



Daran L. Parham, M.D.  
Melissa A. Dietz, M.D.  
Kyle A. Wilson, D.O.

## FINANCIAL POLICY

We are committed to providing you with the best possible care and we are pleased to discuss our professional fees with you at any time. Our fees are reasonable and customary in accordance with other specialists' offices in this area. In case of financial hardship, please make financial arrangements with the Business Office prior to being seen.

### **YOUR RESPONSIBILITIES**

- **KNOW** whether your provider contracts with your plan. A list of insurance companies with whom we participate is on the Patient Forms page of [www.uticaobgyn.com](http://www.uticaobgyn.com). IT IS YOUR RESPONSIBILITY to call your insurance company to ensure our provider is contracted with your particular insurance plan. *If the provider is not contracted with your insurance company and you want to be seen anyway, please be prepared to pay for services at the time of your visit.* We will provide you a copy of your bill to file with your insurance company for reimbursement or we can directly file your claim as a courtesy. We try to verify insurance benefits before your appointment, however OUR OFFICE IS NOT RESPONSIBLE FOR YOUR INSURANCE COVERAGE. You may get better benefits with a referral or a prior authorization. *Please check your insurance benefits.* If our provider refers you to another provider, IT IS YOUR RESPONSIBILITY to make sure that provider is also on your insurance plan. If our provider orders lab tests deemed to be in your best medical interest, IT IS YOUR RESPONSIBILITY to check with your insurance company about insurance coverage and/or out-of-pocket costs you may be required to pay.
- **INFORM** us PRIOR TO YOUR APPOINTMENT if you have a change in insurance company(ies) or insurance plan(s). Many insurance companies have deadlines for timely filing of claims. If we have inaccurate information at the time of service, you may be responsible for payment in full for all services rendered.
- **BRING** your insurance card and photo ID to all your appointments
- **PAY** co-pay, deductible, co-insurance, or self-pay amounts when checking in for appointments. Parents or legal guardians of underage patients are responsible for paying fees incurred. Outstanding balances are due within thirty (30) days of the statement date, or within thirty (30) days of the last insurance payment noted on the statement, whichever is later. We accept Visa, MasterCard, Discover, American Express, debit cards, cash, personal checks (with photo ID) and for your convenience you may pay your provider using Xpress-pay from our website at [www.uticaobgyn.com](http://www.uticaobgyn.com)
- **ADVISE** us two (2) business days in advance if you cannot keep your appointment. As a courtesy, we try to provide reminder calls, emails, and texts; however, knowing your appointment date and time is your responsibility. If you cannot attend your appointment, you may leave a voicemail in our general mailbox if you cannot reach us during business hours. Missing appointments may lead to your dismissal from our practice.
- **ARRIVE** promptly for your appointment, meaning *at least 10 minutes in advance to allow for check-in or 30 minutes in advance to complete required paperwork.* See the Patient Forms page of [www.uticaobgyn.com](http://www.uticaobgyn.com) and save appointment processing time by bringing completed paperwork to your appointment. You may be asked to reschedule if you are late to an appointment.

### **OUR OFFICE'S POLICIES AND RESPONSIBILITIES**

#### **FEES / PAYMENTS / INSURANCE**

1. As a courtesy, we will directly bill your insurance company for services rendered, but you are ultimately responsible for payment for deductibles, co-payments, co-insurance, percentages, non-covered services, services rendered without proper referral authorization, or denied services.
2. We bill services rendered to you accurately and will not change diagnosis codes to get your claim paid. This action is illegal. If your insurance does not cover certain procedures or office visits, this dispute remains between you and your insurance company.

3. If you (or, in the case of minor patients, your parent or legal guardian) do not pay required amounts at the time of your appointment, we may ask you to reschedule. Continued refusal to respect the physician/patient relationship by paying for services in accordance with the practice's financial policies may result in our practice discharging you as a patient. You will receive a written letter of discharge and have sufficient time to secure services of another provider.

4. RETURNED CHECK POLICY: If your check is returned for insufficient or held funds, you will be charged a \$40.00 fee in addition to the balance due. Additional appointments will not be scheduled until your account balance is paid in full. Your account may be submitted immediately for collection if you do not make payment arrangements with our Business Office upon being notified of insufficient funds.

5. COLLECTION: Balances that reach 90 days past due may be sent to our attorney for collection. If sent to our attorney, you would be financially responsible for all collection and legal fees our office incurs through the process used to collect the delinquent balance. **Please remember, your account can legally be turned to our attorney the day it is due. We want to avoid this and are willing to make payment arrangements with you.**

### **APPOINTMENTS POLICY – Cancellations and Missed Appointments**

1. Your time and ours is valuable. Scheduled appointment time is reserved just for you. We make every effort to work efficiently while providing you sufficient time with our providers so that you receive outstanding medical care.

2. We understand that occasionally circumstances may prevent you from contacting us to cancel or reschedule your appointment, and we do not charge you for rare occurrences. However, missed appointments prevent other patients from having your appointment slot and reduce efficiency of our providers.

3. Two (2) or more MISSED appointments during a three (3) month period (when you do not contact us two (2) business days in advance to cancel or reschedule), may result in a \$25.00 administrative fee *that must be paid before we will schedule* additional appointments for you.

4. Excessive missed appointments (two (2) or more during a three (3) month period) may result in our practice dismissing you as a patient. Your health is important to us and we cannot provide proper medical care to patients not attending appointments. You will receive a written letter of dismissal and will have sufficient time to secure services of another provider.

### **MEDICAL RECORDS, FMLA, WIC OR OTHER FORMS**

We are happy to assist you by completing healthcare-related forms and ask that you understand that doing so does take time from our providers and staff.

1. There is an administrative fee of \$30.00 (payable in advance) for completion of forms.

2. You will need to complete your portion of the forms and allow at least ten (10) business days after payment of the administrative fee and our receipt of the forms for completion of FMLA, WIC, Disability, or Return to Work forms. We will complete forms as quickly as possible. A form required for the completion of your forms is available on the Patient Forms page of [www.uticaobgyn.com](http://www.uticaobgyn.com) or from Front Office staff.

3. Medical records authorization forms permitting us to send and/or receive your protected health information are on the Patient Forms page of [www.uticaobgyn.com](http://www.uticaobgyn.com) or available from Front Office staff.

**I have read, understand and agree to the above policies. I authorize treatment of the patient named below and agree to pay all fees and charges for such treatment. Charges shown on statements are considered to be correct unless written notification is received via certified mail within 30 days of the statement date. I agree to pay all charges in accordance with the practice's policies and procedures. I agree to assign my insurance benefits to Utica Women's Specialists and the providers therein, if applicable.**

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Patient or Legal Representative

\_\_\_\_\_  
Responsible Party Name (if different than patient)



Daran L. Parham, M.D.  
 Melissa A. Dietz, M.D.  
 Kyle A. Wilson, D.O.

## PATIENT REGISTRATION FORM

LAST NAME		FIRST NAME		MI	
Address		City		State	
Home Phone		Work		Cell	
SSN#		Date of Birth		Age	
Marital Status					
M   S   W   D					
Email Address					

<b>EMPLOYMENT STATUS</b>					<b>Occupation</b>	
Employed   Student   Self-Employed   Retired   Other						
Patient Employer					Patient Employer Phone	

Spouse's Name		Spouse Cell Phone	
Spouse's Employer		Spouse's Employer Phone	

**EMERGENCY CONTACT: NAME AND PHONE OF CLOSEST RELATIVE NOT LIVING WITH YOU.**

Name		Phone		Relationship	
------	--	-------	--	--------------	--

<b>Ethnicity: Hispanic or Latino:    Y    N</b>				<b>Smoker:    Y    N</b>			
Current Pharmacy Name		Address			Phone		

**REFERRING DOCTOR**

Name		Phone	
------	--	-------	--

**INSURANCE INFORMATION**

<b>Primary Insurance</b>				<b>Secondary Insurance</b>			
Company Name				Company Name			
Policy Holder				Policy Holder			
Policy Holder Date of Birth				Policy Holder Date of Birth			
Policy Holder SSN#				Policy Holder SSN#			
Employer				Employer			
ID#		Group#		ID#		Group #	

I agree that the information provided on this form is accurate to the best of my knowledge. I hereby authorize Utica Women's Specialists, LLC to furnish information to my insurance carrier(s) concerning my illness and treatment, and thereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any unpaid balance, regardless of insurance coverage.

\_\_\_\_\_

Date

\_\_\_\_\_

Signature of Patient or Legal Guardian



## PAST MEDICAL HISTORY

No significant past medical history

Have you ever had any of the following? If yes, please indicate date and treatment:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Diabetes/Diabetes of Pregnancy | <input type="checkbox"/> Allergies                    | <input type="checkbox"/> Hemorrhoids                  |
| <input type="checkbox"/> High Blood Pressure            | <input type="checkbox"/> Anemia                       | <input type="checkbox"/> Hiatal hernia/Acid reflux    |
| <input type="checkbox"/> Cancer                         | <input type="checkbox"/> Anxiety disorders            | <input type="checkbox"/> High Cholesterol             |
| <input type="checkbox"/> Stroke                         | <input type="checkbox"/> Asthma                       | <input type="checkbox"/> HIV (AIDS)                   |
| <input type="checkbox"/> Heart Trouble                  | <input type="checkbox"/> Bladder incontinence         | <input type="checkbox"/> Irritable bowel syndrome     |
| <input type="checkbox"/> Arthritis/gout                 | <input type="checkbox"/> Chronic constipation         | <input type="checkbox"/> Kidney Disease/Kidney stones |
| <input type="checkbox"/> Epilepsy/Seizures              | <input type="checkbox"/> Depression                   | <input type="checkbox"/> Migraine headaches           |
| <input type="checkbox"/> Blood clots, phlebitis, DVTs   | <input type="checkbox"/> Gastritis/Gastric Ulcers     | <input type="checkbox"/> Mitral Valve Prolapse        |
| <input type="checkbox"/> Thyroid Disorder               | <input type="checkbox"/> Endometriosis                | <input type="checkbox"/> Osteoporosis                 |
| <input type="checkbox"/> Hereditary Defects             | <input type="checkbox"/> Heart Disease                | <input type="checkbox"/> Scoliosis                    |
| <input type="checkbox"/> Blood Transfusions             | <input type="checkbox"/> Hepatitis A/B/C              | <input type="checkbox"/> Autoimmune disorder          |
| <input type="checkbox"/> Psychiatric problems           | <input type="checkbox"/> Ear, Nose or Throat problems | <input type="checkbox"/> Tuberculosis                 |

---

---

---

---

---

---

## PAST SURGICAL AND HOSPITALIZATION HISTORY

No Previous Surgeries or Hospitalizations

Do you have any history of the following? **If yes, please give details and dates:**

1. Cholecystectomy \_\_\_\_\_
2. Appendectomy \_\_\_\_\_
3. Hysterectomy \_\_\_\_\_
4. Oophorectomy \_\_\_\_\_
5. Cesarean Section \_\_\_\_\_
6. Tonsillectomy \_\_\_\_\_
7. Laparotomy \_\_\_\_\_
8. Wisdom Teeth \_\_\_\_\_
9. Other surgery \_\_\_\_\_

Have you been hospitalized for any other reason than the surgeries listed above?  Yes  No

If yes, please give details and dates: \_\_\_\_\_

---

---

Please list any allergies to **medications** \_\_\_\_\_

---

Please list any **food** allergies (nuts, shellfish, eggs, etc.) \_\_\_\_\_

---

Any allergies to:  Latex  Adhesive/Tape  Iodine  Nickel  Contrast Dye

## MEDICATION HISTORY

Please list all current prescriptions and over-the-counter medications you currently take.

PRESCRIPTIONS					
Name of Medication	Dosage (total mg)	Number per day	Prescribing Doctor	Reason for medication	Side effects?
OVER-THE-COUNTER MEDICATIONS, VITAMINS, HERBAL, OR NATURAL SUPPLEMENTS					

## SOCIAL HISTORY

Do you consume alcohol?  Yes  No  Daily  Socially

Do you currently smoke?  Yes  No How many packs per day? \_\_\_\_\_ How many years? \_\_\_\_\_

Have you smoked in the past?  Yes  No How long ago did you quit? \_\_\_\_\_

Have you used illicit or IV drugs in the past?  Yes  No

Do you consume caffeine daily?  Yes  No

Do you identify as  heterosexual  homosexual  bisexual  other \_\_\_\_\_

## FAMILY HISTORY

No known significant family history of heart disease (HD), cancer, high blood pressure (HTN), diabetes, or other serious illnesses

Family Member				
	<input type="checkbox"/> HD	<input type="checkbox"/> Cancer Type _____	<input type="checkbox"/> HTN	<input type="checkbox"/> Diabetes
	<input type="checkbox"/> HD	<input type="checkbox"/> Cancer Type _____	<input type="checkbox"/> HTN	<input type="checkbox"/> Diabetes
	<input type="checkbox"/> HD	<input type="checkbox"/> Cancer Type _____	<input type="checkbox"/> HTN	<input type="checkbox"/> Diabetes
	<input type="checkbox"/> HD	<input type="checkbox"/> Cancer Type _____	<input type="checkbox"/> HTN	<input type="checkbox"/> Diabetes

	Age	State of Health	Medical Conditions	Age at Death	Cause
<b>Mother</b>					
<b>Father</b>					
<b>Brother</b>					
<b>Sister</b>					
<b>Spouse</b>					

**Complete this form if your visit is gynecological in nature.**  
**GYNECOLOGIC HISTORY**

Name: \_\_\_\_\_

Age your period began: \_\_\_\_\_

Date of last Pap Smear: \_\_\_\_/\_\_\_\_/\_\_\_\_

Have you ever had an abnormal Pap smear?  Yes  No When? \_\_\_\_\_

Describe any treatment: \_\_\_\_\_

Have you been exposed to DES?  Yes  No

How often does your period come?  Not Applicable  21-30 days apart  Greater than 40 days  
 Less than 20 days  30-40 days apart

How many days do you normally flow?  Less than 2  2-7 days  7-10 days  More than 10 days

Type of flow?  Light  Medium  Heavy

Menstrual cramps?  None  Mild  Moderate  Severe

If yes, what do you take? \_\_\_\_\_ Dosage? \_\_\_\_\_

Do you require additional overnight protection?  Yes  No

Do you stay in bed during your periods?  Yes  No

Do you bleed or spot between periods?  Yes  No

Do you bleed or spot after intercourse?  Yes  No

Date of last mammogram? \_\_\_\_/\_\_\_\_/\_\_\_\_  Never

Do you have:  Breast lumps  Nipple discharge  Breast tenderness  Fibrocystic changes

Do you have pain during or after intercourse?  Yes  No

Do you have any concerns with sexual function? \_\_\_\_\_

What form of birth control do you use?

- |   |   |
|---|---|
| <input type="checkbox"/> Birth Control Pills (Name) _____ | (Number of Mos/Yrs) _____                               |
| <input type="checkbox"/> IUD (Type/Insert Date) _____     | <input type="checkbox"/> Rhythm/Natural Family Planning |
| <input type="checkbox"/> Condoms/Foam/Suppositories       | <input type="checkbox"/> Tubal Ligation                 |
| <input type="checkbox"/> Menopause                        | <input type="checkbox"/> Vasectomy                      |
| <input type="checkbox"/> Not sexually active              | <input type="checkbox"/> Hysterectomy                   |
|   | <input type="checkbox"/> Other _____                    |

Have you reached Menopause?  Yes  No Age of onset: \_\_\_\_\_

Do you have hot flashes?  Yes  No Night sweats?  Yes  No

Trouble sleeping?  Yes  No Vaginal dryness/painful intercourse?  Yes  No

Have you ever taken hormone therapy?  Yes  No

Medication taken \_\_\_\_\_ Duration of treatment \_\_\_\_\_

Reason for discontinuing therapy? \_\_\_\_\_

Do you have a chronic vaginal discharge?  Yes  No

Have you used any medication for the discharge?  Yes  No What? \_\_\_\_\_

Do you douche?  Yes  No How often? \_\_\_\_\_

Have you been treated for a vaginal infection?  Yes  No

- |            |                                      |                                      |  |
|------------|--------------------------------------|--------------------------------------|--|
| What type? | <input type="checkbox"/> Yeast       | <input type="checkbox"/> Chlamydia   | <input type="checkbox"/> Pelvic Inflammatory Disease |
|            | <input type="checkbox"/> Trichomonas | <input type="checkbox"/> Gardnerella | <input type="checkbox"/> Genital warts/HPV virus     |
|            | <input type="checkbox"/> Bacterial   | <input type="checkbox"/> Syphilis    | <input type="checkbox"/> Genital Herpes/HSV virus    |
|            | <input type="checkbox"/> Gonorrhea   |                                      |  |

Burning during urination?  Yes  No

Blood in urine?  Yes  No

Urinary frequency?  Yes  No

Do you get up at night to urinate?  Yes  No How often? \_\_\_\_\_

Do you wet yourself when you cough or laugh?  Yes  No

Have you had a urinary tract infection?  Yes  No How often? \_\_\_\_\_

When was your last UTI? \_\_\_\_\_ Have you seen an urologist?  Yes  No

Are you in a relationship with someone who threatens you or physically hurts you?  Yes  No

Has anyone ever forced you to have sexual activities that made you feel uncomfortable?  Yes  No



## Complete this form if your visit is obstetrical in nature. OBSTETRIC HISTORY

Name: \_\_\_\_\_  
 What was the first day of your last menstrual cycle? \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 Are your periods regular?     Yes    No  
 What was the date of your positive pregnancy test? \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 Newborn's Physician \_\_\_\_\_

Do you have any history of the following? **If yes, please give details and dates:**

1. Diabetes of pregnancy \_\_\_\_\_
2. Trauma, violence \_\_\_\_\_
3. Rh sensitized? \_\_\_\_\_
4. Anesthesia problems \_\_\_\_\_
5. Abnormal Pap? Treatment? \_\_\_\_\_
6. Date of last Pap \_\_\_\_\_
7. Abnormal shaped uterus \_\_\_\_\_
8. Infertility \_\_\_\_\_
9. Assisted reproduction \_\_\_\_\_
10. Blood Disorder/von Willebrand's \_\_\_\_\_

### FAMILY HISTORY FOR FATHER OF BABY

Father of the baby \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

No known significant family history of heart disease (HD), cancer, high blood pressure (HTN), diabetes, or other serious illnesses

Family Member				
	<input type="checkbox"/> HD	<input type="checkbox"/> Cancer Type _____	<input type="checkbox"/> HTN	<input type="checkbox"/> Diabetes
	<input type="checkbox"/> HD	<input type="checkbox"/> Cancer Type _____	<input type="checkbox"/> HTN	<input type="checkbox"/> Diabetes
	<input type="checkbox"/> HD	<input type="checkbox"/> Cancer Type _____	<input type="checkbox"/> HTN	<input type="checkbox"/> Diabetes
	<input type="checkbox"/> HD	<input type="checkbox"/> Cancer Type _____	<input type="checkbox"/> HTN	<input type="checkbox"/> Diabetes

Will you be 35 years old or older at the time of delivery?    Yes    No

Does anyone in either family have the following?

Thalassemia? <input type="checkbox"/> Yes <input type="checkbox"/> No	Muscular dystrophy? <input type="checkbox"/> Yes <input type="checkbox"/> No
Neural tube defects? <input type="checkbox"/> Yes <input type="checkbox"/> No	Cystic fibrosis? <input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital heart defect <input type="checkbox"/> Yes <input type="checkbox"/> No	Huntington chorea? <input type="checkbox"/> Yes <input type="checkbox"/> No
Down syndrome? <input type="checkbox"/> Yes <input type="checkbox"/> No	Mental retardation? <input type="checkbox"/> Yes <input type="checkbox"/> No
Tay-Sachs? <input type="checkbox"/> Yes <input type="checkbox"/> No	Other inherited genetic or chromosomal disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No
Canavan disease? <input type="checkbox"/> Yes <input type="checkbox"/> No	Maternal metabolic disorder (i.e. type 1 diabetes)? <input type="checkbox"/> Yes <input type="checkbox"/> No
Familial dysautonomia? <input type="checkbox"/> Yes <input type="checkbox"/> No	Fragile X syndrome? <input type="checkbox"/> Yes <input type="checkbox"/> No
Sickle cell? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Hemophilia? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Recurrent pregnancy loss or a stillbirth?     Yes    No

Have you or the baby's father had any children with a birth defect not listed above?     Yes    No

Type: \_\_\_\_\_

Are there any medical problems in your family that are significant?     Yes    No

Type: \_\_\_\_\_

Do you live with someone that has Tuberculosis (TB) or have you been exposed to TB?  Yes  No

Do you or your partner have genital herpes?  Yes  No

Have you had a rash or viral illness since your last period?  Yes  No

Have you been treated for a vaginal infection?  Yes  No

What type?  Chlamydia  Bacterial  Pelvic Inflammatory Disease  
 Trichomoniasis  Gonorrhea  HPV virus  
 Syphilis  HSV virus

What is your height? \_\_\_\_\_

What is your usual weight? \_\_\_\_\_

What is your normal

blood pressure? \_\_\_\_\_/\_\_\_\_\_

Do you own cats?  Yes  No

Do you eat fish regularly?  Yes  No

Do you plan to have your tubes tied?  Yes  No

Have you had the Hepatitis B vaccine?  Yes  No

Are you in a relationship with someone who threatens you or physically hurts you?  Yes  No

Has anyone ever forced you to have sexual activities that made you feel uncomfortable?  Yes  No



Daran L. Parham, M.D.  
Melissa A. Dietz, M.D.  
Kyle A. Wilson, D.O.

**CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION  
FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS**

I understand that as part of my healthcare, Utica Women’s Specialists, LLC, Daran L. Parham, M.D., LLC, Melissa A. Dietz, M.D., LLC, and Kyle A. Wilson, D.O., LLC (hereinafter collectively referred to as "UWS") originate and maintain health records describing my health history, symptoms, examinations, test results, diagnoses, treatment, and any plans for future care or treatment. I further understand that this information serves as:

- A basis for planning my care and treatment;
- A means of communication among the health professionals who contribute to my care;
- A source of information for applying my diagnosis and treatment information to my bill;
- A means for a third-party payer to verify that services were billed as actually provided, and;
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

**I further understand and agree that this agreement to release information shall apply to all information accumulated up to this date and acquired in the future until such time as I shall revoke it in writing.**

I understand that UWS has a PATIENT PRIVACY NOTICE that provides a more complete description of information uses and disclosures and that UWS has offered me a copy of such notice.

I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations. **By Oklahoma law, we are required to notify you that the information authorized for release may include records that may indicate the presence of communicable or non-communicable diseases.** I understand that I must revoke this consent in writing, except to the extent the organization has already taken action in reliance thereon.

**I AUTHORIZE UWS TO RELEASE MEDICAL INFORMATION REQUESTED BY INSURANCE COMPANIES WITH WHOM I HAVE COVERAGE OR ANY PUBLIC AGENTS SOLELY TO DETERMINE BENEFITS FOR SERVICES PROVIDED. FURTHER, IF ANOTHER PROVIDER’S OFFICE OR I VERBALLY, OR IN WRITING, REQUEST MEDICAL INFORMATION BE PROVIDED FOR THE PURPOSE OF COORDINATION OF CARE, I AUTHORIZE SAID INFORMATION TO BE RELEASED FOR THAT REASON. RELEASE OF INFORMATION FOR ANY OTHER PURPOSE WILL REQUIRE MY WRITTEN CONSENT OR THAT OF MY LEGAL REPRESENTATIVE.**

I acknowledge that by supplying my personal contact information, I authorize UWS and/or its automated outreach and messaging service to contact me via phone call, voicemail, email and/or text message of appointment related information, balances due and other limited health-related information as permissible by law. I acknowledge that unauthorized parties may unlawfully intercept or access transmission of protected health information (PHI) despite commercially reasonable security efforts by UWS and third-party messaging services and that I shall not hold UWS or its business associates liable for any such unauthorized disclosure.

In addition to the releases outlined above, please indicate below, the persons/organizations to whom we may release your health information:

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

I request the following restrictions to the use and/or disclosure of my health information: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Effective Date