NEW PATIENT INFORMATION

PATIENT INFORMATION

Date: ____/____/____

Name:_____ S.S. # ____-____-____
LAST FIRST MI

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

Home Phone:(___)_____ Cell:(___)_____ Email:_____

Occupation:_____ Employer: _____

Work Status: ☐ Full-Time ☐ Part-Time ☐ Self-Employed ☐ Unemployed ☐ Off-Work ☐ Student

Date of Birth: ____/____/____ Age:_____ Gender: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Children: ☐ Yes ☐ No How many?_____

Spouse's Name:_____ Phone:(___)_____

Spouse's Employer:_____ Phone:(___)_____

Emergency Contact:_____ Phone:(___)_____

INSURANCE/PAYMENT INFORMATION

Is your injury/illness work related? ☐ Yes ☐ No

If yes, have you reported the injury to your employer? ☐ Yes ☐ No Date of Injury: ____/____/____

Is your injury/illness related to an automobile accident? ☐ Yes ☐ No If yes, please complete the following:

Your auto insurance company name and address:_____

_____

Claim #:_____ Policy #:_____

Attorney name and address:_____

_____

Do you have health insurance? ☐ Yes ☐ No If yes, please complete the following:

1. Primary insurance company name:_____

   Address:_____

   Insured's Name:_____ ID #:_____ Group #:_____

2. Secondary insurance company name:_____

   Address:_____

   Insured's Name:_____ ID #:_____ Group #:_____

ASSIGNMENT AND RELEASE

I, the undersigned assign directly to Stillwater Spine & Sports Center, Inc. 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 hereby authorize Stillwater Spine & Sports Center, Inc. to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions and/or request pertaining to my physical condition, including, but not limited to, all records, reports, progress notes, reports of diagnostic tests, x-rays and/or medical opinions.

_____ ____/____/____

RESPONSIBLE PARTY SIGNATURE **RELATIONSHIP** **DATE**

PATIENT CONDITION

Describe your major complaint(s):_____

_____

Date you first noticed symptoms:_____ Describe how they began:_____

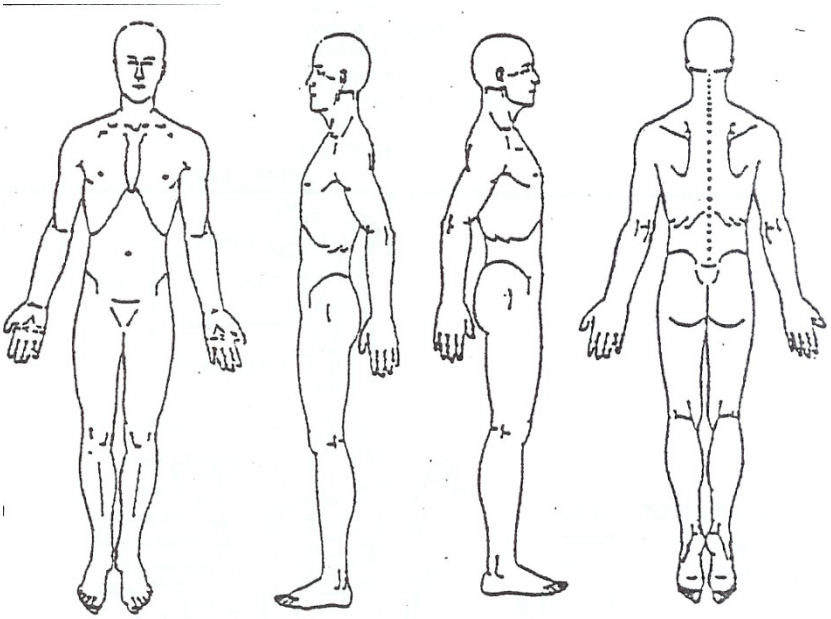
_____

Have you had these symptoms before? ☐ Yes ☐ No If yes, when:_____

How often do you experience the symptoms?

- Constantly (76%-100% of the day)
- Frequently (51%-75% of the day)
- Occasionally (26%-50% of the day)
- Intermittently (0%-25% of the day)

PLEASE MARK BELOW WHERE YOU HAVE SYMPTOMS



How would you describe the symptoms?

Sharp	Shooting	Stabbing	Weakness
Dull	Burning	Stiffness	Throbbing
Numb	Tingling	Cramps	Achy

How are your symptoms changing?

Getting Better Getting Worse No Change

How would you rate your symptoms at their:

	None										Unbearable
Best:	0	1	2	3	4	5	6	7	8	9	10
Worst:	0	1	2	3	4	5	6	7	8	9	10

How do your symptoms affect your ability to perform daily activities?

No Complaints		Mild, forgotten with activity		Moderate, interferes with activity		Limiting, prevents full activity		Intense, preoccupied with seeking relief		Severe, activity not possible
0	1	2	3	4	5	6	7	8	9	10

What makes your symptoms worse?_____

What makes your symptoms better?_____

Have you seen any other health care professionals for this condition? ☐ Yes ☐ No If yes, list the providers:

Name/Address: Date:

Name/Address: Date:

Have you had any tests done for your symptoms? ☐ Yes ☐ No If yes, please check test and give date:

☐X-Rays_____ ☐CT Scan_____ ☐MRI_____ ☐Lab_____ ☐Other:_____

Please indicate findings if known:_____

Last blood tests:_____ Last eye exam:_____ Last dental visit:_____

Any other diagnostic tests in past 3 years, if so what and when:_____

Have you seen any other health care professionals for any other condition? ☐ Yes ☐ No If yes, please list:

Name/Address: Date:

Name/Address: Date:

Primary care provider:

Name/Address: Date:

Name/Address: Date:

*If ***child***, last well child visit:_____ *If ***male***, last prostate exam/PSA evaluation:_____

*If ***female***, last Pap test:_____; Pelvic exam:_____; Breast exam:_____;

Last mammogram:_____; Do you do self breast exams? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No If yes, Due Date:_____

HEALTH HISTORY

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	Yes	No	Dizziness	Yes	No	Kidney Disease	Yes	No	Rheum. Fever	Yes	No
Alcoholism	Yes	No	Eating Disorder	Yes	No	Liver Disease	Yes	No	Ringing in Ears	Yes	No
Anemia	Yes	No	Epilepsy	Yes	No	Loss of Balance	Yes	No	Shortness of Breath	Yes	No
Ankle Swelling	Yes	No	Excessive Thirst	Yes	No	Loss of Sleep	Yes	No	STD	Yes	No
Arthritis	Yes	No	Fainting	Yes	No	Miscarriage	Yes	No	Stroke	Yes	No
Asthma	Yes	No	Fatigue	Yes	No	Mononucleosis	Yes	No	Thyroid Problem	Yes	No
Bleeding Disorder	Yes	No	Fever	Yes	No	Multiple Sclerosis	Yes	No	Tuberculosis	Yes	No
Bowel/Bladder Changes	Yes	No	Fractures	Yes	No	Nausea	Yes	No	Tumors	Yes	No
Breast Lump	Yes	No	General Stiffness	Yes	No	Night Sweats	Yes	No	Ulcers	Yes	No
Cancer	Yes	No	Glaucoma	Yes	No	Numbness	Yes	No	Unintentional Weight Loss	Yes	No
Chemical Dependency	Yes	No	Goiter	Yes	No	Osteoporosis	Yes	No	Vaginal Infections	Yes	No
Chest Pain	Yes	No	Gout	Yes	No	Pacemaker	Yes	No	Venereal Disease	Yes	No
Chronic Cough	Yes	No	Headaches	Yes	No	Pinched Nerve	Yes	No	Visual Problem	Yes	No
Cold Limbs	Yes	No	Heartburn	Yes	No	Pins/Needles Feeling in Limbs	Yes	No	Vomiting	Yes	No
Depression	Yes	No	Heart Problem	Yes	No	Pneumonia	Yes	No	Other_____		
Diabetes	Yes	No	Hernia	Yes	No	Polio	Yes	No	_____		
Diarrhea	Yes	No	Herniated Disc	Yes	No	Prostrate Problem	Yes	No	_____		
Digestive Problems	Yes	No	Herpes	Yes	No	Prosthesis	Yes	No			
			High Cholesterol	Yes	No	Psychiatric Care	Yes	No			
			Hypertension	Yes	No						

EXERCISE

None
Moderate
Daily
Heavy

WORK ACTIVITY

Sitting
Standing
Light Labor
Heavy Labor

HABITS

Smoking: Packs / Day:_____
Alcohol: Drinks / Week:_____
Caffeine: Cups / Day:_____
High Stress: Reason:_____

DIET & WATER

List any special dietary plans that you may be following (Paleo diet, Vegetarian diet, etc.):_____

List any particular dietary items that you may be avoiding (dairy, gluten, etc.):_____

Approximately how many ounces of water do you drink a day?_____

INJURIES / SURGERIES / ACCIDENTS

Description Date

Falls:_____ _____

Head Injuries:_____ _____

Broken Bones:_____ _____

Dislocations:_____ _____

Surgeries (Including Cosmetic):_____ _____

Automobile Accidents:_____ _____

MEDICATIONS

Name	Dosage

VITAMINS / HERBS / SUPPLEMENTS

Name

ALLERGIES

Drugs?_____

Foods?_____

Environmental or chemical?_____

FAMILY HISTORY

Do you have a family history of any of the following diseases: (Check those that apply)

	Brother/Sister	Mother	Maternal GM	Maternal GF	Father	Paternal GM	Paternal GF
Asthma/Hay fever/Hives							
Arthritis							
Autoimmune Disease							
Cancer							
Dementia							
Diabetes							
Epilepsy							
Heart Disease							
High Blood Pressure							
Stroke							

Any other relevant family history?_____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Purpose: In cases where Stillwater Spine & Sports Center, Inc. has directed not to rely on Acknowledgements as a basis to use or disclose health information, this form is used to obtain a patient's consent to our use and disclosure of the patient's protected health information to carry out treatment, payment activities, and healthcare operations, as described more fully in our Notice of Privacy Practices.

SECTION A: PATIENT GIVING CONSENT

Name:_____

Address:_____

Telephone:_____ Social Security Number:_____

SECTION B: TO THE PATIENT-PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, healthcare and practice operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Ashli Scales, Office Manager

Telephone: (406)756-7634

Address: Stillwater Spine and Sports Center, Inc. 3171 U.S. Hwy 93 N., Ste C, Kalispell, MT 59901

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I,_____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, health care and practice operations.

Signature:_____ Date:_____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient:_____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in **the patient's chart.**

Stillwater Spine & Sports Center, Inc.
Tye K. LeDuc, D.C.
3171 Hwy 93 N Suite C, Kalispell, MT 59901. Office – 406.756.7634 Fax – 406.756.7643

INFORMED CONSENT TO CHIROPRACTIC / PHYSICAL THERAPY OR OTHER TREATMENT OR CARE

Please read this consent form carefully, discuss it with your clinician or anyone else if you would like to, and then sign where indicated at the bottom if you consent to the treatment/care offered.

Risks of Care/Treatment: As clinicians who use manual therapy techniques, such as for example spinal joint adjustment or manipulation or mobilization, as well as other treatment modalities, we desire to inform our patients that there are risks associated with such treatment and care that cannot always be avoided despite standard and appropriate care. Some of those risks include:

a) While rare, some patients have experienced muscle and ligament sprains, strains or injuries, as well as fractures following manual therapy.

b) There have been reported cases of injury to a vertebral artery following neck/spinal adjustment, manipulation, mobilization, or treatment. Such vertebral artery injuries may on rare occasion cause stroke, which may result in serious neurological injury and/or physical and cognative impairment. This form of complication is a rare event, occurring about 1 time per 1 million treatments. While this complication is rare, please understand that you may experience this complication despite standard and appropriate care and we cannot avoid this complication in all circumstances.

c) There have been reported cases of disc injuries following chiropractic treatement or manual therapy and physical therapy. Although, no scientific study has ever demonstrated that such injuries are caused, or may be caused, by adjustment or manipulative techniques and such cases are also very rare. Nonetheless, please understand you may experience this complication despite standard and appropriate care, and we cannot avoid this complication in all circumstances.

d) Depending upon the treatment, there are other risks associated with chiropractic and physical therapy treatment, such as soreness, aggravation of injuries, spinal cord complications, burning, freezing, electrical stimulation, infection, etc. It is not possible to outline all those risks here but please understand that they may occur in rare situations despite appropriate and standard care.

Treatments provided at this Clinic, including spinal adjustment, manipulation and/or mobilization, have been the subject of much research conducted over many years and have been demonstrated to be appropriate and effective treatments for many common forms of spinal pain, pain in the shoulders/arms/legs, headaches and other similar symptoms. Treatment provided at this Clinic may also contribute to your overall well-being. The risk of injury or complication from manual treatment is lower than the risk associated with many medications, other treatments, and procedures frequently given as alternative treatments for the same forms of musculoskeletal pain and other associated syndromes. Your clinician will evaluate your individual case, provide an explanation of recommended care and a suggested treatment plan, or alternatively a referral for consultation and/or further evaluation if deemed necessary.

There are likely other forms of treatment available to treat your concerns and symptoms. Your clinician will explain those other options to you, and you should inquire about those other options and research or explore those other options as you deem appropriate after consultation.

You have the right to ask your clinician or any other medical provider questions about risks of chiropractic, physical therapy, or other treatment modalities offered to you at our Clinic. You further have the right to refuse any treatment or stop any treatment recommended to you at any time. We encourage you to investigate these risks on your own.

Acknowledgement: I acknowledge I have discussed, or have been given the opportunity to discuss, with my clinician or anyone else I deem appropriate, the nature of chiropractic, physical therapy, and/or manual treatment in general and my treatment in particular at this Clinic. I have also carefully read this Consent form and have had the ability to ask questions about its content and discuss it with all others as I deem appropriate. After reviewing I understand the contents of this form and am comfortable proceeding with the care offered at Stillwater Spine & Sports Center, Inc. I acknowledge that I may experience complications, which may be serious and life altering and may include those risks or complications outlined above, as well as others not outlined. I acknowledge these complications occur despite appropriate and standard care provided by the clinicians at this Clinic. I have weighed and compared my options and alternatives. I fully accept those risks of complications as I move forward with my decision to undergo the recommended treatment.

Consent: I consent to the chiropractic/physical therapy/ and other manual or therapeutic treatments offered or recommended to me by my clinicians at Stillwater Spine & Sports Center, Inc., including joint adjustment or manipulation or mobilization to the joints of my spine (neck and back), pelvis and extremities (shoulder, upper limbs and lower limbs). I intend this consent to apply to all my present and future treatments at this clinic unless I express an unequivocal withdrawal of this consent. My consent is provided with the understanding of the right to refuse treatment and with an understanding of the risks and injuries that could arise during treatment, risks and injuries that cannot be controlled or prevented by the clinicians providing the care.

Dated this _____ day of_____, 20_____

Patient Signature Patient Date of Birth

(Please print name of patient)

Patient Address

Signature of Witness/Translator

(Please print name of Witness/Translator)

Signature of Guardian (when applicable)

(Please print name of Guardian)

PATIENT WAIVER FOR NON-COVERED SERVICE

Extra-Corporeal Shockwave Therapy (ECSWT) Consent Form

WHAT DOES ECSWT DO?

Extracorporeal shockwave therapy is a non-invasive treatment in which a device is used to pass acoustic shockwaves through the skin to the affected area, it can be utilized in the treatment of tendon and bone pathology.
The shockwaves stimulate the body's own healing mechanisms to facilitate the repair of the damaged tendon and bone.

This is not considered a "covered benefit" under your health insurance plan and as such, your insurance will not pay for these services.

Your provider believes that ECSWT, although not covered by your health insurance is an important part of your care and recommends that you receive this service as part of your current treatment plan. However, since the service listed is not considered to be a covered benefit under your health insurance, should you choose to receive this service; you will be personally responsible for the payment at the time of service. The purpose of this notice is to help you make an informed choice about whether you want to receive this service.

Each shockwave treatment will be a separately billed service from your regularly scheduled appointment and will be billed at a charge of $40.00 per treatment.

Please check ONE box:

☐ I acknowledge that I have been informed in advance of receiving this service and that this service is NOT covered by my health insurance plan. I have chosen to receive this service and understand that I will be financially responsible for the charges indicated above.

☐ I acknowledge that I have been informed in advance of receiving this service and that this service is NOT covered by my health insurance plan. I have chosen NOT to receive this service.

Print Patient Name:_____

Patient Signature:_____

Date:_____

This form must be signed by the patient or legal guardian **PRIOR** to receiving ECSWT and *must be retained in the patient's medical record*.

Stillwater Spine & Sports Center, Inc.

Tye K. Le Duc, D.C.
3171 U.S. Hwy 93 N., Suite C, Kalispell, MT 59901. Office – 406.756.7634 Fax – 406.756.7643

PAYMENT POLICIES

Please read carefully. This is an enforceable contract once signed by you.

Insurance

- We will gladly submit insurance claims to your insurance carrier at no additional charge to the Patient or Responsible Party. We submit claims to only two insurance carriers (primary and one supplemental). The only exception is Medicare which we are legally required to bill in many circumstances. *Medicare* will then submit your claim to any supplemental insurance you may have.
- State law requires that your insurance submit payment to us within 30 days however, sometimes insurance can be reluctant to pay or just plain slow! Payment is due on accounts within 60 days, regardless of your insurance coverage. We will be glad to assist you in contacting your insurance company regarding your claim, but ultimately the Patient or Responsible Party is expected to contact his/her insurance company if the insurance carrier fails to respond, is late responding, pays only a portion of what is due, or denies the claim.
- We will only resubmit your claim one time at no additional charge. If your insurance carrier has not paid after resubmitting your claim, Stillwater Spine & Sports Center, Inc. cannot pursue collection of insurance accounts without additional costs to the Patient or Responsible Party. Should you notice that your insurance has not paid on your account, you are responsible for contacting your insurance carrier to determine the status of your claim.
- If a claim is returned to Stillwater Spine & Sports Center Inc. due to an improper address, incorrect identification number or any other incorrect information, we will resubmit your claim after confirming correct information with you. Claims are submitted via the United States Postal Service. In the event a claim is not received by your insurance carrier, it will be returned to us in the mail.
- Insurance coverage and deductible information will be verified before Stillwater Spine & Sports Center, Inc. considers an account an "Insurance Account". We estimate the Patient's or Responsible Party's portion or co-pay based on information from your insurance carrier. Please realize that this may contribute to a Credit on your account or a Balance Owing greater than was estimated.
- If your insurance carrier is unavailable at the time of service and cannot verify your coverage or deductible, a payment or some portion of payment is required at the time of service. We will reimburse you as appropriate if your insurance subsequently pays for the care.
- Some charges billed by this office **may not** be covered by your insurance. The Patient or Responsible Party is ultimately responsible for any amount over and above what your insurance will cover in addition to any co-pay that applies to your policy. **By signing below, you agree to pay any charges for your care that are not covered by insurance.**

Third Party Liability/Insurance

- Stillwater Spine & Sports Center Inc. reserves the right to not bill your health insurance, Medicare, Medicaid or other supplemental insurance if a third party or potential third party or its insurer(s) is liable or responsible for the treatment you are receiving from us and the related charges. Stillwater Spine & Sports Center Inc. retains the sole discretion to determine whether and when to bill health insurance, Medicare, Medicaid, liability insurance, medical payments insurance, or other supplemental insurance under these circumstances and will comply with applicable laws addressing this situation. See e.g. ARM 37.85.407.

- This situation may arise in the context of us treating you for injuries received in an automobile accident or some other accident or incident where another third party is liable for your injuries and the treatment we are providing. In this situation, we will bill/submit our full charges (not Medicaid/Medicare approved charges or the charges agreed to under any agreement with any health insurer) to the third party and/or their liability insurer and we are entitled to collect full payment directly from them. Your signature below confirms your agreement and consent to this collection directly from the third party or its insurer(s).
- In the event you, directly or through an attorney or agent, make a claim and you collect from a third party or its insurer(s) the amount of Stillwater Spine & Sports Center Inc.'s charges, or any potion thereof, your signature below confirms that you agree to pay from that collection the full amount of Stillwater Spine & Sports Center Inc.'s bills for services. You agree that all collections and payments from third party liability insurance will be at the full, charged amount for Stillwater Spine & Sports Center, Inc.'s services and will not be reduced by any amount authorized by Medicaid/Medicare or any contracted amounts with any health insurers.
- Stillwater Spine & Sports Center Inc. shall also have a lien for the full amount of all treatment charges on any proceeds, recovery, or settlement you receive from a third party or its liability insurer that relates to, includes or is based on the injuries and/or conditions for which we are providing you care or treatement. See e.g. 71-3-1114, MCA.
- If you receive medical payments benefits, reimbursement, or advance payments from any third party or any liability or medical payments insurance (non- health care insurance) policy based on an injury or condition sustained by you which we treated or are treating, you further agree to pay from those benefits, reimbursements or payments the full amount of Stillwater Spine & Sports Center Inc.'s bills for services. You agree that all collections and payments from any third party, liability insurance or medical payment's insurance will be at the full, charged amount for our service and will not be reduced by any amount authorized by Medicaid/Medicare for our service or any contracted amounts with any health insurers.

General

- Payment in full is expected at the time of service. However, we are sensitive to the fact that some Patients may not be able to pay in full. We will assist you in setting up an individual payment plan requiring a monthly payment. We do require, however, that your balance be **kept under $300.00**. In the event that your balance does exceed $300.00, you will no longer be able to receive treatment until a payment has been made. A 1.5% finance charge will be applied to any account on any balance over 60 days.
- In the unlikely event that your account is turned over to a collection agency, the Patient or Responsible Party will be responsible for payment of any and all collection fees, attorney fees and court costs incurred in the collection of your unpaid balance owed, including finance charges. Should an account be designated a "Collection" account, you will be approved as a "Cash Only" account, to be paid in full at the time of service should you require our services in the future.
- Our office can be a very busy place. If we are given plenty of notice on cancelled appointments, we can fill those appointment times. However, we have a *non-cancellation* or *no-show* policy. A $20.00 charge will be applied to your accounts for appointments not cancelled at least 4 hours prior to the scheduled time or for failure to show up for scheduled appointments. **This charge cannot be billed to insurance!**

By signing below, you are stating that you have read, fully understand, and agree to be bound by the terms set forth in these payment policies, including all of the above conditions and agreements.

_____ _____

Date Signature of Patient or Responsible Party

Stillwater Spine & Sports Center, Inc.

Tye K. Le Duc, D.C.
3171 U.S. Hwy 93 N., Suite C, Kalispell, MT 59901. Office – 406.756.7634 Fax – 406.756.7643

PAYMENT OPTIONS

Stillwater Spine & Sports Center, Inc. provides several options for payment, including Cash, Credit Card (we do not accept American Express), or Check. In addition, we accept most major medical insurance (General Insurance), Personal Injury (Pl), Workers Compensation and Medicare/Medicaid. Please inquire at the front desk regarding the option of your choice. Please also read carefully our **PAYMENT POLICIES** that will be provided to you in a separate form.

Cash

Payment is expected at the time of service. However, we are sensitive to the fact that some Patients may not be able to pay in full. We will be happy to assist you in setting up an individual payment plan. We do require, however, that your balance be kept under $300.00. In the event that your balance does exceed $300.00, you will no longer be able to receive treatment until a payment has been made. A 1.5% finance charge will be applied to accounts over 60 days old.

Insurance

Insurance billing and payment is subject to the terms and agreements set forth in our PAYMENT POLICIES provided to you separately. In appropriate circumstances, once your insurance coverage has been verified, Stillwater Spine & Sports Center, Inc. will submit your claim to your insurance carrier at no additional charge to you. We will submit your claim to two carriers (primary and one supplemental). If your insurance carrier fails to respond or denies coverage due to incorrect information, we will *resubmit* your claim once. Some charges billed by this office may not be covered by your insurance. The Patient or Responsible Party is ultimately responsible for any amount over and above what your insurance will cover in addition to any co-pay that applies to your policy.

Things We Don't Like To Do

Our office can be a very busy place. If we are given plenty of notice on cancelled appointments, we can fill those appointments times. However, we have a *non-cancellation* or *no-show policy*. A $20.00 charge will be applied to your accounts for appointments not cancelled at least 4 hours prior to the scheduled time or for failure to show up for scheduled appointments. **This charge cannot be billed to insurance.**

PLEASE FEEL FREE TO TAKE THIS PAGE HOME FOR FUTURE REFERENCE