FULLER DIAGNOSTICS, LLC

INTAKE PAPERWORK PACKET

CHILD & ADOLESCENT FORMS

_____

Name of Patient

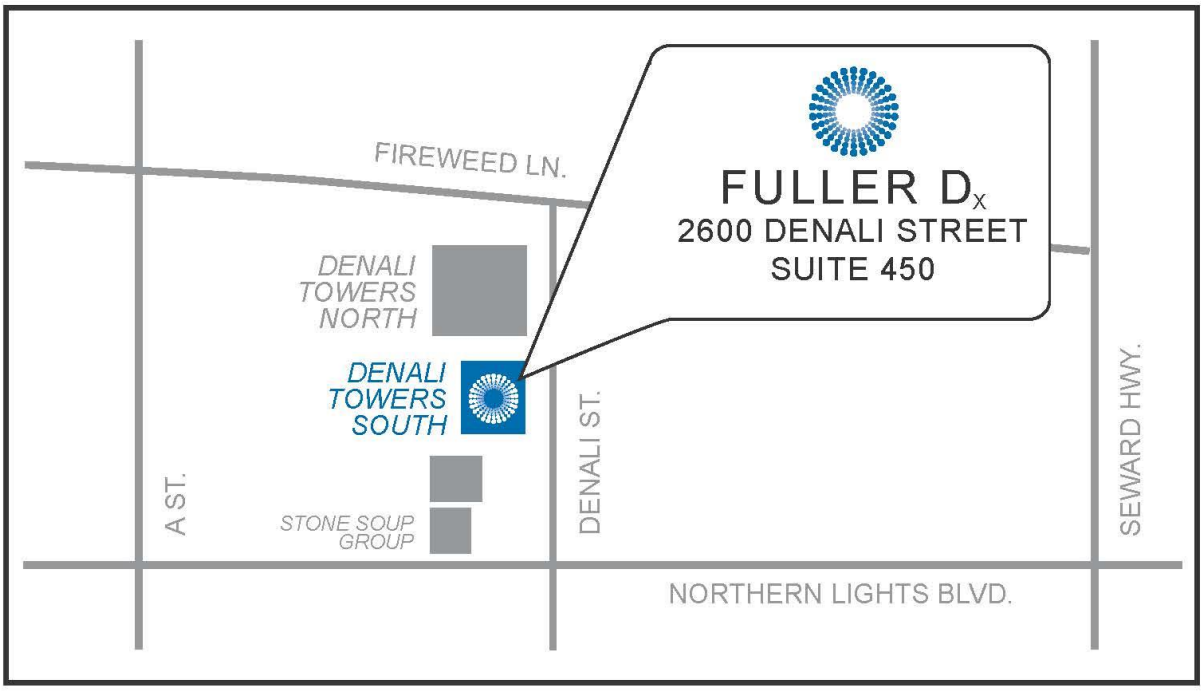
_____ ___/___/_____

Person Completing Date

Fuller Diagnostics, LLC • 2600 Denali Street, Suite 450 • Anchorage, Alaska 99503
Phone: 907.561.0552 *Fax:* 907.561.0562 *Email:* info@fulleralaska.com *Website:* www.fulleralaska.com

FULLER DIAGNOSTICS, LLC

NEUROPSYCHOLOGICAL ASSESSMENT • INDIVIDUAL & FAMILY THERAPY



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FULLER DIAGNOSTICS, LLC

Thank you for choosing FULLER DIAGNOSTICS, LLC. You will need to complete the information packet and return it prior to the initial scheduled appointment. If for any reason you are unable to complete the paperwork please contact our office. The information you provide will be used during the interview with your provider to better focus the time on specific concerns.

Please return this completed form to our office as soon as possible, you may send it via email, fax or mail.

Email: info@fulleralaska.com **Fax:** 907.561.0562

Mailing Address: Fuller Diagnostics, LLC • 2600 Denali Street, Suite 450 • Anchorage, AK 99503

Included within this packet:

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PATIENT REGISTRATION

PATIENT INFORMATION

Last Name: _____ First Name: _____ M.I.: _____

DOB: _____ SSN: _____ Gender: M / F / O

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Emergency Contact Name & Phone: _____Relation to patient: _____

Email address: _____

☐ I authorize the use of this email address for scheduling and billing purposes

PARENT/GUARDIAN/RESPONSIBLE PARTY: Who is the adult responsible for the bill?

Last Name: _____ First Name: _____ M.I.: _____

Relation to Patient: _____ *Photo ID and Proof of Guardianship Required*

***Any patient under the age of 18 and those requiring a guardian beyond the age of 18 must have their guardian available during the evaluation process.*

Marital Status: M / S / D SSN: _____ DOB: _____ Gender: M / F / O

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Employer's Name & Phone: _____

PRIMARY INSURANCE - *ALL INFORMATION MUST BE PROVIDED*

Insurance Name: _____

Claims Address: _____

Policy #: _____ Group #: _____ Effective Date: _____

Policy Holder Name: _____ Relation to Patient: _____ Gender: M / F / O

DOB: _____ SSN: _____Employer Name & Phone: _____

SECONDARY INSURANCE – *IF APPLICABLE, ALL INFORMATION MUST BE PROVIDED*

Insurance Name: _____

Claims Address: _____

Policy #: _____ Group #: _____ Effective Date: _____

Policy Holder Name: _____ Relation to Patient: _____ Gender: M / F / O

DOB: _____ SSN: _____Employer Name & Phone: _____

TERTIARY INSURANCE – *IF APPLICABLE, ALL INFORMATION MUST BE PROVIDED*

Insurance Name: _____

Claims Address: _____

Policy #: _____ Group #: _____ Effective Date: _____

Policy Holder Name: _____ Relation to Patient: _____ Gender: M / F / O

DOB: _____ SSN: _____Employer Name & Phone: _____

CLINIC POLICIES

We are pleased you have chosen to come to our clinic. Please do not hesitate to request clarification of any clinic policies or ask any other questions regarding your service. Our providers and the office staff are happy to respond to any concerns.

Copays, coinsurance and Deductibles are due at time of service. You are ultimately responsible for any balance not covered by your insurance policy. As a courtesy, we will bill your insurance for you. We will make every effort to ensure that claims are complete and accurate when submitted; however, follow up on your insurance claim is your responsibility. **If your insurance does not reimburse us within 90 days, you will become responsible for the balance;** you will be refunded any amount subsequently received by your insurance company.

In certain circumstances, we will make arrangements for a payment plan. However, it is generally unethical and/or illegal for us to waive your co-payment and/or deductible. **In addition, charges related to not attending appointments or canceling appointments without appropriate notice is not covered by insurance you would be responsible for full payment of these fees. Appointments for therapy must be cancelled with at least 24 hours notice.**

MISSED APPOINTMENTS: I understand that therapy appointments cancelled with less than 24 hours' notice will result in a late cancel/ no show fee of $50.00 for the first occurrence. First and second subsequent late cancel/no show for appointments will be charged 50% of the appointment cost and a third will be charged 100% of the appointment cost. If there are multiple late cancel/no show appointments within a calendar year, I understand that my case may go into clinical review to determine continued care. Late cancel/ no show charges are not covered by insurance payments and are the responsibility of the patient and due prior to the next appointment.

FIREARMS/WEAPONS POILCY: It is FULLER DIAGNOSTICS, LLC's policy that all weapons including concealed firearms are prohibited on our premises. The State of Alaska Department of Public Safety dictates that the owners or management of facilities, may deny concealed carry on their premises.

GUARANTEE OF PAYMENT AND ASSIGNMENT OF INSURANCE BENEFITS: For value received, the undersigned guarantor (hereinafter "the Undersigned") and/or patient (hereinafter "the Patient") promises to pay to FULLER DIAGNOSTICS, LLC. (hereinafter "Provider") all charges incurred for services rendered to the Patient. The Undersigned understands that Provider will process the paperwork to complete insurance claim(s) as a courtesy to the Undersigned, and the Undersigned and/or the Patient authorize Provider to release any and all medical information necessary to complete insurance claim(s) and assigns any monies due and owing under the insurance contract to said Provider. It is, however, understood and agreed that the Undersigned is responsible for all monies due and owing for services rendered by Provider in the event insurance does not pay for these services. It is acknowledged that completing and following-up of any insurance claims is ultimately the responsibility of the Undersigned. It is further agreed by the Undersigned that in the event any monies received by Provider from the insurance carrier are at any time after their receipt withdrawn from Provider by the insurance carrier, the Undersigned will be responsible for those monies then due and owing and waives any defense for payment the Undersigned may have against Provider. In the event this account is turned over to an attorney for collection, the Undersigned hereby agrees to pay all costs of collection, not limited to court costs but including reasonable attorney's fees. The Undersigned and/or Patient authorize use of this form of all insurance claim submissions. Your signature indicates you have read the above and agree to the terms contained therein. This agreement is irrevocable.

FULLER DIAGNOSTICS, LLC clinic policies and privacy practices have been reviewed, understood, and agreed to by me.

Patient Name [print]: _____

Responsible Party Name [print]: _____

Responsible Party Signature: _____ Date: _____

LIMITS OF CONFIDENTIALITY FOR PSYCHOTHERAPY

Any other information discussed during therapy sessions, is confidential, and will not be shared without written permission, except under the following conditions:

- The client threatens suicide.
- The client threatens harm to another person(s), including murder, assault, or other harm.
- The client reports suspected child abuse, including but not limited to, physical beatings, and sexual abuse.
- The client reports abuse of the elderly.

State law mandates that mental health professionals may need to report these situations to the appropriate persons or agencies.

In addition, if the client is involved in a legal action and claims mental health issues related to the legal action (i.e., plea of “Not Guilty by Reason of Insanity,” or claiming emotional harm in a lawsuit), mental health records may be required to be released.

Communications between clinicians at Fuller Diagnostics, LLC and the client will otherwise be deemed confidential as stated under **Alaska** state law.

Having read and understood the above, I agree to the Limits of Confidentiality.

Patient Name [print]: _____

Responsible Party Name [print]: _____

Responsible Party Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

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.

OUR LEGAL DUTY

We are required by applicable federal and state laws to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to make changes to this Notice at any time, provided such changes are permitted by applicable law, and to make such changes effective for all health information we may already have about you. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for the purposes of treatment, payment, and health care operations. For example:

Treatment: HIPAA allows us to use and disclose your health information to provide, coordinate, or manage your health care and related services. FULLER DIAGNOSTICS, LLC will not disclose your protected health information without your written or (in rare cases) verbal authorization for release of information, except in cases of emergency.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Health care operations: We may use and disclose your health information in connection with our health care operations. Health care operations include quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, accreditation, certification, licensing, or credentialing activities.

Your authorization: in addition to our use of your health information for treatment, payment, or health care operations, you may give us additional written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To your family and friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your health care or with payment for your health care, *but only if you agree that we may do so.*

Persons involved in care: We may use or disclose health information to notify or assist in the notification of a family member (including identifying or locating), your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your health care. We will also use our professional judgment and our experience with common medical practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.
Marketing health-related services: We will not use your health information for marketing communications without your written authorization.
Required by law: We may use or disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence, or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety of others.
National security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials: health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmates or patients under certain circumstances.
Appointment reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, emails, or letters).

PATIENT RIGHTS
Access: You have the right to inspect or copy your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practically do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access from us directly, or by using the contact information listed at the end of this Notice. We will charge you a reasonable fee for document production expenses. If you request an alternative format, we will charge a reasonable fee for providing your health information in that format.
Disclosure of Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, health care operations, and certain other activities, for the last six years.

HIPAA ACKNOWLEDGEMENT

I hereby acknowledge receipt of Fuller Diagnostics, LLC Notice of Privacy Practices. I understand that the Notice describes how my personal protected health information may be used and disclosed, as well as how I may gain access to my protected health information.

Patient Name [print]: _____

Responsible Party Name [print]: _____

Responsible Party Signature: _____ Date: _____

CONSENT TO TREAT A MINOR

We (Parents Names) _____ and _____, are the are legal custodial parents with decision-making responsibility for (Minor's Name) _____, a minor. If sole legal custodian, please attach a copy of Permanent Court Order Provision.

We hereby consent to our Fuller Diagnostics, LLC Provider in their capacity as a Licensed Clinical Social Worker to begin mental health assessment and treatment of said minor on (Date) _____.

Authorization will be in effect until such time as this psychotherapeutic relationship is terminated. As legal custodial parents, we understand that we have the right to information concerning our minor child in therapy, except where otherwise stated by law. We also understand that this therapist believes in providing a minor child with a private environment in which to disclose himself/herself to facilitate therapy. We therefore give permission to this therapist to use their discretion, in accordance with professional ethics and state and federal laws and rules, in deciding what information revealed by my child is to be shared with us. This is our written consent to the mental health assessment and treatment of minor child under the terms stated above.

I understand I have the following rights with respect to my child's psychotherapy treatment:

- I have the right to withdraw or withhold consent for treatment at anytime.
- I understand that there are potential risks and benefits associated with any type of psychotherapy, and that despite my efforts and the efforts of my child's Provider, his/her condition may not improve. I understand that benefit from psychotherapy cannot be guaranteed or assured.
- I understand that I have the right to access my child's medical information and copies of medical records in accordance with Alaska law.

Both parents must consent for treatment unless the treatment is court ordered or one parents is sole legal custodian (please attach provision).

I have read and understand the information provided above and have had the opportunity to discuss questions with my child's Provider.

Signature of Parent or Guardian: _____ Date: _____

Signature of Parent or Guardian: _____ Date: _____

Signature of Provider: _____ Date: _____

CHILD/FAMILY HISTORY QUESTIONNAIRE

PLEASE NOTE: THIS FORM MUST BE COMPLETED IN FULL

DEMOGRAPHIC INFORMATION

Form completed by: _____ Relationship to child: _____

Child's name: _____ Date of Birth: _____ Age: _____

Gender: M / F / O Race/Ethnicity: _____ Primary Language: _____

Handedness (*circle one*): Right / Left / Both Current Grade: _____

Current School: _____

Who referred you? _____

Who is your Pediatrician/Primary Care Provider? _____

What are your primary concerns regarding your child? _____

_____

FAMILY INFORMATION

Parents names and (age): **Occupation:**

Mother: _____ (____) _____

Father: _____ (____) _____

Guardian: _____ (____) _____

Are biological parent's divorced? Yes / No **Child's age at divorce:** _____

Who has custody: _____ Describe Visitation Schedule: _____

_____

If parent(s) have remarried:

Step-Father's Name: _____ Step-Mother's Name: _____

Contact/Relationship with biological mother: _____

Contact/Relationship with biological father: _____

Number of moves since child's birth? _____ History of OCS involvement? Yes / No

Is your child adopted? Yes / No **Age at adoption:** _____

Child's Religion: _____ How often does child attend service? _____

Other children in family?

Name Age Gender Grade Relationship

_____

_____

_____

_____

Any additional household members? _____

PREGNANCY HISTORY

Duration of pregnancy (weeks) _____ *(Full-term is 40 weeks)*

Circle any of the following problems during the pregnancy: (Please explain below)

Infections Excessive vomiting Preeclampsia Physical injury

Anemia Surgery/Hospitalizations Diabetes High blood pressure

Did biological mother use alcohol, smoke, or use recreational or prescription drugs during pregnancy? Yes / No

If yes, what and how much? _____

Other significant events, complications or medical procedures during pregnancy: _____

_____

Duration of Labor: _____ Spontaneous delivery: Yes / No C-Section: Yes / No

Planned C-Section: Yes / No Emergency C-Section Yes / No

Apgar scores (if known) _____ Birth weight: _____ lbs _____ounces

Complications: (please circle)

"Blue" baby Cord around neck Immature lungs Brain hemorrhage

Suction required Oxygen required Transfusions Treatment for jaundice

Other complications (i.e. infections, birth defects, injury): _____

_____

NICU or specialized care (incubator, oxygen tank, etc.): Yes / No If yes, number of days: ____

Number of days/weeks your child was in the hospital after delivery: _____
Developmental Milestones (months):

_____ Sat up _____ Walked _____ First words (3 words or more)
_____ Crawled _____ Bowel trained _____ Bladder trained (day)
_____ Bladder trained (night)

Does your child have ongoing bladder or bowel accidents: Yes / No

Was there anything in the first three years of your child's life that you thought might affect growth, development, or school success? _____
_____

Previous Illnesses (Circle all that apply):

High fevers	Allergies	Ear Tubes	Recurrent ear infections
Poor Growth	Surgeries	Meningitis	Seizures or staring spells
Breathing problems	Hearing or vision problems		

Please Describe: _____
_____

Any overnight medical hospitalizations? Yes / No If yes, please describe: _____
_____

Behavior Problems during early childhood *(Circle all that apply):*

Hyperactive	Stiff when held	Difficult to calm	Aggressive
Severe separation anxiety	Solitary play	Overly sensitive to sound/touch	
Extreme tantrums	Unusual motor behaviors		

Has your child ever had a serious hit to the head/Concussion or other brain injury?

Yes / No How many times? _____ At what age(s)? _____

Did your child ever have a loss of consciousness (been knocked out)?

Yes / No How many times? _____ At what age(s)? _____

Additional information: _____
_____
_____
_____
_____

CURRENT MEDICAL INFORMATION

Height: _____ Weight: _____ Past or current medical problems: _____

_____

_____

Does your child require glasses or contact lenses? Yes / No

Is their vision fully corrected with glasses/contact lenses? Yes / No

Does your child have a hearing impairment? Yes / No Hearing aid? Yes / No

Does your child have difficulty falling asleep? Yes / No Staying asleep? Yes / No

Typical bedtime: _____

Typically awake at: _____

Hours of sleep per night? _____

History of sleep study? *Yes / No*

Tonsils and/or adenoids removed? Yes / No Sleep better after? Yes / No

---

Does your child have problems with eating or appetite? Circle all that apply:

Recent weight gain/loss Binge eating Unaware of hunger or being full

Picky eater Hiding/hoarding food Appetite changes

Chronically hungry Foods rejected based on texture and/or appearance

Has your child had treatment for a psychological problem? Yes / No

When? _____ Type of treatment *(circle all that apply)*

Individual therapy family therapy group therapy hospitalization residential care

What for? _____

Does your child take medications for behavioral/emotional problems? Yes / No

At what age did your child begin taking medications? _____ Prescribing Doctor_____

What medications has your child taken in the past? _____

Current Medications: _____

_____

_____

Is your child receiving therapy (individual, family or group) now? Yes / No

If Yes, with whom? _____

Has your child ever hurt themselves on purpose? Yes / No How? _____

Has your child ever threatened to hurt themselves? Yes / No

FAMILY HISTORY *(family defined as siblings, parents, grandparents aunts/uncles and first cousins)*

Condition	**Relation**
Learning Problems	
Depression/Bipolar Disorder	
Alcoholism/Drug Addiction	
Epilepsy	
Autism Spectrum Disorders	
Hyperactivity	
Anxiety	
Speech Delay	
Tic or nervous behaviors	
Psychiatric Hospitalization	
Other	

SCHOOL HISTORY

Current School: _____ **Grade:** _____ **Teacher:** _____

Previous schools attended (include preschool and grades)

1. _____ 3. _____ 5. _____

2. _____ 4. _____ 6. _____

Does your child have a current IEP or 504? Yes / No

Classification?

☐ Specific learning disability (SLD)
☐ Speech/language disorder
☐ Emotionally disturbed (ED or SED)
☐ Other health impaired (OHI)
☐ Educational Autism
☐ Early Childhood developmental delay (ECDD)
☐ Intellectual disability
☐ Traumatic Brain Injury

What services and/or accommodations does your child receive?_____

_____

_____

Has your child ever repeated a grade? Yes / No What grade(s): _____

Was your child ever suspended or expelled? Yes / No How many times? _____

Has your child's teacher(s) reported any of the problems below? (*Circle all that apply)*

Social problems	Attention/concentration	Learning/academic
Hyperactivity	Daydreaming	Aggression
Behavior problems	Not following directions	Poor memory
Distractibility	Poor handwriting	Problems with peer relationships

Time your child spends on homework each day _____ (hours)

Time you spend helping _____ (hours)

Comments about school: _____

_____

_____

Does your child participate in sports or other recreational activities? Yes / No

If so, what are they?_____

Is your family/child involved in any litigation or legal proceedings with the following?

☐ Worker's Compensation ☐ Divorce ☐ Custody

☐ Personal injury ☐ DFYS/OCS

SUBSTANCE USE/ABUSE HISTORY

Has your child ever tried/used *(Circle all that apply)*:

Meth	Cocaine/crack	Gas/inhalants	Pain pills/sedatives	Marijuana
Mushrooms	Spice	LSD	Ecstasy	Alcohol

Other: _____

BEHAVIORAL HISTORY:

Please circle any of the following that concern you about your child:

Disobedience	Whining	Poor self/body awareness
Nightmares	Clumsiness	Immature/atypical play
Memory Problems	Moodiness	Verbal Communication
Difficulty sleeping	Headaches	Comprehension
Low self-esteem	Stomach aches	Judgement/Safety Issues
Frequent crying	Lack of friends	Rigid/ritualized behaviors
Dawdling	Unacceptable friends	Attachment
Disorganization	Stealing	Lack of remorse/empathy
Excessive screen time	Hitting	Arguing
Tantrums	Sexual behavior	Lying
Sensory processing	Destruction of property	

Has your child ever: *(Please check all that apply)*

☐ Been physically abused ☐ Been sexually abused

By whom _____ For how long/how many times _____

Circumstances surrounding abuse: _____

_____

_____

_____

_____

Has the above indicated abuse:

☐ Been Reported ☐ Not Been Reported

Results of report:

☐ Substantiated ☐ Not Substantiated

Has your child ever: *(Please check all that apply)*

☐ Been arrested or adjudicated
For what _____ Result _____

☐ Run away from home
When _____ For how long _____

☐ Set a fire
When _____ Where _____

☐ Assaulted someone
Who _____ What Happened _____

☐ Destroyed property
When _____ How _____

☐ Threatened to hurt self
When _____ How _____

☐ Hurt self
When _____ How _____

☐ Threatened to hurt someone else
When _____ Who _____ How _____

☐ Cruelty to animals
When _____ What _____

☐ Used a weapon
When _____ What _____

☐ Has Been Sexually active

☐ Gang Activity

DISCIPLINE

When does your child need to be disciplined? _____

_____

_____

What do you do? _____

_____

_____

How does your child respond? _____

_____

_____

FAMILY ACTIVITIES

What does your child like to do? _____

What do you enjoy doing with your child? _____

What are your child's strong points? _____

What does your family do together? _____

How often do you read to your child? _____

How often does your child read alone? _____

How much screen time does your child have on a typical day? _____

On a typical weekend day? _____

What computer software/Apps do you have for your child? _____

Does your child have a best friend? Yes / No

Does your child play with a consistent group of children in school? Yes / No

In your neighborhood? Yes / No

What problem(s) does your child have in getting along with friends? _____

_____

What problem(s) does your child have in getting along with siblings? _____

What are your child's chores? _____

What problems are there getting them done? _____

ADDITIONAL INFORMATION

Please include any other information that will help us better understand your child.

_____

_____

_____

_____

_____

FULLER DIAGNOSTICS, LLC

AUTHORIZATION TO RELEASE PATIENT HEALTH INFORMATION

Patient Name: _____ **Date of Birth:** ___/___/_____

I authorize FULLER DIAGNOSTICS, LLC to release information as stated below from the patient health information record:

Information to be Released From: _____

Information to be Released To: _____

Information to be Released via: ☐ Email ☐ Fax ☐ Mail

Email/Fax Number/ Mailing Address: _____

Information to be Released: _____

Dates of service for information requested:

Beginning: _____ thru _____

Purpose of Release:

☐ Continuing care ☐ Copies for own use ☐ Transfer to another provider

☐ Legal ☐ Coordination with School ☐ Other: _____

I understand that:

- Authorizing the disclosure of this healthcare information is voluntary. I do not need to sign this form in order to assure treatment or payment.
- I can cancel this authorization at any time. I understand that once the information has been released according to the terms of this Authorization, the information cannot be recalled.
- Any disclosure of information carries with it the potential for further release or distribution by the recipient that may not be protected by confidentiality laws.

This Authorization will expire one year from the date signed below unless another date or event is entered here _____.

Sensitive Records may require specific patient authorization. Please check the applicable box below to request the following records:

☐Mental Health Treatment ☐Sexually Transmitted Diseases ☐AIDS/HIV Treatment

☐Alcohol/Drug Abuse Treatment

Name of Responsible Party [print]: _____

Signature of Responsible Party: _____ Date: _____

Relationship to the Patient: _____

To be filled out by FULLER DIAGNOSTICS, LLC:

Date Records were released: _____

Signature of Employee: _____