Boston Spine
CARE GROUP

PHYSICIAN

Robert J. Banco, M.D.
Orthopaedic Spine Surgeon
Associate Clinical Professor
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25 Washington Street, Unit 1B
Wellesley, MA 02481
Tel: 617-219-6300
Fax: 617-219-6355
bostonspinecaregroup.com

AFFILIATED HOSPITAL

Newton-Wellesley Hospital

Date: _____/ _____/ _____

Dear: _____

Appointment Date: _____Time:_____ AM ◯ PM ◯
Appointment with: _____

Enclosed you will find directions to our **NEW OFFICE** located at **25 Washington Street, Unit 1B, Wellesley, MA 02481** and a blank patient information packet. Please read, fill out and sign all of these forms and bring them to your visit. Please make sure to also read and sign our medication policy.

From Route 128 (I-95) North, Take Exit 38A or Route 128 (I-95) South, Take Exit 38B to Route 16 West Proceed on Route 16 ½ mile to the Newton Wellesley Outpatient Surgical Center. We are located on the first floor. Parking and entrance are located in the back of the building.

- **Please make sure to bring your insurance card and a valid photo ID.**
- **Please bring glasses if you need them to read and a list of the medications you are currently taking with the strength and directions.**
- If your insurance is an HMO that requires you to get referrals for doctor's visits, please contact your PCP'S office to request one and, if possible, bring it with you. Check with your PCP's office the day before your appointment to make sure that the referral has been issued. If we do not have a valid referral at the time of your visit, it is possible that you may not be seen or that you may be financially responsible for the full visit fee. We also ask that you please bring your copayment with you. **For your convenience, we accept Visa®, MasterCard® and Checks. We do not accept cash.**
- We do **REQUIRE that you bring your most recent MRI or CT scan DISCs with you** for your provider to view during your visit. UNLESS YOUR IMAGES WERE DONE AT NWH, YOU STILL MUST BRING A DISC, THIS INCLUDES SHIELDS MRIs. **DO NOT** have them sent to us before your visit. Please feel free to bring any other films you feel may be helpful.

Feel free to contact us at **(617) 219-6300** if you have any questions or concerns. We kindly as that you give us 24-hour notice if you are unable to keep your scheduled appointment.

Please note: If you arrive later for your appointment, there is a possibility your appointment may have to be rescheduled due to time constraints.

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Patient_____ Sex ◯ M ◯ F
Last First Middle

Date of Birth _____ Age_____ Social Security Number 000-000-0000

Address_____
Street City State Zip Code

Home PH _____ Work PH _____

Alternate or Cell Phone #: _____ E-Mail_____

Emergency Contact_____Phone_____

Primary Care Physician Name_____Phone _____

Address_____

Referring Physician Name_____Phone _____

Address _____

Primary Insurance

Name_____
ID#_____
Group#_____
Subscriber _____
DOB of Subscriber_____

Secondary Insurance

Name_____
ID#_____
Group#_____
Subscriber_____
DOB of Subscriber_____

Workers' Compensation (if applicable)

Insurance_____ Claim #_____
Date of Injury_____ Date Last Worked _____
Billing Address _____
Adjuster_____ PH_____ FX _____
RN Manager_____ PH_____ FX _____
Utilization Review Co _____ PH_____ FX _____
Attorney: _____ Address:_____
Attorney PH:_ _____
Employer: _____ Address: _____
Employer PH: _____ Occupation: _____
Pharmacy: _____ Address: _____
Pharmacy PH: _____

I hereby assign to the physician for medical services rendered to me or my dependents. I understand that I am responsible for any amount not covered by my insurance(s. :
Signature_____ Date_____

Name_____ Date_____

MD initials ____

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Please indicate along the line at the point that corresponds to your average BACK/NECK pain over the last few days.

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain Possible

Please indicate along the line at the point that corresponds to your average LEG/ARM pain over the last few days.

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain Possible

Are you experiencing: Numbness ◯ Yes ◯ No

Weakness ◯ Yes ◯ No

Do your legs tire/hurt if you walk too far? ◯ Yes ◯ No

If YES, how far can you walk? ◯ less than 1 block ◯ 1-3 blocks ◯ more than 3 blocks

When did your symptoms begin?

Have you had similar attacks in the past? _____

What was the cause of your pain? _____

How does each of the following affect your pain? (check your answer)

Sitting	◯ Better	◯ Worse	◯ No change	◯ Don't know
Standing	◯ Better	◯ Worse	◯ No change	◯ Don't know
Walking	◯ Better	◯ Worse	◯ No change	◯ Don't know
Lying Down	◯ Better	◯ Worse	◯ No change	◯ Don't know
Rising from chair	◯ Better	◯ Worse	◯ No change	◯ Don't know
Physical activity	◯ Better	◯ Worse	◯ No change	◯ Don't know
Heat Cold	◯ Better	◯ Worse	◯ No change	◯ Don't know
Massage	◯ Better	◯ Worse	◯ No change	◯ Don't know

Name_____ Date_____

MD initials _____

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Patient Intake Questionnaire 3 of 4

Have you had any of the following diagnostic procedures done for evaluation of pain? **(Provide DATE and PLACE below.)**

Bone Scan _____ _____

CT Scan _____ _____

Myelogram _____ _____

EMG _____ _____

X-Rays _____ _____

Blood Work _____ _____

Discogram _____ _____

MRI _____ _____

What kind of treatment have you received in this current episode of pain?

Best Rest	◯ Yes	◯ No	Medication	◯ Yes	◯ No
Brace	◯ Yes	◯ No	Physical Therapy	◯ Yes	◯ No
Chiropractor	◯ Yes	◯ No	Acupuncture	◯ Yes	◯ No
Facet Injections	◯ Yes	◯ No	Epidural Injections	◯ Yes	◯ No
Other Injections	◯ Yes	◯ No	Other: _____		
Spine Surgery	◯ Yes	◯ No	Type: _____		

If yes, (When/Where/by Whom):_____

_____

What medications are you currently taking (dose)?

_____

_____

Medication Allergies/Reactions _____

_____

Have you had any previous complications with anesthetics? ◯ Yes ◯ No

Have you had problems with addiction to prescription or non-prescription medications? ◯ Yes ◯ No

Past surgical history (please include When/Where/by Whom):

_____

_____

Past medical history (please include dates):

_____

_____

Family medical history: _____

_____

Name_____ Date_____

MD initials _____

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Patient Intake Questionnaire 4 of 4

Check all symptoms you now have:

- ☐ Heart trouble
- ☐ Chest pain
- ☐ Heart skipping
- ☐ Palpitations
- ☐ High blood pressure
- ☐ Stroke
- ☐ Bleeding disorder
- ☐ Easy bruising
- ☐ Fainting
- ☐ Lightheaded
- ☐ Incontinence
- ☐ Urinary frequency
- ☐ Blood in urine
- ☐ Menstrual changes
- ☐ Jaundice
- ☐ Renal disorder
- ☐ Vaginal bleeding
- ☐ Vision changes
- ☐ Eye pain/redness
- ☐ Headaches
- ☐ Hearing loss
- ☐ Nose bleeds

- ☐ Abdominal pain
- ☐ Reflux
- ☐ Heartburn
- ☐ Gerd
- ☐ Diarrhea
- ☐ Loss of appetite
- ☐ Constipation
- ☐ Change in bowl habits
- ☐ Significant weight change
- ☐ Unexplained weight loss
- ☐ Pain in joints
- ☐ Decreased range of motion
- ☐ Swollen ankles
- ☐ Leg cramps
- ☐ Numbness
- ☐ Muscle weakness/paralysis
- ☐ Tremor dizziness
- ☐ Excessive sweating
- ☐ Persistent infections

- ☐ Shortness of breathe
- ☐ Cough
- ☐ Wheezing
- ☐ Bloody sputum
- ☐ Throat disorder
- ☐ Thyroid trouble
- ☐ Swollen glands
- ☐ Trouble swallowing
- ☐ Mouth sores
- ☐ Sore throat
- ☐ Anxiety/disorders
- ☐ Depression
- ☐ Nervousness
- ☐ Insomnia
- ☐ Night sweats
- ☐ Fatigue

- ☐ Oral lesions
- ☐ Skin lesions
- ☐ Skin sores
- ☐ Rash/bumps

What is your height: _____ Weight: _____

Relationship Status: ◯ Married ◯ Single ◯ Divorced ◯ Widowed

Children, if so how many? _____

Smoking Status:
- ◯ never smoker
- ◯ current every day smoker
- ◯ current some day smoker
- ◯ former smoker
- ◯ smoker current status unknown
- ◯ unknown, if ever smoked

Years smoked _____

Packs per day:
- ◯ <=0.5
- ◯ 1.0
- ◯ 1.5
- ◯ 2.0
- ◯ >2.0

Approx. quit date:
_____

Do you drink alcohol? ◯ Yes ◯ No drink(s)/week: _____

Indicate your ethnic or racial background:

- ◯ American Indian or Alaskan Native
- ◯ Asian
- ◯ Black or African – American
- ◯ White or Caucasian
- ◯ Hispanic
- ◯ Aboriginal
- ◯ African
- ◯ Caribbean
- ◯ East Indian
- ◯ Middle Eastern
- ◯ Other
- ◯ Unknown

What is your current occupation/work status? _____

Are you currently working? ◯ Yes ◯ No

Are you currently receiving Workers Compensation? ◯ Yes ◯ No

If you are out of work, how long? _____

Do you exercise regularly? ◯ Yes ◯ No

Are you involved in a personal injury lawsuit because of your pain? ◯ Yes ◯ No

Name_____ Date_____

***MD initials*_____**

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Prescription Refill Policy

In order to provide outstanding quality care at Robert J Banco, MD, PC, adheres to a strict prescription refill policy. Medication refills are best addressed at the time of your visit with our providers, this allows you to update the provider on any changes in your medication or advise them of any new or ongoing symptoms.

We understand, however, that sometimes this is not possible and in those situations it will be necessary to follow our refill policy.

It is your responsibility to notify the office in a timely manner when refills are necessary. Approval of your refill may take up to three (3 business days, so please be courteous and plan ahead.

Medication refills will only be addressed during regular office hours (8:30 AM to 4:00 PM). T he afterhours call service or answering machine will not return any phone calls regarding refills. Please contact the office on the next business day to place your refill request.

In order to effectively process your prescription refill request, we will need the following information:

- Date that the request is made
- Spell your first and last name
- Your date of birth
- Spell the name of the medication and dosage
- Date that the current prescription will run out
- State how you are currently taking the medication
- Name and location of your pharmacy
- Contact information were we can reach you

The following guidelines will be followed when processing your refill request:

- There will be NO refills given on Friday's after 12 PM, weekends, or Holidays.
- A process time of **3 days** minimum will be needed for **all** requests.
- There will be no early refills, patient must follow prescription directions.
- Requested medications cannot be picked up at the office.
- Prescription medications that are lost or stolen will not be replaced.
- No refills will be processed for prescriptions not initiated by our providers.
- Some medication refill requests will require a follow up appointment.
- New symptoms and/or events will require an office appointment.
- Signed "Prescription Refill Policy" is required for all medication prescriptions.

By signing below I understand, agree and accept the policy listed above. Failure to comply may subject immediate termination of prescriptive medications.

Patient Signature: _____ Date: _____

Print Name: _____

Name_____ Date_____

***MD initials*_____**

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Patient/Provider Opioid Agreement

The purpose of this agreement is to give you information about the medications you will be taking for pain management. It is also to assure that you and your health care provider comply with state and federal regulations concerning the prescribing and use of controlled substances. Opioids (narcotic analgesics) are a class of medications that are prescribed to help with pain. They can be very helpful in the management of acute episodes of pain and acute postoperative pain. It is important to understand some of the side effects of these medications. Opioids may cause drowsiness that can be worsened by the use of alcohol, benzodiazepines, and other sedating medications. If you are unsure about mixing any medication with an opioid, please ask your health care provider or pharmacist. You must avoid any activity that may be dangers to you or someone else if you feel drowsy or are not thinking clearly.

The long-term use of opioids for pain management is controversial because of uncertainty regarding the extent to which they provide long term benefit. It is the practice and policy of Robert J Banco, MD, PC not to prescribe long term maintenance opioids to our patients. Any prescription for opioids will strictly be for an acute episode (i.e. spine surgery, acute strain or injury), of short duration not to exceed three (3) months, and all patients will be tapered off the medication with a weaning schedule **at the provider's discretion.** If the patient is unable to follow the agreed upon schedule or requires more than three (3) months of prescription medications, he or she may be referred back to the primary care physician or pain management specialist for continued pain management.

Patients entering the practice while currently on a maintenance course of prescribed opioids for chronic pain will need to obtain their maintenance prescription medications from the original prescribed.

Physical dependence will develop with regular use. This does not indicate addiction, but means that a physical withdrawal syndrome will develop if you stop your medication abruptly. Tolerance may develop to the pain relieving effects of opioids, meaning that pain relief may decrease over time. In chronic pain states, this usually occurs slowly, if at all.

Some pain conditions, including post-operative pain, may not improve with opioids. A frequent need to increase doses may indicate that opioids are not effective for a particular pain problem. It could also indicate an underlying problem with addiction or psychological dependence. Discontinuation of opioid medications may occur if pain relief is not adequate in spite of escalating doses, persistent side effects, if goals of opioid therapy are not being met, or there is inability to comply with the treatment agreement.

Opioid medications have potential for abuse or diversion and strict accountability is necessary. For this reason the following policies are agreed to by you, the patient, as consideration for, and a condition of, the willingness of the physician/physician assistant (PA) whose signature appears below to consider the initial and/or continued prescription of controlled substances to treat your chronic pain.

Name_____ Date_____

***MD initials*_____**

1. All prescriptions must come from the physician/PA whose signature appears below or, during his or her absence, by the covering physician, unless specific authorization is obtained for an exception. (Multiple sources can lead to untoward drug interactions or poor coordination of treatment.)

2. All prescriptions **must be obtained at the same pharmacy,** whenever possible. Should the need arise to change pharmacies, you should try to stay within the same pharmacy chain and you **MUST** inform our office. The pharmacy that you have selected is:

   _____ Phone: _____

3. You are expected to inform our office of any new medications or medical conditions, and of any adverse effects you experience from any of the medications that you take.

4. The prescribing physician has permission to discuss all diagnostic and treatment details with dispensing pharmacists or other professionals who provide your health care for purposes maintaining accountability.

5. Stopping opioids abruptly can cause flu-like withdrawal symptoms such as nausea, vomiting, diarrhea, and sweating. While not dangers, this can be uncomfortable. It is best to wean from opioids as instructed by your health care provider.

6. You **CANNOT** share, sell or otherwise permit others to have access to these medications.

7. Prescriptions and bottles of these medications may be sought by other individuals with chemical dependency and should be closely safeguarded. Since the drugs may be hazardous or lethal to a person who is not tolerant to their effects, especially a child, you must keep them out of reach of such people. It is expected that's you will take the highest possible degree of care with your medication and prescription. It is best to lock up your medication in a safe or lock box. You should not leave your medications wh3ere others might see or have access to them.

8. Medications may not be replaced if they are lost, get wet, are destroyed, left on an airplane, have been stolen, etc. If is your responsibility to keep your medications safe.

9. Early refills will generally not be given. Prescription refills may be issues early if the physician/PA

10. or patient will be out of town when a refill is due. These prescriptions will contain instructions to the pharmacist that they not be filled prior to the appropriate date.

11. Renewals are contingent on keeping scheduled appointments. Please do not phone for prescriptions after hours or on weekends as covering providers will not prescribe refills for narcotics.

12. It should be understood that any medical treatment is initially a trial, and that continued opioid prescription is contingent on evidence of benefit. The risks and potential benefits of these therapies are explained in the informational piece of this agreement.

13. It is understood that failure to adhere to these policies may result in cessation of therapy with opioid prescribing by this physician/PA or referral for further specialty assessment.

14. You affirm that you have full right and power to sign and be bound by this agreement, and that you have read, understand, and accept all of its terms.

_____	_____
Provider Signature	Patient Signature
_____	_____
Provider Name (printed)	Patient Name (printed)
Date: _____	Date: _____

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NOTICE OF PRIVACY PRACTICES
EFFECTIVE 9-01-2015

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

Robert J Banco, MD, PC may record, transmit, or maintain, either on paper or electronically, personal information about you, your medical history and your healthcare treatment as part of providing you with healthcare services.
This Notice of Privacy Practices ("Notice") describes how we may use and disclose such information, our obligations regarding the use and disclosure of your medical information, and your rights with respect to the use and disclosure of your medical information. This Notice is required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

OVERVIEW
We are legally required to protect the privacy of information that identifies you or could be used to identify you, and relates to your past, present or future physical or mental health condition(s) or the provision of past, present, or future healthcare services (including payment for those services). This information is called "protected health information" or "PHI" for short.
We are legally required to follow the privacy practices that are described in this Notice. We reserve the right to change our privacy policies and the terms of this Notice at any time. Before any important policy change goes into effect, we will change this Notice.
We will post a copy of this Notice in all our registration areas for public viewing and on our website at **www.bostonspinecaregroup.com**. You may also request a copy of this Notice at any time by contacting Robert J Banco, MD, PC's Compliance Officer at 25 Washington Street, Unit 1B, Wellesley, MA 02481.

USE AND DISCLOSURE OF YOUR PHI BY Robert J Banco, MD, PC
We may use or disclose your PHI to carry out its responsibilities as a healthcare provider. **We** may use or disclose your PHI without your written authorization for the following reasons:
• **Treatment. We** may disclose PHI to physicians, nurses, technicians, hospitals, medical students or other personnel who are involved with the administration of your care at or other locations.
• **Payment.** We may use and disclose PHI so that payment for the treatment and services you receive at Robert J Banco, MD, PC or from other entities, such as an ambulance company, may be billed to and collected from you, or an insurance company or third party. We may also need to disclose this information to insurance companies to establish insurance eligibility benefits for you.
• **Healthcare Operations.** "Healthcare operations" at Robert J Banco, MD, PC include activities related to improving quality of care, staff training, medical education, and business management.
• **Appointment Reminders, Information about Healthcare Related Benefits and Treatment Alternatives.** We may use and disclose medical information to contact you as a reminder that you have an appointment for a treatment or medical care to inform you of treatment alternatives or other healthcare services or benefits that we offer.
• **As Required By Law. We** will disclose PHI when required to do so by federal or state law, including in response to a court or administrative order, subpoena, discovery request, warrant, summons or other lawful process. **We** may also disclose PHI to law enforcement personnel or similar persons to avoid a serious threat to the health or safety of a person or the public.

In addition, **we** may use your PHI without your written authorization under the following circumstances:
• Emergency situations when your authorization cannot be reasonably obtained, including for disaster relief purposes;
• To business associates (outside vendors or consultants that perform services on behalf of Robert J Banco, MD, PC and are contractually required to appropriately safeguard your information);
• To other healthcare facilities where **the** physicians and healthcare professionals have privileges or to physicians from other healthcare facilities who see patients at Robert J Banco, MD, PC;
• With your agreement, to a family member, relative, close personal friend, or any other person you identify;
• To facilitate organ or tissue donation if you are an organ donor;
• In connection with workers' compensation claims;
• To report abuse, neglect, or domestic violence as required by state of federal law;
• For public health and health oversight activities, such as preventing or controlling disease or investigations; or
• To coroners, medical examiners, or funeral directors as necessary to carry out their duties.

Certain actions, such as most uses of disclosures of psychotherapy notes, the use and disclosure of PHI for marketing purposes, and disclosures that constitute a sale of PHI, will be made only with your written permission (authorization). Other uses or disclosures of PHI that are not covered by this Notice or applicable laws also will be made only with your written permission. Massachusetts provides special privacy protections for particularly sensitive conditions or illnesses such as HIV/AIDS, mental health, and substance abuse. **We** will disclose such information only in a manner that is consistent with these laws. You may revoke your permission at any time by writing to the compliance officer at the address below. Once you revoke your permission, we will stop using or disclosing such information for the reasons covered by your written authorization. However, we cannot take back any disclosures made with your permission. We will retain our records of the care provided to you as required by law.

YOUR RIGHTS REGARDING YOUR PHI
Although your medical information is the property of Robert J Banco, MD, PC, you have certain rights regarding your PHI, including the right to:
• **Inspect and Copy.** With certain exceptions, you have the right to inspect or receive a copy of your medical information or both. We may charge a fee for these services. We may deny your request in certain limited circumstances. If you are denied access to your medical information, you may request that the denial be reviewed. Another licensed healthcare professional chosen by Robert J Banco, MD, PC will review your request and our denial.
• **Request an Amendment.** If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend information that is kept by or for Robert J Banco, MD, PC. We may deny your request if you ask us to amend information that (a) was not created by Robert J Banco, MD, PC; (b) is not part of the medical information kept by or for Robert J Banco, MD, PC; (c) is not medical information you are permitted to inspect or copy; or (d) is accurate and complete in the record.
• **Request an Accounting of Disclosures.** You may request a list of the disclosures we have made of PHI that were for purposes other than treatment, payment, healthcare operations and certain other purposes, or disclosures made with your written authorization within the last six (6) years. You may be charged a fee in connection with this request.
• **Restrict or Limit Use or Disclosure.** You may ask us to restrict or limit the use or disclosure of your PHI, including the disclosure of information to someone who is involved in your care or the payment for

your care, like a family member or friend. Your request must state: (1) what information you want to limit; (2) whether you want to limit the physicians use, disclosure or both; and (3) to whom the limits apply, for example, disclosures to your spouse. We are not required to agree to your request, unless it relates to an item or service you paid for in full and out of pocket. In this case, you may request that we not share health information pertaining only to that product or service with your health plan for the purposes of carrying out payment or healthcare operations and we will comply with your request unless the information is needed to provide you emergency treatment or except as required by law.

• **Confidential Communications.** Generally, we will use the address, telephone number and, in some cases, the email address you give us to contact you. You may ask us to communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

• **Notification in the Event of a Breach.** Consistent with federal and state laws, we will notify you in the event unsecured PHI is used or disclosed by an unauthorized individual.

All requests must be submitted in writing to the address below. Your request must be specific and be signed by you or an authorized representative.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint by writing to the address below or by calling Robert J Banco, MD, PC's compliance officer at 617-219-6300. You may also file a complaint in writing with the Secretary of the U.S. Department of Health and Human Services in Washington, D.C. or through the regional office at J.F.K. Federal Building – Room 1874, Boston, MA 02203. The complaint must be filed within 180 days of the alleged violation. There will be no retaliation for filing a complaint.

CONTACT INFORMATION

If you have questions, would like to submit a written request, or need further assistance regarding this policy, please contact Kirsten Gage at:

25 Washington Street, Unit 1B, Wellesley, MA 02481
Phone: 617-219-6300
Fax: 617-219-6355

EFFECTIVE DATE

This Notice of Privacy Practices is effective **September 1, 2015**.

Boston Spine
CARE GROUP

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers, or as a result of a liability or worker's compensation claim.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

By signing below, I acknowledge that I have been offered/received a copy of Robert J Banco, MD, PC's Notice of Privacy Practice document.

Patient Name: _____D.O.B. _____

Signature: _____DATE: _____

Relationship to Patient: _____

Please list below the names, relationships, and phone numbers of any authorized individuals with whom we may discuss your medical or financial information. This permission will extend to making and verifying appointments, billing information, discussing test results, and general care with either the office staff and/or providers.

NAME	RELATIONSHIP	PHONE
_____	_____	000-000-0000
_____	_____	000-000-0000
_____	_____	000-000-0000

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: Initials: Reason: Refused Communication Barrier Emergency Other

Name_____ Date_____

***MD initials*_____**