ Cell: (____)_____

DOB: _____ Relationship To Patient: _____

EMERGENCY CONTACT (Other than telephone number listed above)

Name: _____ Relationship To Patient: _____

Home Phone: _(____)_____ Work: _(____)_____ Cell: (____)_____

PRIMARY MEDICAL INSURANCE

Company: _____ ID#: _____ Group#: _____

Policyholder Name: _____ DOB: _____ Relationship To Patient: _____

SECONDARY MEDICAL INSURANCE

Company: _____ ID#: _____ Group#: _____

Policyholder Name: _____ DOB: _____ Relationship To Patient: _____

VISION INSURANCE **** (Please Note, not all Routine Vision Plans accepted. Please notify the front desk staff to confirm eligibility.)****

ID#: _____ Group#: _____ Policyholder Name: _____

DOB: _____ Relationship To Patient: _____

X _____ **X** _____

Patient Signature

Date

Guarantor Signature

Date

ALTERNATIVE CONTACT/PREFERRED METHOD OF COMMUNICATION FORM

RevBy:

We at Mid Florida Eye Center take your medical confidentiality very seriously. We will not and cannot release information without your written authorization.

This authorization allows our staff to speak with only an individual(s) you designate in the event you are not available to receive phone calls or you have an adult member that helps coordinate your medical care. You should not designate your doctor.

As part of our Patient Privacy Policy, we will not leave any health information with any other person unless you specifically authorize below:

Option 1

(initials) _____ I do **NOT** authorize anyone to receive information regarding my medical care.

Option 2

I authorize my physician and the employees of this clinic to speak with:

1. (Name) _____, my (relationship to patient) _____,
their phone number is: _____, regarding my **APPOINTMENTS AND ACCOUNT/BILL.**

2. (Name) _____, my (relationship to patient) _____,
their phone number is: _____, regarding my **MEDICAL CARE AND TREATMENT** including Test
Results and Lab Results.

Electronic Communication is my preferred method: Yes No

(In order to electronically communicate with you or anyone you designate; we are required to have your written permission. Communication may be in the following forms: Home Phone/Answering Machine, Cell Phone: Voicemail, Cell Phone: Text-Messaging, E-mail, Mail, or Work Phone.)

This authorization will remain in effect unless changed by me while I am a patient at this office. It is my responsibility to notify this office of changes and to complete a new form. Any problems and/or questions concerning this form are to be referred to the Privacy Officer.

I agree that should I desire to revoke this authorization, I will give written notice.

X _____
Patient Signature

Date

X _____
Guarantor Signature

Date



Patient Name: _____
Date of Birth: _____
Patient Account #: _____

REFRACTION WAIVER

Planned procedure: Refraction

Fee Quote: _____ \$69

What is a Refraction? - A refraction is an important measurement that determines the best potential vision of your eyes.

Why is it necessary? - It is necessary to perform a refraction to determine whether eye diseases or refractive errors are responsible for your current visual acuity. A refraction is performed at a new patient visit, an annual visit, a cataract consultation, or anytime there has been a change or decrease in vision.

The purpose of this notice is to help you understand that it may be necessary to have tests performed during the course of your treatment that may or may not be covered by your insurance. Due to the nature of your presenting symptoms/problems it is vital that the physician perform these tests to accurately diagnose or determine a treatment plan.

- Insurance does not pay for all of your health care costs. Your insurance only pays for covered benefits. Some items and services are non-covered benefits and your insurance will not pay for them.
- When you receive an item or services that is not a covered benefit, you are responsible to pay for it, personally or through any other insurance that you may have.

Option 1:

I have read the information and understand that the **REFRACTION IS A NON COVERED SERVICE. I accept full financial responsibility** for the cost of the service. I understand the copay and deductible are separate from, and not included in the refraction fee

(initials)

Option 2:

I have read the information and **DEFER the refraction**. I understand my provider **may NOT be able to FULLY EVALUATE my ocular health**.

(initials)

Patient Signature: _____ Date: _____

Parent/Legal Representative: _____ Date: _____

Fee information given and confirmed by: _____ Date: _____

NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to your insurance carrier, your health information on this form may be shared with them. Your health information which your insurance carrier sees will be kept confidential by your insurance carrier

ATTENTION: If you speak Spanish or American Sign Language, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Please speak to your provider.
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Por favor hable con su proveedor

NOTE: Printed copies of this document are uncontrolled. In the case of a conflict between printed and electronic versions of this document, the controlled version published online prevails

CONSENT FOR CARE AND TREATMENT

NAME: _____

DATE: _____

I understand that Patient, which may be defined as me, my child or a child for whom I have legal responsibility, needs medical care and treatment and I consent to such treatment at Mid Florida Eye Center. Treatment provided by medical providers, nurses, and medical assistants at Mid Florida Eye Center may include evaluation and management, laboratory and other testing; routine medical, nursing and medical assistant care and procedures. I understand that photos or video of Patient may be taken in connection with such treatment and for operational, and quality improvement.

No Guarantee: I acknowledge that no guarantees or warranties have been made with respect to treatment or services to be provided by Mid Florida Eye Center. I understand that all supplies, medical devices and other goods provided to Patient are provided by Mid Florida Eye Center AS IS and Mid Florida Eye Center disclaims any expressed or implied warranties.

Patient Rights: I understand that a copy of Patient Rights and Responsibilities is available upon request. This information tells me how to register a complaint or grievance that I might have relating to Patient's care at Mid Florida Eye Center.

Communicable Disease Testing: I agree that if a Mid Florida Eye Center employee or provider is exposed to Patient's blood or other bodily fluid, pursuant to Florida law, Mid Florida Eye Center may test Patient to determine the presence of communicable diseases including Human Immunodeficiency Virus (HIV) and hepatitis. I understand that these test results will be kept confidential.

Specimen Disposal: I acknowledge that Mid Florida Eye Center may, in its sole discretion, remove, retain, or dispose of any tissue or body parts removed from patient.

Text Messaging: I understand that Mid Florida Eye Center can provide notifications to my cell phone. These texts are Do Not Reply texts for informational purposes only and are not intended as a form of two-way communication. I acknowledge that standard text messaging rates and fees will apply. Messages may include private health and billing information protected under federal and state law. Messaging utilizes a public telephone network and full encryption and security is not guaranteed, and any person with access to my phone will be able to see these messages unless I take steps to protect my phone with a password or PIN. I will have the ability to opt out of text messages at any time by using the STOP function.

Accessing Pharmacy Information: I agree that if a Mid Florida Eye Center employee or provider needs to access my pharmacy information that they have my permission to do so.

Non-Discrimination: Mid Florida Eye Center complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin (including limited English proficiency and primary language), age, disability, or sex (consistent with scope of sex discrimination described at § 92.101(a)(2)). Mid Florida Eye Center does not exclude people or treat them less favorably because of race, color, national origin, age, disability or sex. I acknowledge that I have been given a full copy of the Non-Discrimination and Language Assistance Notice, and that I may request an additional copy at any time.

Notice of Language Assistance Services & Auxiliary Aids and Services: Mid Florida Eye Center provides reasonable modifications for individuals with disabilities, and appropriate auxiliary aids and services in compliance with Section 1557, including qualified interpreters for individuals with disabilities and information in alternate formats, including but not limited to large print, Braille, recorded audio, and accessible electronic formats, free of charge and in a timely manner, when such modifications are necessary. Mid Florida Eye Center also provides language assistance services, including electronic and written translated documents and oral interpretation, free of charge and in a timely manner, to those with limited English proficiency. I understand and acknowledge that a copy of the full Non-Discrimination and Language Assistance Notice has been provided to me at least annually and/or upon my request and in the language or other format that I require, and that I have the option to opt out of receiving this full notice. I understand that Mid Florida Eye Center does not condition the receipt of any aid or benefit on my decision to opt out. I also understand that opting out of receiving the Notice is not a waiver of my right to receive assistance services or auxiliary aids. I acknowledge that should I decide to opt out of receiving the Notice that Mid Florida Eye Center will document my decision to opt out in my patient file. I acknowledge that Mid Florida Eye Center will document my primary language and any appropriate auxiliary aids and services that I require and will provide those services to me as needed.

X _____

Patient Signature

Date

X _____

Guarantor Signature

Date

PRIVACY PRACTICES ACKNOWLEDGEMENT

Notice of Privacy Practices for Mid Florida Eye Center

Our "Notice of Privacy Practices" policy, available at the reception desk and also online at our website, provides detailed information about how we may use and disclose protected health information about you. The details of this policy are in full compliance with all provisions, including those most recently updated, of the Health Insurance Portability and Accountability Act passed in 1996 (HIPPA). Our "Notice of Privacy Practices" states that we reserve the right to change terms within our policy. Should this happen, we will display, and make available, the new policy and its perspective date of implementation. You have the right to request restrictions on how your protected health information may be used or disclosed for treatment, payment or health care operations. We are not required to agree with your restrictions; however, if we do, we are bound by our agreement with you.

By signing below, I acknowledge receipt of "Notice of Privacy Practices" and consent to your use and disclosure of protected health information about me for treatment, payment, and health care operations. I have the right to revoke this consent, in writing, except where the practice has already made disclosures in trust on my prior consent.

X _____
Patient Signature

Date

X _____
Guarantor Signature

Date

NOTICE OF NON-COVERED SERVICES

Your vision insurance and/or medical insurance may not cover certain services performed during your eye examination. These services are considered non-covered services and may result in out-of-pocket expenses.

REFRACTION

A refraction is an important measurement that determines the best potential vision of your eyes. Refractions are often considered a non-covered service by many medical insurance plans.

The fee for a refraction is **due at the time of service** if not covered by your insurance.

Refraction Fee: \$69

CONTACT LENS FITTING

A contact lens fitting is a separate service from a routine eye examination and includes assessment of contact lens fit, prescription determination, lens recommendations, and any necessary follow-up care related to contact lens wear. Contact lens fittings and evaluations are often not covered by medical insurance and may not be fully covered by vision plans.

Fees vary based on the complexity of the fitting and the type of contact lenses prescribed.

Estimated Contact Lens Fitting Fee: \$80-\$225

I understand that refraction and contact lens fitting services may not be covered by my insurance plan. I am responsible for payment of any charges not covered by my insurance. Payment is due according to the practice's financial policies. The estimated fees listed above are estimates only and actual charges may vary based on services provided.

By signing below, I acknowledge that I have been informed that these services may not be covered by my insurance and that I accept financial responsibility for any non-covered charges.

X _____
Patient Signature

Date

X _____
Guarantor Signature

Date

At Mid Florida Eye Center, you can expect to receive medical services in a professional and caring manner. We are committed to providing you with the highest level of service and quality care. In return, it is your responsibility to provide your insurance information. Please have your photo identification and current insurance information available at your visit to ensure that your claim can be processed promptly.

1. **APPOINTMENTS:** We request that you keep scheduled appointments and arrive at the appointed time. If you are unable to keep your appointment, please give at least 48 hours notice. [Cancellations of less than 24 hours prior to your appointment, or a No-Show for your appointment, will result in a minimum \$75 fee per patient, excluding Medicaid patients.] We reserve the right to not make additional routine appointments for you should you have any remaining balance for previous treatment you received with our offices. Additionally, any outstanding balance will need to be addressed before checking in for an appointment.

2. **CO-PAYS:** According to your insurance contract, you are obligated to pay any co-pay (a small fixed amount required by your health insurer), deductible (amount you are liable before your health insurer will make payment), or co-insurance (percentage of total cost of medical expenses after your deductible has been reached) due at the time of service. IF you are unable to pay the co-pay at the time of service, we retain the right to cancel or reschedule your appointment to a time when you are prepared to pay your co-pay. Furthermore, if your appointment is kept without payment of the co-pay at the time of service, we retain the right to levy an administrative charge of \$10 to your account in order to defray the cost of securing the co-pay.

3. **CREDIT CARD FEES:** We reserve the right to pass through credit card processing fees where allowed by state and federal guidelines. If we elect to pass through the credit card processing fee we will advise the patient with a line-item invoice after services have been rendered. Normally, we will levy up to a 2% fee for all credit cards used to pay for services. Fee determination will be in accordance with credit card processor policy as well as state regulation.

4. **PRESCRIPTION REFILLS/FORMS:** Please request any prescription refills and present any forms that need to be completed at the start of your examination. At that time, we have full access to your complete record and can fulfill your request. We reserve the right to charge the state allowable amount for filling out and completing forms or attorney requests for your various needs (ie, SSI, disability, etc.).

5. **EYE EXAMS & GLASSES:** This policy will only apply if you need to purchase eyeglasses and/or contact lenses. You may request a copy of the full policy/procedure for your records. • One Rx check within 90 days of original exam • One Rx remake within 90 days of original order date • One lens remake is allowed during 1 year warranty period • One frame restyle allowed within 30 days including a fee of \$50 • Frames carry a manufacturer warranty against defects for 1 year • All eyewear and/or contact lens orders must be paid in full prior to submitting to vendor • All sales are final

6. **REFERRALS:** If your insurance plan requires a referral, the referral must be presented before seeing a physician. If you do not have the required referral, we reserve the right to reschedule your appointment or you will have to be willing to be responsible for the entire cost of the examination. You will be NOTE: Printed copies of this document are uncontrolled. In the case of a conflict between printed and electronic versions of this document, the controlled version published online prevails. presented with a waiver acknowledging your acceptance as self-pay, and payment will need to be made at the time of service.

7. **RETURNED CHECKS:** Any payment made by check that does not clear our bank account will result in a fee for insufficient funds. Our fee for insufficient funds is \$25 and will be added to your account for each bounced check.

8. **OTHER INSURANCE:** I understand that Mid Florida Eye Center participates with multiple insurance plans and that not all Doctors in the Practice participate with all plans or products within the plans. I understand that it is my responsibility to verify with my insurance carrier that my physician currently participates with my plan. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by Mid Florida Eye Center if I belong to a plan with which Mid Florida Eye Center does not participate.

9. **NON-COVERED SERVICES:** I understand that Mid Florida Eye Center contracts with health care service plans related only to items and services which are covered by the health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care service plans not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the health care plan service plan furnishes to the patient (i.e. refraction, contact lens fittings) and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with Mid Florida Eye Center to obtain necessary health care service plan authorizations.

(Continued on Next Page)

10. FINANCIAL AGREEMENT: I agree that in return for the services provided to me by Mid Florida Eye Center, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Mid Florida Eye Center for payment. I understand and agree that if my account is delinquent and sent to collections, I may be charged up to 35% in administrative fees. If the account is sent to an attorney to assist with collections, I agree to pay collection expenses and reasonable attorney fees. Any benefits of any type under any policy of insurance insuring the patient, or any other party liable to the patient, is hereby assigned to Mid Florida Eye Center. If copayments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Mid Florida Eye Center. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill. I further understand and agree that if I ignore statements of attempts to collect past due amounts, I may have my ability to schedule appointments and/or receive future services from Mid Florida Eye Center limited including possible dismissal as a patient from the practice.

11. PATIENT STATEMENTS: At Mid Florida Eye Center, all accounts are payable within 30 days after you receive your first statement. Credit is extended as a courtesy, and arrangements will be based on demonstrated needs. Payments keep your account current only when arrangements have been made. Please call customer service to set up payment arrangements. As a result of costs associated with sending statements, Mid Florida Eye Center does not send statements to patients for balances under \$5. Billing statements are suppressed until the patient's balance becomes \$5 or more in patient responsibility. As a result, you may receive a statement long after your last appointment or may be asked to pay small balances when presenting for an appointment without having received a statement. Patients should remit small balances owed to Mid Florida Eye Center upon receipt of their explanation of benefits from their insurance.

12. PATIENT DISMISSAL: I agree and understand that Mid Florida Eye Center may initiate separation and/or dismissal of me as a patient of the practice for any of the following non-exclusive reasons: NOTE: Printed copies of this document are uncontrolled. In the case of a conflict between printed and electronic versions of this document, the controlled version published online prevails.

- (a) Disruptive, aggressive, violent, and/or threatening behavior towards physicians, staff, and/or other patients;
- (b) Repeated failure to attend scheduled appointments;
- (c) Non-compliance with physician instructions and recommended treatment and/or other erosion of physician/patient relationship; and
- (d) Non-payment of past due amounts and/or failure to pay any past due amounts as agreed in any payment arrangement you entered with Mid Florida Eye Center. Please note, making payments that are less than an agreed amount per a payment arrangement will be considered and treated as non-payment for purposes of this provision.

Patients who are dismissed from the practice will be notified in writing and will be given 30 days to find alternative vision care. Appointments for emergency visits will be allowed during the 30 days but payment of an emergency visit will be collected at check-in with any additional amounts due collected at check-out.

The physicians and staff at Mid Florida Eye Center appreciate your confidence in allowing us to participate in your eye care. Your signature indicates that you have read, understand and agree to the financial responsibilities policies and procedures of our office.

X _____
Patient Signature

Date

X _____
Guarantor Signature

Date

PATIENT MEDICAL HISTORY

NAME: _____ DATE: _____

Please check YES or NO if you have or ever had any of the following:

- Y N Cancer - Type_____
 - Y N Taken Flomax / Hytrin / Cardura
 - Y N High Blood Pressure
 - Y N Stroke / CVA
 - Y N Heart Disease / Murmur
 - Y N Heart Attack
 - Y N Congestive Heart Failure
 - Y N Irregular Heartbeat / Palpitations
 - Y N Asthma
 - Y N COPD
 - Y N Migraines
 - Y N Arthritis
 - Y N Sleep Apnea - Use a CPAP? Y N
 - Y N High Cholesterol
 - Y N Thyroid Disease
 - Y N Diabetes - Oral Diet Insulin
 - Y N GERD
 - Y N Kidney Disease
 - Y N Kidney Stones
 - Y N Liver Disease
 - Y N Hepatitis - A B C
 - Y N Auto-Immune Disease - Type_____
 - Y N Infectious Diseases_____
 - Y N Dementia / Memory Loss
 - Y N MRSA
- Have you received a pneumonia vaccine? Y N
- Have you ever smoked? Y N - Do you still smoke? Y N
- Do you drink alcohol? Y N - Daily Occasionally Rarely

SURGERIES

Please check the box if you have had any of the surgeries listed below:

- Bypass
- Pacemaker
- Heart Stents
- Knee Replacement
- Hip Replacement
- Prostate
- Colostomy
- Mastectomy
- No Surgical Procedures
- Thyroidectomy
- Appendectomy
- Gallbladder
- Back Surgery
- Cataract Surgery
- LASIK / RK
- Retinal Detachment
- Cornea Transplant
- Glaucoma Procedure
- Eyelid Procedure

OTHER EYE DIAGNOSIS

Have you been diagnosed with any of the following eye diseases/disorders:

- Cataracts
- Glaucoma
- Macular Degeneration
- Diabetic Retinopathy
- Corneal Disease
- Amblyopia / Lazy Eye
- Other _____
- Other _____
- Other _____

ALLERGIES

Yes - Please list below No Known Allergies Latex Allergy? Yes No

MEDICATIONS

Please list any medications you take, prescription or over the counter; You may provide a list if available:

FAMILY HISTORY

Do you have any FAMILY history of: (Mother, Father, Siblings, Grandparents)

- Diabetes Y N Who: _____
- Glaucoma Y N Who: _____
- Macular Degeneration Y N Who: _____
- Blindness Y N Who: _____
- Adopted/Unknown

X _____
Patient Signature

_____ Date

X _____
Guarantor Signature

_____ Date

REVIEW OF SYSTEMS

NAME: _____ DATE: _____



**CATARACT & RETINA
LASER INSTITUTE**
EXCELLENCE IN EYE SURGERY

Please check all that apply to your **current** and **past** health.
Boxes that are not checked will be considered a negative response.

General / Constitutional

- Overall Healthy
- Weight Loss / Gain
- Fatigue
- Fever and Chills
- Weakness

Integumentary (Skin)

- Skin Cancer
- Rash
- Bruising
- Suspicious growths
- Itching

Ears/Nose/Mouth/Throat

- Dry Mouth
- Sinus Pain / Infections
- Ringing in ears
- Vertigo
- Wears hearing aids

Respiratory

- COPD
- Asthma
- Emphysema
- Oxygen use
- Shortness of Breath

Cardiovascular

- Chest Pain
- Hypertension
- Heart attack
- Heart Surgery
- Palpitations

Gastrointestinal

- Heartburn / Acid reflux
- Diverticulitis
- Nausea
- Hernia
- Ulcers

Musculoskeletal

- Arthritis
- Back pain
- Swelling of joints
- Stiffness
- Muscle pain / joint pain

Neurological

- Memory Loss
- Headaches
- Parkinson's disease
- Seizures
- Tremors

Endocrine

- Diabetes
- Hyperthyroidism
- Hypothyroidism
- Frequent Urination
- Excessive thirst

Psychiatric

- Anxiety
- Depression
- Stress

Allergies / Immunological

- Allergic reaction to medications
- Allergic reaction to foods
- Seasonal / Environmental allergies
- Autoimmune disease

Other conditions or medical problems not listed?:

X _____
Patient Signature

Date

X _____
Guarantor Signature

Date



Name: _____

DOB: _____

Date: _____

Person# _____

VISUAL ASSESSMENT FORM AND LIFESTYLE QUESTIONNAIRE

Occupation: _____

Hobbies: _____

Circle the degree of difficulty you have doing the following activities because of your vision.

Functional Vision Assessment

Circle One

Would you like to be less dependent on glasses??	Distance	Near	Both	
Difficulty seeing street signs or driving (curbs, highway exits, traffic lights, halos/glare in lights)	No	Mild	Moderate	Severe
Difficulty seeing under glare (halos,, starburst, tracking golfball in sky, driving in bright Sunlight, oncoming headlights)	No	Mild	Moderate	Severe
Difficulty seeing TV or movies (faces, numbers, printing)	No	Mild	Moderate	Severe
Difficulty reading small print with glasses (books, newspaper, pill bottles, instructions, cell phone)	No	Mild	Moderate	Severe
Difficulty with personal correspondences (writing checks, reading bills, filling out forms)	No	Mild	Moderate	Severe
Difficulty with leisure activities (playing cards, bingo, bowling, golfing)	No	Mild	Moderate	Severe
Difficulty functioning around the house (cooking, general household upkeep, stairs, telephone)	No	Mild	Moderate	Severe
Difficulty recognizing faces of people (church, grocery store, clubs, other daily activities)	No	Mild	Moderate	Severe

Please circle the activities you would prefer to do with less dependence on glasses:

- Reading Seeing pill bottles Looking at a menu Looking at your watch Using a cell phone
- Card or table games Sewing Applying makeup Using a computer Seeing price tags
- View dashboard of car Seeing price tags/shelves Shopping Bingo Driving
- Playing sports, like golf Watching TV Watching live sports Going to moviesSwimming

X _____
Patient Signature

Date

X _____
Parent or Guardian Signature

Date