PATIENT CONFIDENTIAL INFORMATION

Referring source: ____________________ **Primary Physician:** ________________________

I : Personal Information:

*Name: (First)____ (Middle)_________ *(Last)__________________________

*Address:____ Apt: _____ City: ______________ State: _______ Zip:_________

*Home Phone :( )________________ *Cell phone :( )________________ Biz phone : _________________

Age: _______ *Date of Birth:______ / _____ / ______ *Sex: M / F Marital: M_ S_ D_ W_ Other______

Social Security # : _______________________ Driver's License No:_______________________________

*Email: ____ (Only use for notice)

Employer company:____ Work company Phone:__________ Ext______

Employer company's Address:____

In case of emergency contact:

*Name: ______________________________ Relationship:______________________ Email:________________________

*Address:_____________________________________ Apt: _____ City: ___________ State: ________Zip:_________

*Home Phone :( )_______________ *Cell Phone :( )_______________ Work Phone :( )______________Ext______

II. Responsible party :(Who is financially responsible for the account?)

Name:[ ]self ____________________________ Relationship to patient:________________________

Address:[ ]same as patient's ___________________________ City: _____________State: ___________Zip:_________

Date of Birth: _______________ Social Security # : _______________________ Home Phone :( )_______________

Employer: ___________________________Work Phone :( )______________Ext________

Patient's Authorization

I hereby authorize TrendCare Acupuncture / Acupuncturist, to give me and/or my dependents reasonable and proper medical care by today's standards and to apply for benefits on behalf of myself and/or dependents for all services rendered. I certify that the information I have reported herein is correct and authorize the TrendCare Acupuncture or Acupuncturist to release all necessary information (including medical records) to secure the payment of benefits. I hereby assign directly to TrendCare Acupuncture or Kuan-chung Chou all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all my insurance claims submitted, and permit a copy of this authorization to be used in place of original. This authorization may be revoked by either me or above named carriers at any time in writing.

* I also acknowledge that I received a copy of HIPPA Privacy Act.
* I already review and agree to follow the rule of Acupuncture Procedure / Policy, First Times Acupuncture Need to Known and security camera recording policy.
* Patient must fill the "Patient Progress Form" for insurance medical records every visit. If patient didn't do it, your insurance may reject to pay your treatment.

I have read the above information and certify it to be true and correct to the best of my knowledge and belief and hereby authorize this office to do whatever is necessary, in accordance with state statutes, for the care and management of this complaint.

X____ Date ______/______/_______

Authorized Signature of Subscriber/Beneficiary or Guardian

Current Medical History

First Name________________ Last Name ________________ date:____/_____/______

Chief Complaint (Main reason for Visit): ____
(We Submit This diagnosis to your Insurance company)
2nd Complaint: ____

What is your condition due to / initial cause?

A) MOTOR Vehicle Accident, date:_____ , Reason:___________________ Police Report: Y/N Lawsuit : Y/N

B) Work injury, date:_____ , C): Other Accident(specify), ________________date:_____ D): Unknow_________

How long have you had your problem? ___________________ How often _______

Since the date of accident, the symptoms are A)Improve, B)Getting worse , C) About same, D)Come and go with activites, E) Constant

Do you have Pregnancy/peacemaker/heart disease/Respiratory/Allergies/Fractures/ Metal or Machine inside the body /Other _________

Female only: Are you pregnant? Y/N, First day of last menstrual period:_______________

Has a physician given you a diagnosis for this condition?_____________Name:______ Date:_______

X-ray/MRI/ lab tests for this condition? : Area:_________Any fractures? Y/N, What were the finding of the examination? ___________

Prior Automobile Accident or Work related injuries before this accident? No / Yes____________________

Prior Episodes? Y N , if Yes please explain:_______________________________

Please describe your activities of daily living & work Activities:______________________

Does your pain radiate to another part of your body? :______________________

Have you ever received any previous physical; therapy or chiropractic care ?No Yes__________________

Do it cause by Car Accident Y/N ? ________ When:____ :

What reduces your complaints / pain? A)Rest, B)Medication , C) Hot/cold pack or shower, D)Other:_________

What makes your condition WORSE ?____

Is it worse at certain times of year?______________ Certain weather?_____________

What treatments or medication are you currently using? ______________________________effective?___________

What treatments or medication have you tried in the past? (Chemotherapy, Steroids, ...)_____________ effective?_________

Is there anything else about your health/medical history that we should know about?________________

Past Medical History

Surgeries/Medical Procedures : __________________________________ date _______

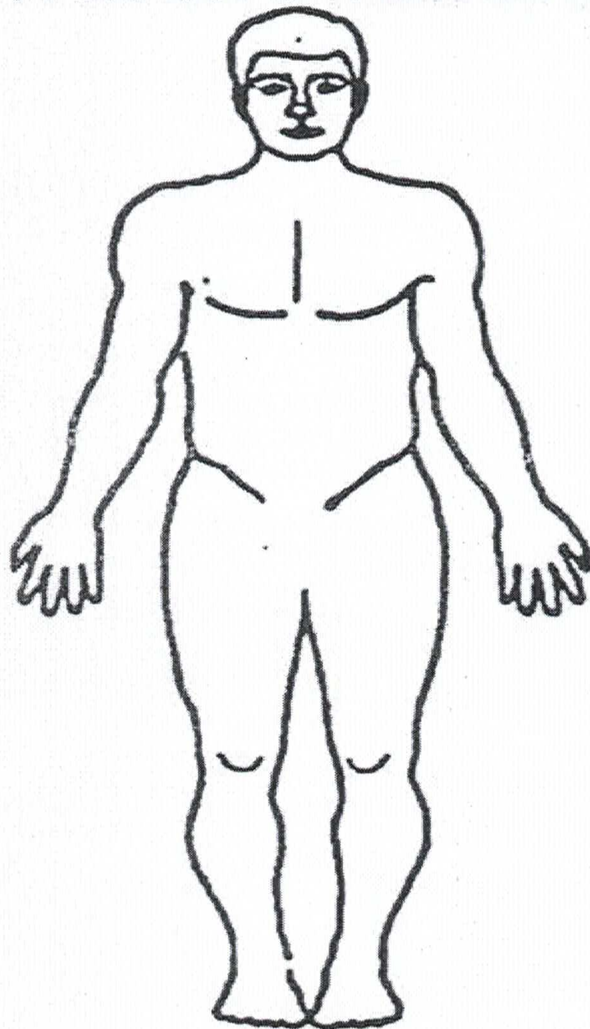
Past Physical Traumas (car accident, fall, , broken bones or dislocations .) _________________________________

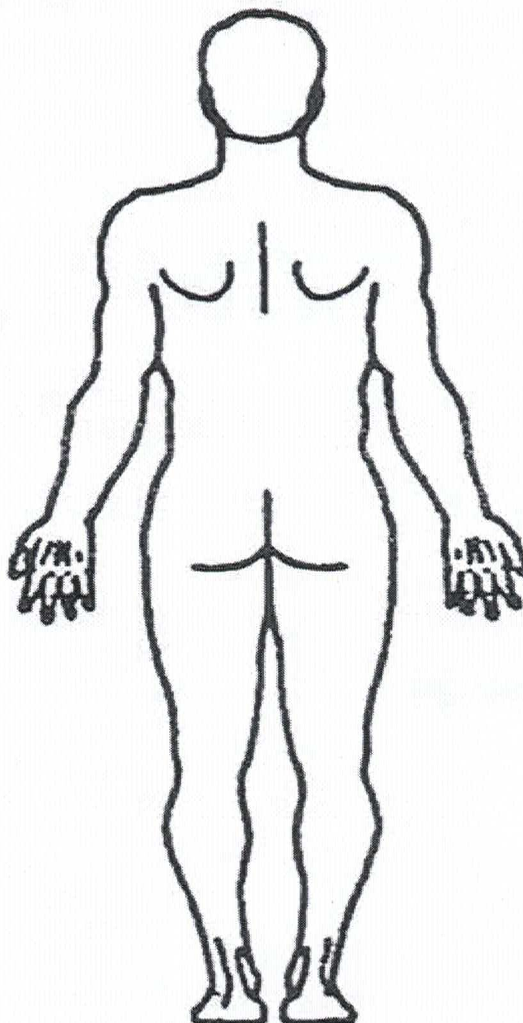
Past Emotional Traumas (divorce, death in family, .)__________________________________

Check any of the following conditions you have or have had in the past:

___Appendicitis	___Blood clots	___Heart disease	___Mononucleosis	___Stroke
___Alcoholism	___Bronchitis	___Headaches	___Multiple sclerosis	___Thyroid disorder
___Allergies	___Chicken pox	___Hepatitis	___Mumps	___Tuberculosis
___Antibiotic use	___Cancer	___Herpes	___Nervous disorder	___Vascular disease
___Appendicitis	___Diabetes	___Hypertension	___Osteoporosis	___Ulcers
___Arthritis	___Depression	___IBS	___Pacemaker	___Gout
___Asthma	___Emphysema	___Jaundice	___Parasites	___Measles
___Birth trauma	___Gall bladder disorder	___Kidney disorder	___Phlebitis	___Seizures
___Bleeding disorder	___Glaucoma	___Liver disorder	___Pneumonia	___Other__________

MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.





Ache	Numbness	Pins& Needles	Burning	Stabbing
^^^^	====	0000	XXXX	////

Please indicate the pain locations on model's body and the numb between 0 and 10 that best describes your pain.

A) Pain location: ________________ Pain intensity: ________________ (1 – 10 , 10 is unbearable) Pain frequency: Occasional/Intermittent/Frenquent/Constant ______________ (? times/per day/week) Dull / Sharp / Dull to Sharp Range of motion: ______________ (%)	B) Pain location: ________________ Pain intensity: ________________ (1 – 10 , 10 is unbearable) Pain frequency: Occasional/Intermittent/Frenquent/Constant ______________ (? times/per day/week) Dull / Sharp / Dull to Sharp Range of motion: ______________ (%)
C) Pain location: ________________ Pain intensity: ________________ (1 – 10 , 10 is unbearable) Pain frequency: Occasional/Intermittent/Frenquent/Constant ______________ (? times/per day/week) Dull / Sharp / Dull to Sharp Range of motion: ______________ (%)	D) Pain location: ________________ Pain intensity: ________________ (1 – 10 , 10 is unbearable) Pain frequency: Occasional/Intermittent/Frenquent/Constant ______________ (? times/per day/week) Dull / Sharp / Dull to Sharp Range of motion: ______________ (%)

First Name________________ **Last Name** ________________ **date:**____/_____/_____

Financial Policy

<u>Please initialize each paragraph</u>

To our patients:
It is the goal of our office to have our fully understand their insurance coverage and financial responsibilities. We participate with many provider organizations throughout the area. Below is an outline policy.

Insurance company / Auto insurance / Compensation insurance:

X _________ (Initialize) **It is Your** (patient) **Responsibility to check your acupuncture benefit with your insurance.** I understand TrendCare Acupuncture / Acupuncturist **DO NOT** check my insurance benefit. **Patient must fill the "Patient Progress Form" for insurance record every visit. If patient didn't do it, your insurance may reject to pay your treatment.** I hereby assign directly to TrendCare Acupuncture / Kuan-chung Chou all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. Before the service, Patient may needs to provide the authorization letter from your insurance company, the letter must issue to TrendCare Acupuncture / Kuan-Chung Chou and allow to do the acupuncture service.

We value your patronage and try to accommodate all questions regarding your insurance; but ultimately it is the patient's responsibility to contact their insurance company regarding their coverage. I hereby authorize TrendCare Acupuncture, to give me and/or my dependents reasonable and proper medical care by today's standards and to apply for benefits on behalf of myself and/or dependents for all services rendered.

For those patients covered by insurance, we will accept assignment of benefits. **Some of policies DO NOT cover your treatment, some of policies have deductible, some of policies need to get your Doctor referral / pre-certification / pre-determination / pre-authorization before the treatment, some of policies ONLY cover some conditions or limitations (for example : anesthesia, osteoarthritis of the knee, tension headache, chronic back pain and neck pain.....) even your benefit is cover the acupuncture. You may also have diagnosis (code) from your medical doctor.** We will assist you in dealing with the insurance company, but ultimately the responsibility lies with you. If, after **30 days**, the insurance company hasn't paid, the balance will be due, in full, by you and we will charge the insurance schedule fee each time when you get the acupuncture service until your insurance pay the fee. All balance over 30 days is subject to interest in amount of 1.5% per month mandated by State law. We reserve the right to apply $50 re-billing fee and $25 late charge toward overdue financial agreement

Self Pay:

X __________ (Initialize) We request full payment at time of service. Patient will be charge the discount fee by each time. If you take the package, Refunds that you don't use service are not offered for the Cost Savings Option. Refund that you don't use service is available within the 3 months. Package is available for 3 years. Package is NO transfer to others. For financial assistance application (Good Samaritan Discount) to people and family who meet the certain income requirement. Please sign to get the discount price.

X __________(Initialize) **Herbal Medicine**: All herbal medicine is customized formula. It is no return and no refund.

X __________(Initialize) **Schedule Fee**: If my Insurance doesn't cover the medical care service, **I agree to pay most of the insurance schedule fee (first visit (New patient Office visit + Acupuncture(45 mins)): $195 - $250, Follow-up: $96- $130 /per visit/45 mins) for acupuncture service. I authorize TrendCare Acupuncture or collection company to bill me or charge my credit card for the full payment (Debit cards not allowed). I am giving up my right to a jury or court trial for the collection issue, financial issue or any other issue. We offer a discount rate ONLY when paying at the time of service for acupuncture in which we are NOT billing insurance.**

X ___________(Initialize) **Cancellation less than 24 hour / Missing Appointment fee:**
Your appointment time is reserved specifically for you. In the event of a missed appointment or an appointment cancelled with less than 24 hours notice you may be charged a **$50 fee**. Insurance will not pay for a missed appointment.

Confidentiality notice:
The information contained herein is for the sole use of our office. It will be shared with a collection agency/court should I fail to pay a balance on my account; or with the legal system should that become necessary. In the event account becomes delinquent customer will be liable for all reasonable collection fee including but not limited to collection company professional fee and processing fees. If I fail to pay the balance in 30 days, I am hereby authorized the collection company to report my account balance information to any credit reporting agency and credit bureau. In the event I / patient authorize/agree TrendCare Acupuncture's collection company to give a lawsuit action, I / Patient agree and shall be responsible for all court fee / attorney fees and filing fees. The law suit court is assigned at Fairfax county, VA or Montgomery county, MD.

I have read the above information and certify it to be true and correct to the best of my knowledge and belief and hereby authorize this office to do whatever is necessary, in accordance with state statutes, for the care and management of this complaint. I understand that nothing relieved me of primary responsibility and obligation to pay for medical services provided when statement is rendered.

Patient Name(Print): ____________________ Date of Birth : ___ / ___ / ___

X Patient Signature: ______________________ Date :_____/_____/_____ (Authorized Signature of Subscriber/Beneficiary or Guardian)

PATIENT NAME:

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process, except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. Further, the parties will not have the right to participate as a member of any class of claimants, and there shall be no authority for any dispute to be decided on a class action basis. An arbitration can only decide a dispute between the parties and may not consolidate or join the claims of other persons who have similar claims.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, as to whether this agreement is unconscionable, and any procedural disputes, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the healthcare provider, including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the healthcare provider and/or other licensed healthcare providers, preceptors, or interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the healthcare provider, including those working at the healthcare provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the healthcare provider, and/or the healthcare provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages. This agreement is intended to create an open book account unless and until revoked.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) and provide National Arbitration and Mediation ("NAM") with the party arbitrator's contact information within thirty days of the date Respondent files its initial responsive pleading. A third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties from a list of arbitrators supplied by National Arbitration and Mediation ("NAM") within thirty days thereafter. The list supplied by NAM shall be a list of between 5 and 10 arbitrators, depending upon availability. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's equal share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit. Either party shall have the absolute right to bifurcate the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder, any existing court action against such additional person or entity shall be stayed pending arbitration. The parties agree that provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that, where not in conflict with this agreement, the Healthcare Malpractice Dispute Resolution Rules and Procedures of NAM shall govern any arbitration conducted pursuant to this Arbitration Agreement. A copy of NAM rules are available on its website at https://www.namadr.com or by calling 1-800-358-2550 to request a copy of the rules.

Article 4: General Provision: All claims based upon the same incident, transaction, or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the healthcare provider within 30 days of signature and, if not revoked, will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment), patient should initial here. _______. Effective as of the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

Both parties agree that this agreement may be electronically signed, and that the electronic signatures appearing on this agreement are the same as handwritten signatures for the purposes of validity, enforceability, and admissibility.

Patient Name (print): ______________________ Signature: ______________________________ Date: ______________

Parent or Guardian (print): ___________________ Signature: ______________________________ Date: ______________

Office Name: _____________________________ Signature: ______________________________ Date: ______________

ALSO SIGN THE INFORMED CONSENT ON REVERSE SIDE

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ACUPUNCTURE INFORMED CONSENT TO TREAT

I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding the care recommended, the benefits and risks associated with the care, alternatives, and the potential effect on my health if I choose not to receive the care. Acupuncture is not intended to substitute for diagnosis or treatment by medical doctors or to be used as an alternative to necessary medical care. It is expected that you are under the care of a primary care physician or medical specialist, that pregnant patients are being managed by an appropriate healthcare professional, and that patients seeking adjunctive cancer support are under the care of an oncologist.

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist indicated below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with, or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I appreciate that it is not possible to consider every possible complication to care. I have been informed that acupuncture is a generally safe method of treatment, but, as with all types of healthcare interventions, there are some risks to care, including, but not limited to: bruising; numbness or tingling near the needling sites that may last a few days; and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal, and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. I will notify a clinical staff member who is caring for me if I am, or become, pregnant or if I am nursing. Should I become pregnant, I will discontinue all herbs and supplements until I have consulted and received advice from my acupuncturist and/or obstetrician. Some possible side effects of taking herbs are: nausea; gas; stomachache; vomiting; liver or kidney damage; headache; diarrhea; rashes; hives; and tingling of the tongue.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand that, as with all healthcare approaches, results are not guaranteed, and there is no promise to cure.

I understand that I must inform, and continue to fully inform, this office of any medical history, family history, medications, and/or supplements being taken currently (prescription and over-the-counter). I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

I understand that there are treatment options available for my condition other than acupuncture procedures. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, I understand that I have the right to a second opinion and to secure other options about my circumstances and healthcare as I see fit.

By voluntarily signing below, I confirm that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I agree with the current or future recommendations for care. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Both parties agree that this agreement may be electronically signed, and that the electronic signatures appearing on this agreement are the same as handwritten signatures for the purposes of validity, enforceability, and admissibility.

PATIENT NAME:

ACUPUNCTURIST NAME:

(Date)

PATIENT SIGNATURE: **X**

(Or Patient Representative) (Indicate relationship if signing for patient)

ALSO SIGN THE ARBITRATION AGREEMENT ON REVERSE SIDE

Allied Professionals' Insurance Services All Rights Reserved, Rev. 9/4/20

Insurance Information:

If you cover by insurance, you **MUST provide ALL of insurance** company's information. Even primary / secondary is NOT cover).
I understand that **It is Patient's Responsibility to check your acupuncture benefit with your insurance.**

How many insurances you TOTALLY have (include Medicare / Medicaid..)? __1, __ 2, __ 3

- If you fail to provide ALL insurance information, your insurance will reject to pay your treatment.
- If you fail to provide all correct information and need to resubmit to your insurance, you will be charged 10% resubmit claim fee.
- That you understand and agree that insurance policies are an arrangement between an insurance carrier and yourself.
- That you must pay all deductibles, co-pay, co-insurance.

1st Insurance : __HMO __PPO

- Do my this PLAN benefit COVER by acupuncture treatments? Yes / NO / Unknown
- Is Dr. Kuan-Chung Chou (NPI:1477694461) / Trendcare Acupuncture (EIN: 871540309) in my **PLAN** network provider ? Yes / NO / Unknown
- Do this acupuncture policy COVER by your health "Conditions or Problem" treatment ? Yes / NO / Unknown
- Do this acupuncture policy Need referral or Pre-Authorization ? Yes / NO / Unknown

*If your answer is "NO" or "Unknown", you may be request to pay your treatment fee before acupuncture service. Or you can call your insurance before your service.

PolicyHolder : ____________________ Insured's Birth Date:____________
Relationship to patient: ____________________ Insured's SSN:____________
Insurance company Name:____________________ Plan Name : ____________
ID#:____________ Group #:____________
Group Name::____________________ Plan / Coverage type : HMO / PPO /____________
Employer company:____________________ Work company Phone:____________
Employer company's Address:____________________

Secondary Insurance(patient's):
Name of Insured : ____________________ Insured's Birth Date:____________
Relationship to policyholder: self / spouse / child / other Insured's SSN:____________
ID#:____________

2nd insurance : __HMO __PPO

- Do my this PLAN benefit COVER by acupuncture treatments? Yes / NO / Unknown
- Is Dr. Kuan-Chung Chou (NPI:1477694461)/ Trendcare Acupuncture (EIN: 871540309) in my **PLAN** network provider ? Yes / NO / Unknown
- Do this acupuncture policy COVER by your health "Conditions or Problem" treatment ? Yes / NO / Unknown
- Do this acupuncture policy Need referral or Pre-Authorization ? Yes / NO / Unknown

*If your answer is "NO" or "Unknown", you may be request to pay your treatment fee before acupuncture service. Or you can call your insurance before your service.

PolicyHolder : ____________________ Insured's Birth Date:____________
Relationship to patient: ____________________ Insured's SSN:____________
Insurance company Name:____________________ Plan Name : ____________
ID#:____________ Group #:____________
Group Name::____________________ Plan / Coverage type : HMO / PPO /____________
Employer company:____________________ Work company Phone:____________
Employer company's Address:____________________

Secondary Insurance(patient's):
Name of Insured : ____________________ Insured's Birth Date:____________
Relationship to policyholder: self / spouse / child / other Insured's SSN:____________
ID#:____________

You must fill out the PROGRESS Form each time. If don't fill out this form, your insurance may reject to pay for your treatment. I understand that I am financially responsible for all charges whether or not paid by insurance. I have read the above information and certify it to be true and correct to the best of my knowledge and belief and hereby authorize this office to do whatever is necessary, in accordance with state statutes, for the care and management of this complaint.

X____________________ Authorized Signature of Subscriber/Beneficiary or Guardian Date ______/______/______