PLASTIC & RECONSTRUCTIVE SURGERY
Gregg M. Anigian, M.D., P.A.

MEDICAL HISTORY

Name: _____ Date: _____

Reason for Consultation: _____
_____

Allergies (drug): _____
_____

Age: _____ Height: _____ Weight: _____

Do you smoke: yes/no How Much? _____
Do you drink: yes/no How Much? Never _____ Occasionally _____ Regularly_____

Medications currently taking: (prescription, over the counter, herbal)
_____ _____
_____ _____

Operations: Date: Complications with surgery/anesthesia?
_____
_____

Family History: Is there a history of any of the following in your blood relatives?
Diabetes: _____ Prolonged Bleeding: _____
Hepatitis: _____ Cancer (type): _____
Heart Attack/Stroke: _____ High Blood Pressure: _____

Have you ever had a blood transfusion? _____
Date of last physical exam: _____
Have you ever taken any aspirin-containing drugs in the last two weeks? _____
If female, Date of your last menstrual period: _____

Medical History: (*please mark the appropriate answer if you have a history of:*)

Have you, in the last 21 days, traveled to any of the following countries OR have you had potential contact with person(s) with known or suspected Ebola?
Guinea, Liberia, Nigeria, Sierra Leone, Senegal, Democratic Republic of Congo
Reponses: YES NO (*Please circle one*)
* *Based on the negative response to the screening question no further immediate action, as it pertains to Ebola exposure, was necessary per BSWH guidelines.*

Shortness of breath	yes____ no___	Irregular Pulse	yes____ no___
Visual Problems	yes____ no___	Anemia	yes____ no___
Heart Disease	yes____ no___	Murmurs	yes____ no___
Kidney Problems	yes____ no___	Joint Pains	yes____ no___
Stomach Problems	yes____ no___	Hepatitis	yes____ no___
High Blood Pressure	yes____ no___	Diabetes	yes____ no___
Prolonged Bleeding	yes____ no___	Cancer	yes____ no___
Fainting or Black out spells	yes____ no___	If yes, what type?	_____
Autoimmune Disease	yes____ no___		_____
Viral Diseases	yes____ no___		_____
Herpes (Cold Sores)	yes____ no___		

PLASTIC & RECONSTRUCTIVE SURGERY

Gregg M. Anigian, M.D., P.A.

PATIENT INFORMATION

Referred by:_____ **Phone #:**_____

Name:(First)_____ (MI) _____ (Last) _____
Date of Birth_____ Age _____ Gender: M F Marital Status: S M W D
Address:(Street)_____
(City, State, Zip) _____
Home #:_____ Cell#:_____
Employer:_____ Work#_____
Social Security#:_____ Driver License#_____
Email:_____ Permission to communicate via email: ❑ yes ❑ no
Pharmacy Name:_____ Pharmacy #:_____

Emergency Contact:_____Telephone:_____
Parent/Guardian (if patient is a minor)_____

Spouse Name:_____ Date of Birth:_____
Work#:_____ Cell#:_____

Internist or Family Physician:_____
Telephone#:_____

INSURANCE INFORMATION

(Must be filled out even if copy of insurance card has been made)

Insurance Co:_____ ID #:_____
Primary Insured (if you are not the primary insured this information must be filled out so that a claim can be submitted to your insurance company):_____
Subscriber's Employer:_____ Subscriber's DOB:_____

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including private insurance and any other health plans, to Dr. Gregg M. Anigian. I transfer my title of reimbursement from my insurance company to Dr. Gregg M. Anigian. I hereby agree to pay any and all charges that are not covered by insurance (and any deductible and co-insurance). I also agree to pay any charges incurred during a grace period if I have insurance purchased thru the marketplace. I hereby authorize said assignee to release all information necessary to secure payment. I authorize my insurance claim form to be sent via electronic claim filing. I authorize the release of my medical records or insurance claims to be sent via fax or email. I understand that I am financially responsible for any and all charges whether or not they are covered by insurance.

I authorize Dr. Gregg M. Anigian to disclose complete information concerning his medical findings and treatment of the undersigned, from the initial office visit until the date ofthe conclusion of such treatment, to those individuals who, in Dr. Gregg M. Anigian's sole determination, are required to receive such information for the purpose of medical treatment, scheduling a procedure with another facility/anesthesia, medical quality assurance , peer review and outside coding/billing services via e-mail or fax. I understand this is my private health information and by signing this agreement I am authorizing this information to be faxed or emailed. This Assignment/Agreement will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

Patient's Signature: _____ **Date:**_____

Witness Signature:_____
(REV. 7/2015)

PLASTIC & RECONSTRUCTIVE SURGERY

Gregg M. Anigian, M.D., P.A.

FINANCIAL POLICY

Thank you for choosing Dr. Gregg M. Anigian as your health care provider. We are committed to providing excellent health care services to you, our patient. As a part of our professional relationship, it is important that you have an understanding of our financial policy.

All patients must read and sign this form prior to receiving services.

Payments for services are due at the time services are rendered unless payment arrangements have been approved in advance by our staff. We accept cash, checks, MasterCard and Visa.

COSMETIC: There is a fee for cosmetic consultations and payment is due the day of the visit. Payment in full is required two weeks in advance for patients who undergo cosmetic procedures. A $25 no show fee may be assessed if you do not cancel your appointment within 24 hours prior to you appointment. A $50 fee is assessed for personal checks that are returned due to insufficient funds.

INSURANCE: Plan provisions require patients present a current insurance card at time of service otherwise, payment is due in full, and no adjustment will be made later. If we are not a contracted provider with your insurance plan, full payment is expected at the time service is rendered. A $ 25 no show fee may be assessed if you do not cancel your appointment within 24 hours prior to you appointment. A $50 fee is assessed for personal checks that are returned due to insufficient funds.

It is your responsibility to provide us with your most current insurance information. If you fail to provide accurate insurance information in a timely manner, your insurance company may deny the claim. If the claim is denied, you will be financially responsible for services rendered.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize, however, that:

* Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract. It is your responsibility to know and understand the level of services covered by your insurance company.
* Our fees are generally considered to fall within the acceptable range by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies that pay a percentage (such as 50% or 80%) of "U.C.R.". "U.C.R." is defined as usual, customary, and reasonable.
  This statement does not apply to companies that reimburse based on an arbitrary "schedule" of fees, which bears no relationship to the current standard of cost and care in this area.
* Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. In the event your service is not covered by your insurance carrier, you will be responsible for payment of that service and will be billed accordingly.
* Copayments, coinsurance and/or deductibles are due at the time of service. We will estimate the amount you owe based on information we receive from your insurance company. However, you are responsible for paying the full amount determined by your insurance company once they have paid your claim – regardless of our estimation.
* If payment from your insurance company is not received within 45 days from the date of service you will be responsible for payment in full.

We must emphasize that, as a medical care provider, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the service is rendered. We realize that temporary financial problems may affect timely payment on your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

I have read the above and as the patient or his duly authorized representative understand and accept these terms.

SIGNATURE:_____ **DATE:**_____

Gregg M. Anigian, M.D., P.A., FACS

Plastic Surgery

Dear Patient:

We are pleased that you have chosen the office of Dr. Gregg Anigian for a consultation and we look forward to meeting you. For your convenience, several items are enclosed:

- **Patient Information Questionnaires** (2 pages-front & back). Please fill out the attached forms and bring back with you on the day of your appointment.
- **Your appointment card.**
- **HIPPA** compliance information for your file.

LOCATION:
We are located in Presbyterian Professional Bldg. II, on the east side of the Presbyterian Hospital of Dallas complex, which is located east of 75 Central Expressway and south of 635 LBJ Freeway. The entrance to our building is on Walnut Hill Lane near the intersection of Greenville Avenue.

Parking is located in the front, the side and rear of our building and requires payment to exit the lot ($1.00-$3.00). Validation for parking is not available through our office. Please allow ample time to reach our office, especially during inclement weather.

MEDICAL INFORMATION:
Your first office visit is only for a consultation. If surgery is required, the specifics will be discussed during the consultation.

Please bring with you any medical reports that concern this visit, such as previous biopsy reports, x-ray reports and films, mammogram or sonogram reports and films.

MEDICAL INSURANCE:
PLEASE BRING YOUR INSURANCE CARD WITH YOU. We require 2 forms of identification, therefore insurance cards are required for all consultations. If you do not have your insurance card, we will be happy to keep your appointment but we will not be able to file a claim for your visit. If we are not a participating provider with your insurance plan, or you do not have your insurance card, full payment is expected at the time service is rendered and our office will not file a claim. Please inform our office of any insurance changes.

If you are covered by a HMO/PPO plan, please make sure Dr. Gregg Anigian is a listed provider. It is also your responsibility to obtain an authorization/referral number from your primary care physician (PCP), prior to your visit if your plan requires one.

COSMETIC CONSULTATIONS:
Cosmetic consultations are $50 and if you proceed with surgery $50 is deducted from the surgery fee.

APPOINTMENT CANCELLATIONS:
If you are unable to make your scheduled appointment please call our office 24 hours prior to your appointment and we will be happy to assist you in rescheduling.

PAYMENT METHODS:
Acceptable of payments are cash, check or credit card. We accept Visa, Mastercard or Discover.
Again, we look forward to meeting you and establishing a long-term relationship. If you have any questions please do not hesitate to call our office.

Best regards,
Dr. Gregg Anigian's office

Certified, American Board of Plastic Surgery
Fellow of the American College of Surgeons
8220 Walnut Hill Lane ∫ Suite 108 ∫ Dallas, Texas 75231
214/369-0006 ∫ Fax 214/369-0190

The American Society for Aesthetic Plastic Surgery, Inc.

AMERICAN SOCIETY OF PLASTIC SURGEONS

NOTICE OF PRIVACY PRACTICE

Gregg M. Anigian, M.D.,P.A.
North Dallas Surgery Center, LLP.

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

If you have any questions about this Notice, please contact our Privacy Contact, Debra Dickerson.

This medical practice collects health information about you and stores it in a chart (and on a computer)(and in an electronic health record/personal health record). This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

Treatment. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services that we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that preforms a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured, or after you die.

Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

Health Care Operations. We may use and disclose medical information about you to operative this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population-based efforts to improve health or reduce health care costs, their protocol development, case management or care-coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts.

Appointment Reminders. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.

Sign In Sheet. We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

Notification and Communication With Family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you had instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster, even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

Marketing. Provided we do not receive any payment for making these communications, we may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or setting of care that may be of interest to you. We may similarly describe products or services provided by this practice and tell you which health plans this practice participates in. We may also encourage you to maintain a healthy lifestyle and get recommended tests, participate in a disease management program, provide you with small gifts, tell you about government sponsored health programs or encourage you to purchase a product or service when we see you, for which we may be paid. Finally, we may receive compensation, which covers our cost of reminding you to take and refill your medication, or otherwise communicate about a drug or biologic that is currently prescribed for you. We will not otherwise use or disclose your medical information for marketing purposes or accept any payment for other marketing communications without your prior written authorization. The authorization will disclose whether we receive any compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization.

Required by Law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

Public Health. We may, and are sometimes required by law, to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

Health Oversight Activities. We may, and are sometimes required by law, to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by law.

Judicial and Administrative Proceeding. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery requires or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

Law Enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of death.

Organ or Tissue Donation. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

Public Safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

Proof of Immunization. We will disclose proof of immunization to a school that is required to have it before admitting a student where you have agreed to the disclosure on behalf of yourself or your dependent.

Specialized Government Functions. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

Workers' Compensation. We may disclose your health information as necessary to complete with workers' compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

Change of Ownership. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

Breach Notification. Inn the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current e-mail address, we may use e-mail to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate.

Psychotherapy Notes. We will not use or disclose your psychotherapy notes without your prior written authorization except for the following: 1) use by the originator of the notes for your treatment, 2) for training our staff, students and other trainees, 3) to defend ourselves if you sue us or bring some other legal proceeding, 4) if the law requires us to disclose the oversight activities concerning your psychotherapist, 6) to avert a serious and imminent threat to health or safety, or 7) to the coroner or medical examiner after you die. To the extent you revoke an authorization to use or disclose your psychotherapy notes, we will stop using or disclosing these notes.

Research. We may disclose your health information to researchers conducting research with respect to which your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.

When this medical practice may not use or disclose your health information: Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

Your Health Information Rights

Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.

Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

Right to Inspect and Copy. You have the right to inspect and copy your health information with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible within 60 days of receiving a written request, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also send a copy to any other person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.

Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. All information related to any request to amend will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

Right to a Paper or Electronic Copy of this Notice. You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail.

If you would like a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

Changes to this Notice of Privacy Practices. We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with the terms of this Notice currently in effect. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment.

Complaints. Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Office listed at the top of this Notice of Privacy Practices. If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

DHHS Office of Civil Rights, OCRMail@hhs.gov.

The complaint form may be found at:
www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf.

You will not be penalized in any way for filing a complaint.

This notice was published and becomes effective on September 23, 2013.

GREGG M. ANIGIAN, M.D., P.A.

8220 Walnut Hill Lane, Suite 108, Dallas, Tx. 75231

Phone: 214-369-0006, Fax: 214-369-0190

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

In our efforts to comply with the Health Insurance Portability and Accountability Act (HIPPA), we need to be certain that we guard your privacy according to your wishes when it comes to your family, friends and co-workers.

Please circle your response to the following:

May we leave messages on your cell phone? YES NO N/A

May we leave messages on your voice mail at home? YES NO N/A

May we leave messages on your voice mail at work? YES NO N/A

May we leave messages concerning your appointments with co-worker, receptionist or secretary that regularly answers your calls? YES NO N/A

May we correspond with you via e-mail regarding your personal health information, appointments, office specials & events? YES NO N/A

Your email address: _____@_____

May we discuss your appointment, treatment or financial issues with your spouse?

YES NO N/A

Please list the names of your Spouse/Family Member/Caretaker or Friend that we may discuss your appointments, treatments or financial issues with:

1.

2.

If you are over the age 18 and living at home, may we discuss your appointments, treatments or financial issues with your parent(s) or guardian?

Parent(s) Guardian name: _____ YES NO N/A

You must inform our office, in writing, of any changes in your directives. This consent takes effect on the date indicated below. Please sign and acknowledge that you have received a copy of our Notice of Privacy Practice.

Signature:_____ Date: _____

Print Name:_____ Date of Birth: _____

PLASTIC & RECONSTRUCTIVE SURGERY

Gregg M. Anigian, M.D., P.A., FACS
8220 Walnut Hill Lane Suite 108
Dallas, Texas 75231
214-369-0006 (phone) 214-369-0190 (fax)

Insurance Coverage

I understand during the course of my office visits/treatments with Dr. Gregg Anigian, that it is my responsibility to inform the office of ANY insurance changes prior to my visit/treatment to ensure Dr. Anigian is properly reimbursed.

If I do not inform Dr. Anigian's office of my insurance changes and my visit/treatment is denied by the insurance company, I understand I will be financially responsible for any fees incurred including office consultations and surgeries performed by Dr. Gregg Anigian.

I acknowledge that Dr. Anigian's office has advised me to not change insurance plans during the course of being treated by Dr. Anigian due to the possibility non-payment by my insurance.

I also acknowledge that if I have a secondary insurance plan, Dr. Anigain's office will not file with the secondary insurance – only the primary insurance.

Patient's Name: _____

Patient's Signature: _____

Date: _____

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

I am authorizing the office of Dr. Gregg M. Anigian, M.D., P.A. to release my protected health information Via fax or e-mail for purposes of scheduling my procedure, scheduling of anesthesia, ordering supplies, billing purposes, filing of any insurance claim or any purpose Dr. Anigian's office deems necessary.

Patient's Name: _____

Patient's Signature: _____

Date: _____