TAMPA BAY

PSYCHIATRIC SERVICES, PL

Boguslaw Gluszak, MD
Cheryl Buss, LCSW

3848 Flatiron Loop, Suite 102
Wesley Chapel FL 33544
Tel: 813 699 4020
Fax: 813 464 7682

5664 Marquesas Circle
Sarasota FL 34233
Tel: 941 527 0159
Fax: 813 464 7682

Mailing Address:
1767 Lakewood Ranch Blvd. # 255
Bradenton FL 34211

www.tampabaypsychiatricservices.com

PATIENT INFORMATION

Date: _____

Patients Last Name _____First _____ _____MI _____

SSN:_____ DOB_____ Age_____ Sex: M F

Address_____

City_____ State _____Zip Code_____

Home Phone #_____ Cell Phone for Text reminders_____

Parents/Legal Guardians (for minor patients)

Mother/Guardian: _____tel: _____

Father /Guardian: _____tel: _____

Name of Primary Insurance: _____Member ID#_____

Group #_____Subscriber _____ DOB_____

Subscriber's Employer_____ _____

Secondary Insurance: We do not file secondary insurance claim.

Primary Care Physician:_____Tel: _____

Address:_____

Therapist: _____Tel: _____

How were you referred to this office:_____

How do you want to be reminded about your appt? Home Tel ___ Alt. Tel. ___ E-mail _____

PATIENT HISTORY FORM

LAST NAME _____ FIRST NAME: _____ DOB: _____ DATE _____

Review of Systems (2 pages)

Circle **Yes** or **No.**

General Symptoms	NOW		PAST		(Comments)
Weight change	Y	N	Y	N	
Chills	Y	N	Y	N	
Sleep Disorder	Y	N	Y	N	
Other					

Eyes					
Double vision	Y	N	Y	N	
Glaucoma	Y	N	Y	N	
Cataracts	Y	N	Y	N	
Other					

Ear/Nose/Throat/Mouth					
Hearing changes	Y	N	Y	N	
Sore throat	Y	N	Y	N	
Sinus problem	Y	N	Y	N	
Other					

Cardiovascular					
Chest pain	Y	N	Y	N	
Irregular heartbeat	Y	N	Y	N	
Swelling in ankles	Y	N	Y	N	
Other					

Psychologic					
Are you generally happy?	Y	N	Y	N	
Do you feel depressed?	Y	N	Y	N	
Do you feel anxious?	Y	N	Y	N	
Do you feel safe in your home?	Y	N	Y	N	

Endocrine					
Excessive thirst	Y	N	Y	N	
Too hot/cold	Y	N	Y	N	
Tired/sluggish	Y	N	Y	N	
Other					

Hematologic/Lymphatic					
Swollen glands	Y	N	Y	N	
Blood clotting problem	Y	N	Y	N	
Bruising	Y	N	Y	N	
Other					

Allergic/Immune					
Hay Fever	Y	N	Y	N	
Drug allergies	Y	N	Y	N	
Food	Y	N	Y	N	
Other					

Genitourinary	NOW		PAST		(Comments)
Change in stream	Y	N	Y	N	
Nocturia (getting up at night)	Y	N	Y	N	
Urinary frequency > 8 times/day	Y	N	Y	N	
Other					

Musculoskeletal					
Bone pain	Y	N	Y	N	
Muscle pain	Y	N	Y	N	
Joint pain	Y	N	Y	N	
Other					

Skin					
Rash	Y	N	Y	N	
Lumps or bumps	Y	N	Y	N	
Moles, skin tags	Y	N	Y	N	
Other					

Neurological					
Tremors	Y	N	Y	N	
Dizzy spells	Y	N	Y	N	
Numbness/tingling	Y	N	Y	N	
Other					

Respiratory					
Wheezing	Y	N	Y	N	
Frequent cough	Y	N	Y	N	
Shortness of breath	Y	N	Y	N	
Other					

Gastrointestinal					
Abdominal pain	Y	N	Y	N	
Nausea/vomiting	Y	N	Y	N	
Indigestion/heartburn	Y	N	Y	N	
Other					

Sexual History		
Change in sex drive?	Y	N
Sexual performance satisfactory?	Y	N
Other (i.e. sexual trauma)		

Last Exams or Lab tests: Please enter date (mo/yr)

Dental: _____	Eye : _____
Pelvic: _____	PAP smear: _____
Mammogram: _____	Cholesterol: _____
Colonoscopy: _____	Stool Tested: _____
Prostate _____	PSA test: _____

Living Will? ☐ Yes ☐ No Advanced Directive? ☐ Yes ☐ No Doctor's signature: _____

(Please Complete Other Side)

Medical History

Medical ☐ None (*High Blood Pressure, Diabetes, Cancer, Heart Disease, etc.*)

Pregnancy History

Year	Sex	Complications

Surgical ☐ *None (Tonsillectomy, Appendectomy, Hysterectomy, Hernia, etc* - Please enter year surgery was done if known*)*

Allergies to medications? ☐ None (If Yes, please explain type of reaction, i.e. hives, wheezing, upset stomach, swelling, etc.)

Last Immunizations: FLU ___/___/___ PNEU___/____/___ Tetanus ___/___/___ Other _____ ___/____/___

Current prescription medicines: ☐ **None**

Name of drug	mg dose	# tablets	# times per day

Additional current prescription medicines:

Name of drug	mg dose	# tablets	# times per day

Current Non-Prescription Medicine (Aspirin, Tylenol, Ibuprofen, Aleve, vitamins, anti-acids, herbals.)

Family History

Father: ☐ Living - Age: _____ ☐ Deceased, Age at Death_____ (Cause) _____
Mother: ☐ Living - Age: _____ ☐ Deceased, Age at Death_____ (Cause) _____
Siblings: Number Living _____ Number deceased _____ (Cause) _____

List other illnesses in your family (Example - Diabetes, heart disease, colon, breast, or prostate cancer, arthritis, depression etc)

(Family Member) (Illness) (Family Member) (Illness) (Family Member) (Illness)

_____= _____ _____ = _____ _____= _____

Social History

Caffeine ☐ Yes ☐ No If yes, how much? _____
Smoke? ☐ Yes ☐ No If yes, how much? _____ # of packs/day _____ # of years When did you stop smoking? _____
Alcohol? ☐ Yes ☐ No If yes, how much? _____

Occupation. _____ ☐ Retired Significant prior industrial or agricultural exposures? ☐ Yes ☐ No

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed **Number of children** _____ ☐ None

Exercise regularly? ☐ Yes ☐ No If yes, what and how frequently?

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Consent for Treatment

I, the undersigned, do hereby consent to participate in the Tampa Bay Psychiatric Service, PL Assessment Process and if I so choose, subsequent treatment if recommended. I understand that the Assessment is a collaborative effort between my family (if indicated), other professionals or healthcare providers, Tampa Bay Psychiatric Service, PL staff and myself to determine a diagnosis and treatment recommendations. Participation in the Assessment process does not constitute a treatment contract with Tampa Bay Psychiatric Service, PL to assume responsibility for my medical / psychiatric care.

_____

Signature **Date**

Financial Responsibility Consent

I, the undersigned have read and agree to the _Tampa Bay Psychiatric Services, PL fee policy. I acknowledge full financial responsibility for services rendered by TBPS, whether covered by insurance company or not. I further authorize Tampa Bay Psychiatric Services, PL to release all necessary medical information to my insurance company to secure payment of benefits. I authorize the use of this signature on all my insurance submissions.
I also authorize Tampa Bay Psychiatric Services to charge this credit card any payments due for the telehealth services.

_____

Signature of Insured / Guardian **Date**

_____

Address (if different than patient's)

Credit Card information:

Credit card: Visa _____ Master Card_____ Discover _____ Am. Express_____

Name on the card:_____

Card number _____

Expiration date _____ Security code _____

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NOTICE OF PRIVACY PRACTICES

Privacy Officer: Boguslaw Gluszak, MD
Notice Effective Date: 1/01/2010

*****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.*****

We understand your medical information is private and we strive to protect the confidentiality of your medical records. The new federal regulations require that we issue this official notice of our privacy practices. You have the right to the confidentiality of your medical information, and this practice is required by law to maintain the privacy of that information. The practice is required to abide by the terms of the Notice of Privacy Practices currently in effect and to provide notice of its legal duties and privacy practices with respect to the protected health information.
This notice will be followed by any health care professional authorized to enter information in your medical records. All employees, staff and other personnel at this practice who may need access to your information must abide by this Notice. All subsidiaries, business associates, sites and locations of this practice may share medical information with each other for treatment, payment purposes or health care operations described in this notice. Except where treatment is involved, only the minimum necessary information needed to accomplish the task will be used.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

The following categories describe different ways that we may use and disclose medical information without your specific consent or authorization. Examples are provided for each category of uses or disclosures. Not all possible uses or disclosures are listed.

For Treatment:
We may use and disclose medical information about you to provide you with medical treatment or services. Example: In treating you for a specific condition, we may need to know if you are allergic to specific drugs that could influence with medications we prescribe for the treatment purpose.

For Payment:
We may use and disclose medical information about you so that treatment and services you receive from us may be billed and payment may be collected from your insurance, third party or you. Example: We may need to send your protected health information, such as your name, office visit date and codes identifying your diagnosis and treatment to your insurance company for payment.

Health Care Operations:
We may use and disclose medical information about you for health care operations to assure that you receive quality care. Example: we may use medical information to review our treatment and services and evaluate the performance of our staff in caring for you.

Other Uses or Disclosures That Can Be Made Without Consent or Authorization

- As required during an investigation by Law enforcement agencies
- To avert a serious threat to public health and safety
- As required by military command authorities for their medical records
- To workers' compensation or similar programs for processing of claims
- In response to legal proceeding
- To a coroner or medical examiner for identification of body
- In an inmate, to the correctional institution or law enforcement official
- As required by US Food and Drug Administration (FDA)
- Other healthcare providers' treatment activities

- Other covered entities' healthcare operations activities (to the extent permitted under HIPAA)
- Uses and disclosures required by law
- Uses and disclosures in domestic violence or neglect situations
- Health Oversight activities
- Other public health activities

We may contact you to provide appointment reminders, information about treatment alternatives or other health related benefits and services that may be of interest to you.

Uses and disclosures of Protected Health Information Requiring Your Written Authorization:
Other uses and disclosures of medical information not covered by this Notice or the Laws that apply to us will be made only with your written authorization. If you give us a written authorization to use or disclose the medical information about you, you may revoke the authorization, in writing, at any time. If you revoke your authorization, we will thereafter no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your authorization, and that we are required to retain our records of the care we have provided you.

YOUR INDIVIDUAL RIGHT REGARDING YOUR MEDICAL INFORMATION

Complaints:
If you believe your privacy rights have been violated, you may file the complaint with the Privacy Officer or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized or discriminated against for filing the complaint.

Right to Request Restriction:
You have the right to request a restriction or limitation on the medical information we use or disclose about you for your treatment, payment or health care operations or to someone who is involved with or in your care or the payment for your care. We are not legally bound to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with the emergency treatment. To request restrictions you must submit your request in writing... In your request, you must tell us what information you want limited.

Right to Request Confidential Communication:
You have the right to request how we should send our communications to you about medical matters, and where you would like these communications sent. We will not ask you for the reason for your request. Your request must specify how or where you wish to be contacted. We reserve the right to deny the request, if it imposes an unreasonable burden on the practice.

Right to Inspect and Copy:
You have a right to inspect and copy medical information that may be used to make decisions about your care.
Usually this includes medical and billing records but does not include psychotherapy notes, information compiled for use in civil, criminal or administrative action or proceeding and protected health information to which access is prohibited by law. To inspect and copy medical information that may be used to make decisions about your care, you must submit your decision in writing. If you request a copy of the information, we reserve the right to charge the fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain, very limited circumstances. If you are denied access to your medical information, you may request that denial be reviewed.

Right to a Paper Copy of This Request:
You have a right to a paper copy of this Notice at any time. Even if you agreed to receive this copy electronically, you are still entitled to a paper copy.

Right To Amend:
If you feel the medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept.
To request an amendment, your request must be submitted in writing. In addition you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if the information was not created by us, is not part of the medical information kept at this practice, is not part of the information which you would be permitted to inspect and copy, or which we deem to be accurate and complete. If we deny your request for an amendment, you have the right to file a statement of disagreement and any corresponding rebuttals will be kept on file and sent out with any future request for information pertaining to the appropriate portion of your records.

Changes to This Notice:
We reserve the right to change this notice. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice, with the effective date at the very beginning of the notice.

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NOTICE OF PRIVACY PRACTICES
PATIENT ACKNOWLEDGEMENT

I understand that, under The Health Insurance Portability and Accountability Act of 1996 (HIPAA) I have certain right to privacy in regards to my protected health information (PHI).
I have received, read and understood The Notice of Privacy Practices.
The practice reserves the right to change the terms of its Notice of Privacy Practice. I understand the Practice will provide current Notice of Privacy Practice on request.

Patient Name:_____ DOB: _____

Patient Signature_____Date_____

Patient's Parent/Guardian Signature:_____

Printed Name _____

Relationship to the Patient _____

I was unable to obtain the patient's signature
Date_____
Reason_____
_____
_____

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FEE SCHEDULE – JULY 2021

Self Paid (no insurance) fees:	
Psychiatric Evaluation, M.D,	**$300**
Follow up, 15-20 minutes,M.D.	**$120**
Follow up/Ind. Therapy, M.D.	**$200**
Individual Therapy, Counselor	**$150**

Please note that time scheduled for your appointment is reserved only for you. We do not offer that time to anybody else. If you have conflict in your schedule, please call the office to re-schedule as soon as possible.

No Show Fees:

No Show / Late Cancellation, Medication Management appt – $120
No show / No call 1 hr Therapy, M.D. - $200 (full cost)
No show / No call 1 hr Therapy, Counselor - $150 (full cost)

First appointment deposit $100
48 hrs advanced notice is required for cancellations

Documentation: - $15 /page:
(for example: letters, disability questionnaires, life insurance questionnaires, etc.)

Returned check - $30 (If requested, we will gladly hold checks until certain date)

Court Appearance and Legal Consultations - $300/hr

Medications are refilled ONLY during medication follow up appointment. Please check before the visit if you need refills for your medication, and let Dr Gluszak know at the appointment. You will be provided with enough refills until your next visit.

Dr Gluszak does not use "automatic" refill requests from the pharmacies. Taking psychiatric medications needs to be closely supervised and followed up with the physician on regular basis.
If you require refill due to the missed appointment there will be $20 refill charge.

I have read and accepted the above terms.

Patient Name:_____

Patient/Guardian'sSignature_____Date_____

REFILL POLICY

As of August 1st, 2016 there is a fee of $25 for calling in prescriptions.

Refilling medication through pharmacies can be very frustrating and time consuming. It is our policy to give enough medication and refills to get you through to your next appointment. Please schedule appointments prior to your last dose of your last refill and do not wait until your medication runs out.

- There is no refills without appointment on new medications/new dosages.
- You must have your next appointment on schedule in order to get prescription refill.
- Note that some prescriptions (including stimulants used for treatment of ADHD/ADD) cannot be called in by the doctor. Physical prescription must be submitted to the pharmacy.

  Please have a list of all medication that require refill at your appointment.

If refills are required, please allow **48 business hours** to process the request.

Prescriptions refills are done during regular business hours
(Mon-Fri 8 am – 6 pm)

Dr Gluszak reserves the right to refuse refilling any medication if he believes it is clinically necessary to evaluate patient before prescribing medication.

I have read and accepted the above terms.

Patient Name:_____

Patient/Guardian'sSignature_____Date_____

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PSYCHIATRIST/THERAPIST – PATIENT CONTRACT
OUTPATIENT SERVICES

Welcome to our practice.

This document contains important information about our professional services and business policies. Please read it carefully and jot down any questions you might have so that we can discuss them at our next meeting. When you sign this document, it will represent an agreement between us.

Psychiatric / Therapy Services

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the therapist and client, and the particular problems you bring forward. There are many different methods I may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

Our first sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the doctor you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

Meetings

I normally conduct an evaluation that will last from one to two sessions. During this time, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 48 hours advance notice of cancellation [unless we both agree that you were unable to attend due to circumstances beyond your control]. [If it is possible, I will try to find another time to reschedule the appointment.]

Professional Fee-for-Service Fees

Psychiatric Evaluation/Consultation with M.D. -$300
Psychotherapy and/or medication follow-up 50min with M.D. - $200
Psychotherapy and/or medication follow-up 15-20 min, with M.D. - $120
Psychological Evaluation, with Therapist - $150
Psychotherapy, 50 min., with Therapist - $150

No show/late cancellation (20 min. apt) – full fee $120
No show/late cancellation (1hr therapy) full fee - $200 (M.D), $130 (Therapist)

If you have an insurance plan, that we are contracted with, you will be responsible for your co-payment at the time of visit. If your health plan requires treatment authorization, you are responsible for obtaining it prior to our first appointment. If the claim gets rejected due to the lack of authorization, you will be responsible for the charges.

If we are out-of-network provider for your insurance, we will fill out forms and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of my fees. It is very important that you find out exactly what mental health services your insurance policy covers.

In addition to scheduled appointments, I charge this amount for other professional services you may need, though I will break down the hourly cost if I work for periods of less than one hour. Other services include report writing, telephone conversations lasting longer than 5 minutes, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. Please understand that I will bill for my standard rate and this will not be reimbursable by the insurance company. If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time even if I am called to testify by another party. [Because of the difficulty of legal involvement, I charge $300 per hour for preparation and attendance at any legal proceeding.]

Billing and Payments

You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. Payment schedules for other professional services will be agreed to when they are requested. [In circumstances of unusual financial hardship, I may be willing to negotiate a fee adjustment or payment installment plan.]

If your account has not been paid for more than 30 days and arrangements for payment have not been agreed upon, your credit card on file may be charged for past dues fees, or I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. If such legal action is necessary, its costs will be included in the claim. In most collection situations, the only information I release regarding a client's treatment is his/her name, the nature of services provided, and the amount due.

Insurance Reimbursement

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment.

You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. Our staff can also help you understand your benefits.

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. Managed Health Care plans

such as HMOs and PPOs often require authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While a lot can be accomplished in short-term therapy, some clients feel that they need more services after insurance benefits end. [Some managed-care plans will not allow me to provide services to you once your benefits end. If this is the case, I will do my best to find another provider who will help you continue your therapy.]

You should also be aware that most insurance companies require you to authorize me to provide them with a clinical diagnosis. Sometimes I have to provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any report I submit, if you request it.

Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end our sessions. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above [unless prohibited by contract].

Contacting Me

I am often not immediately available by telephone. I will not answer the phone when I am with a client. When I am unavailable, you can leave message for me with our staff or on my voice mail [that I monitor frequently). I will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are difficult to reach, please inform me of some times when you will be available. In emergencies, please dial 911 or contact your family physician or the nearest emergency room and ask for the psychiatrist on call. If I will not be available for an extended time, I will provide you with the name of a colleague to contact, if necessary.

Professional Records

The laws and standards of my profession require that I keep treatment records.
You are entitled to receive a copy of your records, or I can prepare a summary for you instead. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. If you wish to see your records, I recommend that you review them in my presence so that we can discuss the contents. Clients will be charged an appropriate fee for any professional time spent in responding to information requests.

Minors

If you are under eighteen years of age, please be aware that the law may provide your parents the right to examine your treatment records. It is my policy to request an agreement from parents that they agree to give up access to your records. Before giving them any information, I will discuss the matter with you, if possible, and do my best to handle any objections you may have with what I am prepared to discuss.

Confidentiality

In general, the law protects the privacy of all communications between a client and a psychiatrist, and I can only release information about our work to others with your written permission. But there are a few exceptions.

In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order my testimony if he/she determines that the issues demand it.

There are some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about a client's treatment. For example, if I believe that a child [elderly person, or

disabled person] is being abused, I must [may be required to] file a report with the appropriate state agency.

<I would do so with the client in the office.>

If I believe that a client is threatening serious bodily harm to another, I am required to take protective actions. These actions may include notifying the potential victim, contacting the police; or seeking hospitalization for you. If you threaten to harm yourself, I may be obligated to seek hospitalization for you or to contact family members or others who can help provide protection.

If a similar situation occurs, I will make every effort to fully discuss it with you before taking any action. I may occasionally find it helpful to consult other professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my client. The consultant is also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have at our next meeting. I will be happy to discuss these issues with you if you need specific advice, but formal legal advice may be needed because the laws governing confidentiality are quite complex, and I am not an attorney.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

Signature: _____

Name Printed: _____

Date: _____

Original to file
Copy to client