Lotus
CENTER OF HEALTH

(910) 726-9976
www.lotuscenterofhealth.com
1721 New Hanover Medical Park Dr
Wilmington, NC 28403

Ashli Gibson, MSN, PMH-NP, CNM

This document is to inform you about the process of obtaining psychiatric services and what you can expect from me as your provider. This document contains several things you need to be aware of, so please read it carefully.

About Your Provider

I am a Psychiatric Mental Health Nurse Practitioner (License #5019203) and a Certified Nurse-Midwife (License #640) licensed under the North Carolina Board of Nursing. I am also a Certified Perinatal Mental Health Professional through Postpartum Support International. I hold Masters of Science in Nursing degrees from East Carolina University and Frontier Nursing University.

I have twelve years of experience in perinatal health including six years as a labor and delivery nurse and six years as a Certified Nurse-Midwife. In this role, I provide gynecological, pregnancy, postpartum, and mental health services. I also provide psychiatric services to male, female, and gender non-identifying individuals ranging in age from 18-90 years of age. The issues I work with include postpartum depression, post-traumatic stress, anxiety, depression, grief, bipolar, ADHD, OCD, menopause, and general health counseling. My interests include working with pregnant individuals, postpartum individuals, and individuals with reproductive concerns through the lifespan.

Credentials

I am a member of Postpartum Support International (PSI) and the American College of Nurse Midwives.

Therapeutic and Treatment Process

This is a voluntary process that you can leave at any point if you feel it is not working for you. It is imperative that you are involved in this process. I may ask you to be involved in introspective work in addition to finding an individualized pharmacological treatment plan that works best for you. I take a holistic approach rooted in evidence-based medicine to meet you, the client, where you are currently, and help you to accomplish your goals. I have experience utilizing pharmacology, pharmacogenomic testing, lab assessment, and health counseling in order to empower you along your individual health journey.

Psychiatric Nurse Practitioners are trained in therapy; however, I will likely encourage you to seek additional talk therapy services with a licensed therapist. Our sessions will primarily focus on medication management and behavioral changes, whereas talk therapy sessions allow much more time and space to explore your individual mental health needs. I work closely with many therapists in the community. We will work closely to find a therapy option that is best suited for you.

There are no guarantees in this process and there are some risks involved. Most pharmaceutical treatments have side effects and some have potential risks which will be thoroughly explained to you in addition to alternative treatments including the option of deferring treatment. Informed consent is a pillar of my practice and as the client, I will respect your right to autonomy and informed decision-making. In addition to potential treatments with medication, I will encourage you to assess and potentially change some current behaviors that can impact your mental health. You may experience changes to your life that cause great joy and relief, as well as pain and sadness. Ultimately, I will serve as a partner in your process while you guide your health care journey.

ADHD and Benzodiazepine refills require an appointment every 2-6 months. ADHD medication prescriptions will require a drug screen at the initial visit. If you miss or cancel a follow up appointment, understand that your controlled substance medication may not be refilled until your next appointment. Current regulations allow these visits to occur via tele-health, however, this is subject to change. If regulations change, you will be notified, and in-person visits may be required.

Ethical Guidelines

As a Nurse Practitioner, I strive to uphold the NC Board of Nursing's regulations and ethical standards. If you would like to read over this Code and get an idea of what you can expect from me, you can visit the NCBON website: https://www.ncbon.com/practice-nurse-practitioner-nurse-practitioner-laws-rules.

Here are a few key points you need to be aware of:

1) Our relationship will always be professional.
2) Confidentiality will always be a priority (discussed more in detail below).
3) I will do my best to help you with any concern you present to me. However, there may be some instances where I am not competent, and I will need to refer you to another colleague. I will include you in this decision and we will work it out collaboratively. Per NC law, I have a supervising physician that I collaborate with. If I have concerns about your care or need to consult, they are immediately available to serve as a team member in your care. Their information is available upon request.

Confidentiality

I will protect the confidentiality of information received in our counseling relationship as specified by federal and state laws, written policies and ethical standards. For any of the following matters, legally and ethically, I may break confidentiality and involve others who can help. Exceptions to confidentiality are listed below. (ACA Code of Ethics is cited in parentheses.)

A. If mandated by a court of law (Section B1e).

B. Danger to self or others: if disclosure is required to prevent clear and imminent danger to yourself and/or others. This may include contacting family members or others who can help provide protection, initiating hospitalization, notifying the police, or alerting individuals who may be at risk of harm if danger to others is expressed (Section B1c):

C. Child and adult/elder abuse: if I am made aware of the potential or actual occurrence(s) of physical/sexual abuse of minors, persons with disabilities or senior citizens (Section B1c);

D. Communicable and fatal diseases: I will disclose information to an identified third party who is at high risk of contracting a disease from you that is both communicable and fatal, providing that you have not already informed him/her or are not intending to do so (Section B1d).

E. DSM-V (Diagnostic and Statistical Manual) diagnoses are used for clinical and billing purposes. These diagnoses become part of your individual file.

There are rare cases of judicial proceedings – if you are involved in judicial proceedings, you have the right to prevent me from providing any information about your treatment. However, in some circumstances in which your emotional condition is an important element, a judge may require testimony through a court order. Although these situations can be rare, I will make every effort to discuss the proceedings accordingly. I also reserve the right to consult with other professionals when appropriate. In these circumstances, your identity will not be revealed and only important clinical information will be discussed. Please note that such consultants are also legally bound to keep this information confidential.

Legal matters requiring the testimony of a mental health professional can arise. This, however, can be damaging to the relationship between a patient and his/her provider. As such, I recommend that you hire an independent forensic mental health professional for such services if necessary.

There may be times in which administrative assistants will access your record for billing and administrative purposes. If a referral is necessary, this will be discussed in session and your provider will work to collaborate with referring professionals to coordinate your care. Please note, however, that although I attempt to identify top quality professionals with very high standards of care, I cannot be responsible for the services/treatment that they provide. It is always your responsibility to determine if a professional referral is acceptable, and alternative options will be considered. Your health information will be shared with referring practices only by your permission. If insurance reimbursement is pursued, insurance companies also often require information about diagnosis, treatment, and other important information (as described above) as a condition of your insurance coverage.

Length of Session and Tardiness

Intake appointments are 60-90 minutes and follow-up visits are 30 minutes. Please understand that the first appointment is a consultation, and that attending this appointment does not guarantee a patient-provider relationship. If indicated, medications may be prescribed or continued if you are currently taking medications, but this will be based on the clinician's judgment. It may be deemed that another provider would be a better fit and I will help you to find alternative services. Scheduling an appointment reserves a specific block of time to be spent directly on your care. Please arrive on time. To prevent other patients from having to wait, I may not be able to extend your appointment due to late arrival. If you are more than 10 minutes late, your visit will be canceled.

Tele-medicine visits are offered for follow-up visits. All initial visits must be in person. The potential risk of tele-medicine services is that there could be a partial or complete failure of the equipment being used which could result in mental health staff's inability to complete the evaluation, mental health services, and/or prescription process.

There is no permanent video or voice recording kept of the telehealth service's session. All existing confidentiality protections apply. All existing laws regarding client access to mental health information and copies of mental health records apply.

Cancelation Policy

Please cancel or reschedule your appointment by 5pm the business day prior to the scheduled appointment. Cancellations after 5pm or appointments not canceled/rescheduled will be charged a fee of $100. If an appointment is not canceled or rescheduled, any future appointments may be canceled without notice. Three canceled visits will result in the termination of services.

Cost

Payment via cash, credit card or HSA is expected at the time of the service. I currently accept most insurance plans. For those without insurance, please contact the office to inquire about our discounted self-pay rate. When using insurance, all co-payment, deductible or co-insurance amounts are quoted by your insurance company and final determination of a claim will be made when an explanation of benefits has been processed. Clients are responsible for charges not covered or reimbursed by insurance. In the event of non-payment, clients agree to assume the cost of interest, collection and legal action (if required).

Client Records

I will be keeping notes of all our sessions and phone conversations. These notes will be descriptive and non-judgmental, containing information on what we talk about in sessions. These are for your benefit, as well as mine. It will allow us to see what has transpired and how far you have progressed during this process. You will have access to your record through the electronic medical record. In order to share information, I need a signed release of information from you. I will not share any of your protected health care information without your explicit consent.

Use of Diagnosis

Insurance companies require a mental health diagnosis be indicated in order to reimburse for services. Any diagnosis that is given will be part of your permanent insurance records.

Medication Refills/Emergency Situations

You can request medication refills through your account in the electronic medical record or by contacting the office. This will be checked throughout the week, however, medications requested after lunchtime on Friday afternoon will not be filled until Monday morning of the following week. I am the sole psychiatric prescriber at this practice and am the only one checking medication refill requests/messages. Please allow 48 hours for the provider to respond to a request. If you need assistance, you can call the office for an expedited response. Please be aware of your medication supply. Refills and supplies will be discussed at each of your appointments.

If you find yourself in a crisis which you feel needs immediate attention, call 911 or go to the nearest emergency room. If you deem it necessary to speak with me prior to the next business day, call Lotus Center of Health at (910) 726-9976 during business hours**. Please also note that messages sent through the electronic health record should never be used for urgent or emergency issues. I cannot ensure that email messages will be received or responded to in a timely fashion.**

Additional Resources:

RHA Mobile Crisis Unit 24/hr Line:

844-709-4097

Coastal Horizons Rape Crisis Center 24/hr Line

910-392-7460

Trillium Health Services 24/hr Crisis Line

1-877-685-2415

National Suicide Prevention 24/hr Lifeline

1-800-273-8255

Disputes/Complaints

If you feel I have, in any way, acted unethically or unprofessionally towards you, I hope you will discuss this with me. However, if you do not feel comfortable doing that, you may contact Lotus Center of Health's practice manager through the main phone line, and/or the North Carolina Board of Nursing:

https://www.ncbon.com/discipline-compliance-public-complaint

If I deem that our relationship has become non-productive, I have the right to terminate psychiatric services at my discretion. In this instance, I will ensure you have medication refills, and you will not be put at risk as a result of a termination. I will also assist you in finding a different provider.

By signing below, you acknowledge you have read the informed consent and had the opportunity to ask any questions you may have. You will be given a copy of this informed consent to keep for your records, in order to refer back to it. If any questions come up during this process, please do not hesitate to ask.

Printed Name: _____

Signature: _____ **Date:** _____

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What prompted you to seek mental health services at this time?

_____
_____
_____

Have you seen someone previously for mental health concerns and if so, were you given a diagnosis?

_____
_____
_____

Are you currently taking any medications or supplements? If so please list the names and the dosages.

_____
_____
_____

Have you tried any other medications in the past and if so, which ones?

_____
_____
_____

Do you drink alcohol or do any recreational drugs? If so, which ones?

_____
_____
_____

What is your gender identity and preferred pronouns?

_____
_____
_____

Well-being assessment

1. If 0 represents the worst possible life you could be living and 10 represents the best possible life you could be living, where are you currently? _____

2. How would you rate your physical health (0 not at all healthy, 10 the healthiest)? _____

3. How would you rate your nutrition? (0 is the worst possible, 10 is the best possible)? _____

3a. Are you able to buy the food you need? _____

4. How often do you worry about being able to meet your monthly living expenses? (0 never, 10 always)
_____

5. Do you do physical activity or move your body regularly? If so, how often and for how long?
_____

5a. What activity do you do? _____

6. Do you feel you have limitations because of your health? _____

7. How do you rate your overall mental health (0 poor – 10 excellent)? _____

8. I understand my purpose in life (0 strongly disagree to 10 strongly agree) _____

9. I am content with my friendships and relationships (0 strongly disagree to 10 strongly agree)
_____

10. How often do you feel lonely? (0 never to10 always) _____

11. How much time do you spend on social media per day? _____

12. How much time do you estimate you use screens per day (video games, TV, etc)? _____

13. Do you have a spiritual practice? _____

14. Do you spend time outside? How? _____

15. If there is one thing in your life that you think could be improved that impacts your mood or mental health, what would that be? _____

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

ID #: _____ DATE: _____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
	add columns		+	+

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

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GAD-7 Anxiety

Over the last two weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid, as if something awful might happen	0	1	2	3

Column totals _____ + _____ + _____ + _____ =

Total score _____

If you checked any problems, how difficult have they made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Scoring GAD-7 Anxiety Severity

This is calculated by assigning scores of 0, 1, 2, and 3 to the response categories, respectively, of “not at all,” “several days,” “more than half the days,” and “nearly every day.”
GAD-7 total score for the seven items ranges from 0 to 21.

0–4: minimal anxiety

5–9: mild anxiety

10–14: moderate anxiety

15–21: severe anxiety

Lotus Center of Health New Patient Intake Form

Visit Date: _____

PATIENT INFORMATION

Patient name *(last, first, M.I):*	**Preferred Name:**	
Gender Identity:	**Date of birth**:	**Age:**
Sex at birth:	**Pronouns:**	
Address:	**Phone Number:**	
SSN#:	**Primary care:**	
Email:	**Specialists:**	
Emergency contact name/relationship/number:	**Pharmacy:**	

Reason for visit: ☐ Routine ☐ Problem

What have you tried?:

Did it help?:

ALLERGIES

Allergy:	Reaction:

CURRENT MEDICATIONS: *Include prescribed, over-the-counter drugs, vitamins, herbal remedies or supplements, inhalers, etc.:*

Name of medication (space on back if needed)	strength/dose	Frequency	Reason for taking

PERSONAL MEDICAL HISTORY (space on back)

☐ Yes ☐ No	**High blood pressure**	☐ Yes ☐ No	**Heart disease**	☐ Yes ☐ No	**Seizures**
☐ Yes ☐ No	**Migraines**	☐ Yes ☐ No	**CVA/TIA/Stroke**	☐ Yes ☐ No	**Liver/Gall bladder disease**
☐ Yes ☐ No	**High cholesterol**	☐ Yes ☐ No	**Diabetes**	☐ Yes ☐ No	**Kidney disease**
☐ Yes ☐ No	**Blood cloting disorder/DVT**	☐ Yes ☐ No	**Cancer**	☐ Yes ☐ No	**Mental health issue**
☐ Yes ☐ No	**GYN disorder**	☐ Yes ☐ No	**Thyroid/endocrine disease**	☐ Yes ☐ No	**Other: (space on back)**

SURGICAL HISTORY

Year	Type of surgery	Reason for surgery

FAMILY HISTORY

Family history of major illnesses? *(mother, father, siblings)* please list:	☐ Yes ☐ No
Relatives with breast, ovarian, uterine, or colon cancer? If yes, who & age:	☐ Yes ☐ No or unknown

SOCIAL HISTORY			
Do you smoke cigarettes or vape? ☐ Yes - How many/day?	How many years?	☐ Quit, year:	☐ No
Do you drink alcohol? ☐ Yes - How many/day?	How many/week?		☐ No
Do you use drugs? ☐ Yes - describe			☐ No
Exercise regularly? ☐ Yes	☐ Moderate (walking, yoga):	☐ Vigorous (running):	☐ No
Do you feel safe in your own home? ☐ Yes	☐ No - explain		
Do you have any history of emotional, physical, sexual abuse? ☐ Yes - *type?*			☐ No
Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed			
Current job/school:			

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HIPAA Compliance Patient Consent Form

(This form must be completed by the patient**)**

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change. If so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

You consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease. The practice may condition receipt of treatment upon execution of this consent.

Call, email, or send a text to you to confirm appointments? YES NO

Leave a message on your answering machine at home or cell phone? YES NO

Discuss your medical condition with a family member or designated individual? YES NO

IF YES, please name the members allowed: _____

This consent was signed by (print name): _____

Signature: _____Date: _____

IF minor -please print your name and relationship to minor: _____

Parent/Guardian Signature: _____ Date: _____

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Filing Insurance Claims

To file any claims, we must have the most recent insurance information. The information below should be completed in full. Failure to provide accurate information could result in a denied insurance claim and any unpaid balance will be your responsibility.

*This information is only required if you are a dependent on the Insurance Policy.

Subscriber Name: _____
Subscriber Date of Birth: _____
Subscriber Primary Address: (if different from patient): _____
_____
Subscriber Relationship to patient: _____

Billing

We encourage all patients to sign up for the Practice Fusion patient portal or provide us with a valid email. Any invoices for outstanding balances will be sent through text, the patient portal or email with a secure link to pay your balance online. Any outstanding balance must be paid within 30 days. If you have a balance and return for an appointment before 30 days, you will be required to pay your outstanding balance before being seen. If you have any questions about the portal, please ask one of our receptionists.

I have read and understand the above:

Patient name (printed): _____
Patient Signature: _____
Date: _____

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No-Show, Late Arrival & Cancellation Agreement

Our goal is to provide excellent care in a timely manner. This means attending scheduled appointments, if an appointment must be changed, it is important to do so as early as possible, so we may schedule wait-list patients in open slots.

- I shall give at least 24-hour notice if I need to change or cancel an appointment.
- I understand that late cancellations (less than 24-hour notice) may be reviewed on an individual basis. Repeated late cancellations may result in a missed appointment fee of $100.
- I understand that multiple reminders by phone and/or email serve as opportunities for patients or caregivers to confirm, cancel or reschedule an upcoming appointment.
- I understand that missing (no-show) appointments will result in a $100 fee. These situations will be considered on a case-by-case basis and could result in a dismissal from the practice.
- I understand that rescheduling an appointment may result in a delay in scheduling my next appointment.
- I understand that arriving 15 minutes or more late for an appointment will result in that appointment being rescheduled. Repeated late arrivals may result in a no-show fee of $100.

We understand that emergencies, illnesses and unforeseen situations occur. We ask that you make every effort to keep your appointment. Missed appointments and late cancellation may be reviewed on an individual basis.

I understand and agree to the above:

Patient name (printed): _____

Patient signature: _____

Date: _____

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Lotus Zero-Tolerance Practice Policy

Lotus Center of Health operates a zero-tolerance policy for any abuse or bad behavior towards our staff and patients. This could be physical, verbal or online abuse.

All practice staff have a right to care for others without fear of being attacked, abused, or treated badly in any way. To successfully provide our services, mutual respect between staff and patients must be in place. Our staff aims to be polite, helpful, and sensitive to all patients' individual needs and circumstances. We respectfully remind patients that we are people who are working hard to provide excellent care while navigating many simultaneous demands.

Aggressive behavior, be it physical, verbal or online, will not be tolerated and may result in you being removed from the practice and, in extreme cases, the authorities contacted.

In order for Lotus to maintain good relations with our patients, we ask you to read and take note of the occasional types of behavior we have seen, which are unacceptable:

- Using disrespectful or derogatory language, shouting or raising of voices
- Any physical violence towards a member of our team or other patients
- Racist, xenophobic, sexist, homophobic or other intolerant language, discrimination or sexual harassment
- Being aggressive, belligerent, bullying or manipulating towards staff
- Causing damage to, or theft of, any equipment from the practice premises, staff or patients
- Obtaining drugs and/or medical services fraudulently
- Posting slanderous online content

The removal of patients from our practice is an exceptionally rare event and is a last resort in an impaired provider-patient relationship. We value successful relationships based on mutual respect and trust. When the relationship has irreversibly broken down, the practice will consider all factors before removing a patient from care.

If a patient is discharged from Lotus, they would have access to our healthcare services for emergency purposes only for 30 days. After that, we are not required to provide care for that individual. Please sign below acknowledging that you have read and understand the above information.

Patient signature: _____ Date: _____

Print name: _____

TERMS OF RECEIPT OF MEDICAL CARE OR TREATMENT

CONSENT FOR TREATMENT: The patient is under the control of the attending physician. The undersigned consents to any medical treatments or procedures (except for invasive procedures which require special consent), X-ray, examination, diagnostic and laboratory procedures, medications, injections, taking of photographs or video for clinical, education or identification purposes, and hospital services rendered to the patient of the general and special instructions of the attending physician(s) or other providers assisting in the care of the patient. The undersigned is aware that the practice of medicine is not an exact science and acknowledges that no guarantee or assurance has been made or implied to the patient as to the result that may be obtained from examination or treatment. The undersigned has been informed of his/her patient rights and responsibilities.

RELEASE OF INFORMATION: The undersigned hereby authorizes Dr. Sarah Gore, DO to disclose the patient's medical record or other medical information to any person or corporation which is or may be liable for all or part of Dr. Sarah Gore's charges or to any person or corporation who has the responsibility for reviewing such charges, including but not limited to medical service organizations, health maintenance organizations, insurance companies, employers, welfare funds, or peer review organizations. The undersigned agrees that Dr. Sarah Gore, DO may copy medical record(s) which is/are to be sent to a receiving facility in the event that the undersigned may be transferred to another care provider/facility. The undersigned acknowledges and consents that the medical records, laboratory results, radiology reports and billing information may be sent or disclosed to another medical facility, physician office, or provider involved in the care of the patient or responsible for any part of the patient's charges.

REQUEST FOR PAYMENT, ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION FOR MEDICARE PATIENTS: The undersigned requests payment of authorized Medicare benefits, if any, for any services furnished to the patient by Dr. Sarah Gore, DO and hereby assigned to Dr. Sarah Gore, DO. The undersigned authorizes Dr. Sarah Gore, DO to submit a claim for such services to Medicare. The undersigned authorizes any holder of medical or other information about the patient to release to Medicare, or its agents, claims processors or utilization reviewers, any information needed to determine these benefits or benefits for related services.

ASSIGNMENT OF INDIVIDUAL BENEFITS: If the undersigned is entitled to medical benefits of any type whatsoever arising out of any policy of insurance insuring the patient or any other party liable to the patient, the undersigned authorizes Dr. Sarah Gore, DO to submit a claim for such services, and benefits are hereby assigned to Dr. Sarah Gore, DO for application on the patient(s) bill. It is agreed that Dr. Sarah Gore, DO may receive any such payment and shall discharge the paying insurance company of any and all obligations under the policy to the extent of such payment. The undersigned and/or patient are responsible for charges not covered by the insurance company. The undersigned certifies that the patient information contained on this form that is given by or on behalf of the patient is applying for payment from all third-party payors is correct.

FINANCIAL AGREEMENT: The undersigned understands and agrees that the patient and our guarantor are financially responsible to Dr. Sarah Gore, DO for charges for medical services or treatments provided to, or on behalf of, the patient if such services are not covered by the hospitalization plan, insurance, or Medicare. The undersigned certifies that he/she has read the foregoing and is the patient or guarantor of this bill or is duly authorized by the patient as the patient's general agent to execute the document and accept the terms. In the event that my account(s) is not satisfied in full my account may be reported to the credit bureaus. The undersigned hereby agrees that upon the discharge of the patient by Dr. Sarah Gore, DO, the undersigned will be responsible for the patient and will make necessary arrangements to have the patient transferred from Dr. Sarah Gore, DO.

I HAVE READ OR HAVE HAD EACH OF THE SECTIONS READ TO ME, AND ALL OF MY QUESTIONS HAVE BEEN ANSWERED.

By affixing my signature below, I affirm that I am the patient, or I am authorized to act on behalf of the patient to sign this document verifying consent to the above stated terms.

Patient Signature _____ **Date** _____

Guarantor Signature _____ **Date** _____

Relationship to Patient _____

THIS FORM IS PART OF THE PERMANENT MEDICAL RECORD