WISE CHIROPRACTIC

CONFIDENTIAL HEALTH INFORMATION

Please allow our staff to photocopy your driver's license and insurance details.
All information you supply is confidential. We comply with all federal privacy standards.
Please print clearly.

Wise Chiropractic
18130 US Highway 441
Mount Dora, FL 32757

Today's Date (MM/DD/YYYY) _____

Have you consulted a chiropractor before? ○ No ○ Yes When? _____

Patient Number (office use only) _____

Whom may we thank for referring you? _____ If so, whom? _____

Age _____

Gender ○ Male ○ Female

Race ○ American Indian ○ Alaskan Native ○ Asian ○ Black or African American ○ Native Hawaiian ○ Other Pacific Islander ○ Other ○ White ○ Decline to answer

Ethnicity ○ Hispanic or Latino ○ Not Hispanic or Latino ○ Decline to specify

Birth Date (MM/DD/YYYY) _____

Your Last Name _____ Your Social Security Number _____

Your First Name _____ Your Middle Name (or Initial) _____

Smoking Status (age 13 and over) ○ Never A Smoker ○ Former Smoker ○ Current Every Day Smoker ○ Current Some Day Smoker ○ Heavy Smoker ○ Light Smoker

Address _____

Marital Status ○ Married ○ Single ○ Divorced ○ Widowed ○ Separated

City _____ State/Province _____ ZIP/Postal Code _____ Preferred Language _____

Home Phone _____ Cell Phone _____ Spouse's Name _____

Email Address _____ Child's Name and Age _____

Emergency Contact _____ Emergency Contact's Phone _____ Child's Name and Age _____

Your Occupation _____ Child's Name and Age _____

Your Employer _____ Work Phone _____

Address _____ May we contact you at work? ○ Yes ○ No

City _____ State/Province _____ ZIP/Postal Code _____ Preferred method of contact? ○ Home Phone ○ Cell Phone ○ Work Phone ○ Email

Primary Care Provider's Name _____

Insurance Carrier _____ Policy Number _____

Insured's Last Name _____ Birth Date (MM/DD/YYYY) _____ Who carries this policy? ○ Self ○ Spouse ○ Parent

Insured's First Name _____ Insured's Middle Name (or Initial) _____

Insured's Employer _____

Address _____

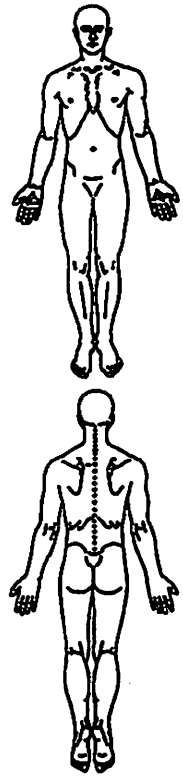
City _____ State/Province _____ ZIP/Postal Code _____ Employer's Phone _____

CONFIDENTIAL HEALTH INFORMATION

Please describe your Primary Complaint in the space below. Use the Secondary and Additional Complaint boxes if they apply.

Primary Complaint	Secondary Complaint	Additional Complaint
The primary symptom that prompted me to seek care today is: _____	The secondary symptom that prompted me to seek care today is: _____	The additional symptom that prompted me to seek care today is: _____
And are the result of (darken circle):	**And are the result of (darken circle):**	**And are the result of (darken circle):**
○ An accident or injury ○ Work ○ Auto ○ Other _____	○ An accident or injury ○ Work ○ Auto ○ Other _____	○ An accident or injury ○ Work ○ Auto ○ Other _____
○ A worsening long-term problem ○ An interest in: ○ Wellness ○ Other _____	○ A worsening long-term problem ○ An interest in: ○ Wellness ○ Other _____	○ A worsening long-term problem ○ An interest in: ○ Wellness ○ Other _____
Onset (When did you first notice your current symptoms?) _____	**Onset** (When did you first notice your current symptoms?) _____	**Onset** (When did you first notice your current symptoms?) _____
Prior interventions (What have you done to relieve the symptoms?)	**Prior interventions** (What have you done to relieve the symptoms?)	**Prior interventions** (What have you done to relieve the symptoms?)
○ Prescription medication ○ Acupuncture	○ Prescription medication ○ Acupuncture	○ Prescription medication ○ Acupuncture
○ Over-the-counter drugs ○ Chiropractic	○ Over-the-counter drugs ○ Chiropractic	○ Over-the-counter drugs ○ Chiropractic
○ Homeopathic remedies ○ Massage	○ Homeopathic remedies ○ Massage	○ Homeopathic remedies ○ Massage
○ Physical therapy ○ Ice	○ Physical therapy ○ Ice	○ Physical therapy ○ Ice
○ Surgery ○ Heat	○ Surgery ○ Heat	○ Surgery ○ Heat
○ Other _____	○ Other _____	○ Other _____

Location
(Where does it hurt?)
Circle the area(s) on the illustration.
"O" for current condition
"X" for conditions experienced in the past



1. What else should Wise Chiropractic know about your current condition? _____

_____

2. How does your current condition interfere with your:

Work or career: _____

Recreational activities: _____

Household responsibilities: _____

Personal relationships: _____

3. Review of Systems

Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please darken the circle beside any condition that you've **Had** or currently **Have** and initial to the right.

a. Musculoskeletal

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
○	○	Osteoporosis	○	○	Arthritis	○	○	Scoliosis	○	○	Neck pain	○	○	Back problems	○	○	Hip disorders
○	○	Knee injuries	○	○	Foot/ankle pain	○	○	Shoulder problems	○	○	Elbow/wrist pain	○	○	TMJ issues	○	○	Poor posture

NONE ○ Initials ____

b. Neurological

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
○	○	Anxiety	○	○	Depression	○	○	Headache	○	○	Dizziness	○	○	Pins and needles	○	○	Numbness

NONE ○ Initials ____

c. Cardiovascular

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
○	○	High blood pressure	○	○	Low blood pressure	○	○	High cholesterol	○	○	Poor circulation	○	○	Angina	○	○	Excessive bruising

NONE ○ Initials ____

d. Respiratory

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
○	○	Asthma	○	○	Apnea	○	○	Emphysema	○	○	Hay fever	○	○	Shortness of breath	○	○	Pneumonia

NONE ○ Initials ____

e. Digestive

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
○	○	Anorexia/bulimia	○	○	Ulcer	○	○	Food sensitivities	○	○	Heartburn	○	○	Constipation	○	○	Diarrhea

NONE ○ Initials ____

f. Sensory

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
○	○	Blurred vision	○	○	Ringing in ears	○	○	Hearing loss	○	○	Chronic ear infection	○	○	Loss of smell	○	○	Loss of taste

NONE ○ Initials ____

g. Skin

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
○	○	Skin cancer	○	○	Psoriasis	○	○	Eczema	○	○	Acne	○	○	Hair loss	○	○	Rash

NONE ○ Initials ____

_____
Patient name

_____
Patient Number
(office use only)

_____
Doctor's initials

Wise Chiropractic

(Continued from previous page)

h. Endocrine

Had Have ○ ○ Thyroid issues | Had Have ○ ○ Immune disorders | Had Have ○ ○ Hypoglycemia | Had Have ○ ○ Frequent infection | Had Have ○ ○ Swollen glands | Had Have ○ ○ Low energy | NONE ○ Initials ____

i. Genitourinary

Had Have ○ ○ Kidney stones | Had Have ○ ○ Infertility | Had Have ○ ○ Bedwetting | Had Have ○ ○ Prostate issues | Had Have ○ ○ Erectile dysfunction | Had Have ○ ○ PMS symptoms | NONE ○ Initials ____

j. Constitutional

Had Have ○ ○ Fainting | Had Have ○ ○ Low libido | Had Have ○ ○ Poor appetite | Had Have ○ ○ Fatigue | Had Have ○ ○ Sudden weight gain/loss (circle one) | Had Have ○ ○ Weakness | NONE ○ Initials ____

Patient name

Patient Number (office use only)

○ All other systems negative

Past Personal, Family and Social History

Please identify your past health history, including accidents, injuries, illnesses and treatments. Please complete each section fully.

PERSONAL

4. Illnesses

Check the illnesses you have **Had** in the past or **Have** now.

Had	Have		Had	Have	
○	○	AIDS	○	○	Tuberculosis
○	○	Alcoholism	○	○	Typhoid fever
○	○	Allergies	○	○	Ulcer
○	○	Arteriosclerosis	○	○	Other: _____
○	○	Cancer			_____
○	○	Chicken pox			
○	○	Diabetes			
○	○	Epilepsy			
○	○	Glaucoma			
○	○	Goiter			
○	○	Gout			
○	○	Heart disease			
○	○	Hepatitis			
○	○	HIV Positive			
○	○	Malaria			
○	○	Measles			
○	○	Multiple Sclerosis			
○	○	Mumps			
○	○	Polio			
○	○	Rheumatic fever			
○	○	Scarlet fever			
○	○	Sexually transmitted disease			
○	○	Stroke			

5. Operations

Surgical interventions, which may or may not have included hospitalization.

- ○ Appendix removal
- ○ Bypass surgery
- ○ Cancer
- ○ Cosmetic surgery
- ○ Elective surgery: _____
- ○ Eye surgery
- ○ Hysterectomy
- ○ Pacemaker
- ○ Spine _____
- ○ Tonsillectomy
- ○ Vasectomy
- ○ Other: _____

6. Treatments

Check the ones you've received in the **Past** or are receiving **Currently.**

Past	Currently	
○	○	Acupuncture
○	○	Antibiotics
○	○	Birth control pills
○	○	Blood transfusions
○	○	Chemotherapy
○	○	Chiropractic care
○	○	Dialysis
○	○	Herbs
○	○	Homeopathy
○	○	Hormone replacement
○	○	Inhaler
○	○	Massage therapy
○	○	Physical therapy
○	○	Medications

(Please list below all prescription, over-the-counter, natural supplements, enzymes, vitamins and minerals):

7. Allergies

Are you allergic to any medications?

Yes ○ No ○ If Yes please list: _____

8. Injuries

Have you ever...

- ○ Had a fractured or broken bone
- ○ Had a spine or nerve disorder
- ○ Been knocked unconscious
- ○ Been injured in an accident
- ○ Used a crutch or other support
- ○ Used neck or back bracing
- ○ Received a tattoo
- ○ Had a body piercing

9. Family History

Some health issues are hereditary. Tell Wise Chiropractic about the health of your immediate family members.

FAMILY

Relative	Age (If living)	State of health Good	Poor	Illnesses	Age at death	Cause of death Natural	Illness
Mother		○	○			○	○
Father		○	○			○	○
Sister 1		○	○			○	○
Sister 2		○	○			○	○
Brother 1		○	○			○	○
Brother 2		○	○			○	○
_____		○	○			○	○

10. Are there any other hereditary health issues that you know about? _____

11. Social History

Tell Wise Chiropractic about your health habits and stress levels.

SOCIAL

Alcohol use	○ Daily	○ Weekly	How much? _____	Prayer or meditation?	○ Yes	○ No
Coffee use	○ Daily	○ Weekly	How much? _____	Job pressure/stress?	○ Yes	○ No
Tobacco use	○ Daily	○ Weekly	How much? _____	Financial peace?	○ Yes	○ No
Exercising	○ Daily	○ Weekly	How much? _____	Vaccinated?	○ Yes	○ No
Pain relievers	○ Daily	○ Weekly	How much? _____	Mercury fillings?	○ Yes	○ No
Soft drinks	○ Daily	○ Weekly	How much? _____	Recreational drugs?	○ Yes	○ No
Water intake	○ Daily	○ Weekly	How much? _____			

Hobbies: _____

Consultation Notes

Doctor's Initials

Wise Chiropractic

12. Activities of Daily Living
How does this condition currently interfere with your life and ability to function?

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	○	○	○	○
Rising out of chair	○	○	○	○
Standing	○	○	○	○
Walking	○	○	○	○
Lying down	○	○	○	○
Bending over	○	○	○	○
Climbing stairs	○	○	○	○
Using a computer	○	○	○	○
Getting in/out of car	○	○	○	○
Driving a car	○	○	○	○
Looking over shoulder	○	○	○	○
Caring for family	○	○	○	○

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Grocery shopping	○	○	○	○
Household chores	○	○	○	○
Lifting objects	○	○	○	○
Reaching overhead	○	○	○	○
Showering or bathing	○	○	○	○
Dressing myself	○	○	○	○
Love life	○	○	○	○
Getting to sleep	○	○	○	○
Staying asleep	○	○	○	○
Concentrating	○	○	○	○
Exercising	○	○	○	○
Yard work	○	○	○	○

13. What is the major stressor in your life? _____ **14. How much sleep do you average per night?** _____ **Hours**

15. What is the type and approximate age of your mattress and pillow? _____ **16. What is your preferred sleeping position?** _____

17. Describe your typical eating habits: ○ Skip breakfast ○ Two meals a day ○ Three meals a day ○ Snacking between meals

18. What would be the most significant thing that you could do to improve your health? _____

_____

19. In addition to the main reason for your visit today, what additional health goals do you have? _____

_____

Acknowledgements
To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initials ____ **I instruct the chiropractor to deliver the care that, in his or her professional judgement, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.**

Initials ____ **I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.**

Initials ____ **I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY):** _____

Initials ____ **I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.**

Initials ____ **I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.**

Initials ____ **To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.**

_____ _____
Patient (or Guardian's) signature Date (MM/DD/YYYY)

Consultation Notes

Patient name _____

Patient Number (office use only) _____

Doctor's Initials _____

Wise Chiropractic

WISE CHIROPRACTIC

CONFIDENTIAL HEALTH INFORMATION

Wise Chiropractic
18130 US Highway 441
Mount Dora, FL 32757

If your injury is NOT due to an Automobile Collision, please skip this portion of the form.
Please provide staff with a copy of your automobile insurance card and a copy of the police report, if it is available.
Please print clearly.

Today's Date (MM/DD/YYYY) _____ Patient Number (office use only) _____

Your First Name _____ Your Middle Name (or initial) _____ Your Last Name _____

Insured's/Policy Holder Name(s) _____ Policy Number _____ Claim Number _____

Date of Accident _____ Time _____

Have you contacted your auto insurance company?
O Yes
O No
O N/A (LOP)

Location of Accident _____

Year/Make/Model of your Vehicle _____ Year/Make/Model of other Vehicle _____

AUTO INJURY

Were You: O Driver O Passenger O Pedestrian

Did you strike the other vehicle? O Yes O No

Did the other vehicle strike you? O Yes O No

Were you struck from: O Behind O Right Side O Left Side O Front O Parked

As a result of the Accident, were traffic citations issued to you? O Yes O No

Did Police arrive at the scene? O Yes O No

Did EMT arrive at the scene? O Yes O No

Were the roads conditions at time of the accident: O Wet O Dry

Approximately how fast were you traveling? _____ MPH

Approximately how fast was the other car traveling? _____ MPH

Where were you looking at the time of Impact? O Behind O Right O Left O Down Other:_____

Were you wearing your seatbelt? O Yes O No

Did your head hit the headrest? O Yes O No

Did your (chest/head) hit the steering wheel? O Yes O No

Did your head hit the windshield/side window? O Yes O No

Did your knees hit the dashboard? O Yes O No

Did the airbags deploy? O Yes O No

Did the seat break? O Yes O No

Did you see the crash coming? O Yes O No

Were objects thrown around in the car? O Yes O No

After the Impact did you feel? O Disoriented O Discomfort O Immediate Pain O Tightness O Lost Consciousness O Frightened and was Stunned O Went straight to the Hospital

Describe the accident (be specific):

Did you require post-accident hospitalization?

O Yes

O No

Have you lost any days of work?

O Yes If Yes, _____ through _____

O No

ON THE JOB INJURY

Employer

Address

How did the injury occur?

Did you report the injury to your foreman or employer?

O Yes

O No

Patient (or Guardian's) signature

Date

ASSIGNMENT OF INSURANCE BENEFITS, RELEASE & DEMAND

Insurer and Patient Please Read the Following in its Entirety Carefully

Wise Chiropractic
18130 US Highway 441
Mount Dora, FL 32757

I, the undersigned patient/insured knowingly, voluntarily and intentionally assigned the rights and benefits of my automobile insurance, a/k/a Personal Injury Protection (hereinafter PIP), Uninsured Motorist and Medical Payments policy of insurance to the above health care provider. If the provider's bills are applied to a deductible, I agree this will serve as a benefit to me. This assignment of benefits includes the cost of transportations, medications, supplies, overdue interest and any potential claim for common law or statutory bad faith/unfair claims handling. If the insurer disputes the validity of this assignment of benefits then the insurer is instructed to notify the provider in writing within five days of receipts of this document. Failure to inform the provider shall result in a waiver by the insurer to contest the validity of this document. The undersigned directs the insurer to pay the health care provider the maximum amount directly without any reductions & without including the patient's name on the check. To the extent the PIP insurer contends there is a material misrepresentation on the application for insurance resulting in the policy of insurance is declared voided, rescinded or canceled, I, as the named insured under said policy of insurance hereby assign the right to receive the premiums paid for my PIP insurance to this provider and to file suit for recovery of the premiums. The insurer is directed to issue such a refund check payable to this provider only. Should the medical bills not exceed the premium refunded, then the provider is directed to mail the patient/named insured a check which represents the difference between the medical bills and the premiums paid.

Disputes: The insurer is directed by the provider and the undersigned to not issue any checks or drafts in partial settlement of a claim that contains or are accompanied by language releasing the insurer or its insured/ patient from liability unless there has been a prior written statement agreed to by the health care provider (specifically the Office Manager) and the insurer as to the amount payable under the insurance policy. The insured and the provider hereby contests and objects to any reductions or partial payments. Any partial or reduced payments, regardless of the accompanying language, issued by the insurer and deposited by the provider shall be done so under protest, at the risk of the insurer, and the deposit shall not be deemed a waiver, accord, satisfaction, discharge, settlement or agreement by the provider to accept a reduced amount as payment in full. The insurer is hereby placed on notice that this provider reserves the right to seek the full amount of the bills submitted. If the PIP insurer states it can pay claims at 200% of Medicare then the insurer is instructed & directed to provide this provider with a copy of the policy of insurance within10 days. Any effort by the insurer to pay a disputed debt as full satisfaction must be mailed to the address above, after speaking with the Office Manager and mailed to the attention of Wise Chiropractic. See Fla. Stat. §673.3111.

EUOs and IMEs: If the insurer schedules a defense examination or examination under oath (hereinafter "EUO") the insurer is hereby INSTRUCTED to send a copy of said notification to this provider. The provider or the provider's attorney is expressly authorized to any EUO or IME set by the insurer. The health care provider is not the agent of the insurer or the patient for any purpose.

This assignment applies to both past and future medical expenses and is valid even if undated. A photocopy of this assignment is to be considered as valid as the original. I agree to pay any applicable deductible, co-payments for the services rendered after the policy of insurance exhausts and for any services unrelated to the automobile accident. The health care provider is given the power of attorney to: endorse my name on any check for services rendered by the above provider and to request and obtain a copy of any statements or examinations under oath given by patients.

Release of Information: I authorize this provider to: furnish an insurer's intermediary, the patient's other medical providers, and the patient's attorney via mail, fax or email with any and all information that may be contained in the medical records; to obtain insurance coverage information (declaration sheet & policy of insurance) in writing and telephonically from the insurer; request from any insurer all explanation of benefits (EOBs) for all providers and non-redacted PIP payout sheets; obtain any written and verbal statements the patient or anyone else provided to the insurer; obtain copies of the entire claim file, the property damage file and all medical records, including but not limited to documents, reports, scans, notes, bills, opinions, X-rays, IMEs and MRIs from any other medical provider or any medical records from this provider private and confidential. The insurer is not authorized to provide these medical records to anyone without the patient's and the provider's prior express written permission.

Demand: Demand is hereby made for the insurer to pay all bills within 30 days without reductions and to mail the latest non-redacted PIP payout sheet and the insurance coverage declaration sheet to the above provider within 15 days. The insurer is directly to pay the bills in the order they are received. However, if a bill from this provider and a claim from anyone else is received by the insurer on the same day the insurer is directed to not apply this provider's bill to the deductible. If a bill from this provider and claim from anyone else is received by the insurer on the same day the insurer is directed to pay this provider first before the policy is exhausted. In the event the provider's medical bills are disputed or reduced by the insurer for any reason or amount, the insurer is to: set aside the entire amount disputed or reduced; escrow the full amount at issue and not pay the disputed amount to anyone or any entity, including myself, until the dispute is resolved by a Court. Do not exhaust the policy. The insurer is instructed to inform in writing the provider of any dispute.

Certification: I certify that: I have read and agree to the above; I have not been solicited or promised anything in exchange for receiving health care; I have not received any promises or guarantees from anyone as the results that may be obtained by any treatment or service; and I agree the provider's prices for medical services, treatment and supplies are reasonable, usual and customary.

Caution: Please read before signing. If you do not completely understand this document please ask us to explain it to you. If you sign below we will assume you understand and agree to the above.

Patient's Name	Patient's Signature (if patient is a minor, signature of parent/guardian)	Date

CONFIDENTIAL
HEALTH INFORMATION

Wise Chiropractic
18130 US Highway 441
Mount Dora, FL 32757

I have the right and the **duty to confirm** that the services have already been provided. I was **not solicited** by any person to seek any services from the medical provider of the services above. This means that no person has initiated contract with me and/or persuaded me to use the doctor or licensed professional, clinic or medical institution that provided the services. The medical provider has **explained** the services to me for which payment is being claimed. If I notify the insurer in writing of a billing error, I may be entitled to a portion of any reduction in the amounts paid by my motor vehicle insurer. If entitled, my share would be at least 20% of the amount of the reduction, up to $500.

The undersigned licensed medical professional affirms the statement numbered 1 above and also;

I have **not solicited** or caused the insured person, who was involved in a motor vehicle accident, to be solicited to make a claim for Personal Injury Protection benefits.

I have **explained** the services rendered to the insured group, or his or her guardian, **sufficiently** for that person to sign this for with informed consent.

The accompanying statement or bill is **properly completed** in all material provisions and all relevant information has been provided therein. This means that each request for information has been responded to **truthfully, accurately** and in a **substantially complete** manner.

The coding procedures on the accompanying statement or bill are proper. This means that **no service has been up coded, unbundled** or constitutes an invalid or **no medically necessary diagnostic test** as defined by Section 627.732 (15) and (16), Florida Statutes or Section 627.736 (5)(b) 6, Florida Statutes.

Insured Person (patient receiving treatment) or Guardian of Insured Person:

_____	_____	_____
Patient's Name (Print)	**Patient's Signature**	**Date**

Licensed Medical Professional Rendering Treatment (Signature by his/her *own hand*):

_____	_____	_____
Name (Print)	**Signature**	**Date**

Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of Claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree per Section 817.234(1)(b), Florida Statues.

Note: The original of this form must be furnished to the insurer pursuant to Section 627.736(4)(b), Florida Statutes and may not be electronically furnished. Failure to furnish this form may result in non-payment of the claim.

AUTHORIZATION TO RELEASE INFORMATION/RECORDS

Wise Chiropractic
18130 US Highway 441
Mount Dora, FL 32757

I, _____, request _____ to release my chiropractic and/or medical records including diagnosis, prognosis, initial treatment, x-rays and reports to: **Wise Chiropractic, Inc.**

I will be responsible for incurring the costs associated with this request if known in advanced. Thank you for your prompt attention.

Additional Information: _____

_____

_____

_____

_____

_____ _____

Patient's Signature (or guardian if a minor) **Date**

_____ _____

Witness Signature **Date**