AllerVie HEALTH

New Patient Packet

Thank you for making your first appointment with AllerVie Health!

AllerVie Health and our Board-Certified Allergists and Immunologists are committed to helping patients achieve and maintain optimal health and quality of life -- free from the symptoms and suffering of allergies, asthma, and related immunological conditions.

Please complete the new patient packet following this letter, and bring it along with your insurance and driver's license to your first appointment. Please keep in mind that your first appointment can be lengthy due to the extensive information you will be provided to assist you in managing your continued good health.

Here are a few things to know for your first appointment:

- **Discontinue all Antihistamines FIVE days prior to your appointment.** Common medications containing Antihistamines are Benadryl, Triaminic, cough and cold medicines. Do not stop taking Singulair or asthma inhalers. For a complete list, visit **allervie.com** and click on **For Patients**.
- Please wear clothing that will allow allergy testing with ease. A two piece outfit, ex., shirt and pants work best.
- We love children! However, if you are being allergy tested you will need to remain stationary and it will be difficult to keep an eye on small children.
- We have Wi-Fi available in most locations for your convenience.
- Your visit as a new patient can last up to a few hours depending on testing needs. Please be prepared to stay at our office for the duration of your visit.
- **Remember that in order to be tested on the day of your initial visit you will need to discontinue certain medications five days prior to your appointment.** If you are concerned or have questions about which medications to discontinue, please do not hesitate to call our office.

Should you need to cancel or reschedule your appointment, please contact our office 24 hours before your appointment to avoid any cancellation fees, up to $50.

We look forward to serving you and helping you find relief from your allergy symptoms!

Sincerely,
The AllerVie Health Team

Thank you for choosing our practice. We are committed to providing you with quality and affordable healthcare. Below is information regarding our privacy policy, consent for treatment and payment policy as it relates to patient and insurance responsibility for services rendered. Please review it, then sign/accept in the space provided. A copy will be provided to you upon request. If you have any questions please feel free to contact our office. Thanks so much for being our patient.

Acknowledgment Form for Purposes of Treatment, Payment and Healthcare Operations

I acknowledge the use or disclosure of my Protected Health Information (PHI) by AllerVie Health and its Subsidiaries and Partners for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bills or to conduct healthcare operations of AllerVie Health. I understand that diagnosis or treatment of me by the healthcare providers of AllerVie Health may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my Protected Health Information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. AllerVie Health is not required to agree to the restrictions that I may request. However, if AllerVie Health agrees to a restriction that I request, the restriction is binding on AllerVie Health and Healthcare Providers of AllerVie Health. I have the right to revoke this consent, in writing, at any time, except to the extent that Healthcare Providers of AllerVie Health or AllerVie Health has taken action in reliance on this consent.

My "Protected Health Information" means health information, including my demographic information, collected from me and created or received by my healthcare provider, another healthcare provider, a health plan, my employer or a healthcare clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

The Notice of Privacy Practices for AllerVie Health is provided in the patient reception area and I understand I have a right to review the Notice of Privacy Practices prior to signing this document. I also understand a personal copy of AllerVie Health's Notice of Privacy Practices can be provided to me for review upon request. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of healthcare operations of AllerVie Health.

AllerVie Health reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by reviewing the notices provided in patient reception area or by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Authorization and Consent for Treatment

The undersigned agrees, whether he or she signs as agent or as a patient, that in consideration of agreed upon services to be rendered, including allergy extracts and injections, by AllerVie Health to the patient, he or she hereby obligates himself or herself, assumes financial responsibility, and agrees to the AllerVie Health payment policy as outlined below regarding all charges for such services incurred by said patient. The undersigned consents to treatment as determined and discussed with and agrees to medication history review and reconciliation. The undersigned also specifically agrees that AllerVie Health can use PHI to communicate via phone, email or text for essential follow up needs, or appointment reminders, as well as conduct analysis for internal business purposes, customize patient needs for services and create de-indentified information to use and disclose in anyway permitted by law, including to third parties in connection with commercial and marketing efforts. This office will file and collect from insurance when insurance benefits are present. I hereby authorize AllerVie Health to use "Signature on File" in lieu of an original signature for all medical claims submitted for services rendered to patient. I acknowledge that all information regarding my identity is correct and accurate to my knowledge. By signing/accepting this document I understand that I am held accountable for any false information which could result in a fine or penalty and should notify AllerVie Health if any of my information should change or if my identity is compromised or stolen.

Payment Policy

ALL DEDUCTIBLES, CO-PAYMENTS, AND CO-INSURANCE ARE DUE AT THE TIME OF SERVICE

Insurance: We participate with most insurance plans. We will bill your insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility.

Claims Submission: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company.

Referrals: If you have an insurance plan with which we are contracted, you may need a referral authorization from your primary care physician/ pediatrician. ***If we have not received a referral at least 24 hours prior to your arrival at the office, your appointment may be rescheduled.***

Labs: All lab work is performed by an outside reference lab. AllerVie Health does not verify benefits coverage on lab services. Patients will receive a bill directly from the lab regarding any balances after insurance is filed. If you would like to check your lab benefits prior to these services being rendered, please inform the nurse.

Co-payments and Deductibles: All co-payments, deductible and co-insurance must be paid at the time of service. This arrangement is part of your contract with your insurance company.

Proof of Insurance: All patients must complete our patient information form before seeing our providers. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

Coverage Changes: If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

Methods of Payment: We accept payment by cash, check, Visa, MasterCard, American Express and Discover.

Patient Statements: If you have an unpaid balance, you will receive a statement by mail or email monthly. The statement amount is due and payable when the statement is issued, and past due if not paid upon receipt. Balances over 90 days will be will be turned over to an attorney or collection agency for collections. All payments made go to the oldest outstanding balance.

Self Pay: We accept self-pay for our services at select AllerVie locations. If you are uninsured or wish to self-pay for our services, we will also provide financial counseling for you at your appointment. Payment is due in full at the time of service.

No Show Fee: Should you need to cancel or reschedule your appointment, please contact our office 24 hours before your appointment to avoid any cancellation fees, up to $50.

By accepting the terms outlined above I understand that all bills are payable upon presentation, and that I, not the insurance company, is ultimately responsible for payment of the services.

Signature and Acceptance

I understand that selecting Agree and entering name/initials via portal, or signature below constitutes a legal signature confirming that I acknowledge and agree to the above policies set forth by AllerVie Health.

Patient or Legal Guardian/Responsible Party Signature	Printed Name	Date

Relation to Patient *(if applicable)*: _____

Medications to Hold for Testing

Prescription Antihistamines

- Atarax, Vistaril (hydroxyzine)
- Allegra (fexofenadine)
- Clarinex
- Periactin (cyproheptadine)
- Rondec
- Pediatex
- Pedi-Ox
- Rynnatan
- Q-DAL
- Tussionate
- Tussi-12
- Tannihist
- Xyzal
- *Doxepin/Adapin/Sinequan will need to be held longer than 5 days, but DO NOT STOP it until you have seen the allergist

Over-the-Counter Antihistamines

- Claritin, Alavert, Triaminic, Allerchews, Store Brand Non-Sedating Antihistamine (loratidine)
- Zyrtec (ceterizine)
- Benadryl (diphenhydramine)
- Tavist (clemastine)
- Chlorpheniramine (Like Chlor-Trimeton, Actifed, Allerest)
- NyQuil, Robitussin Night Cold, Tylenol Flu Night Time (doxylamine)
- Tylenol or Advil PM (contain diphenhydramine)
- Dramamine (dimenhydrinate)
- Anything that contains loratadine
- Anything that contains diphenydramine
- Anything that contains brompheniramine
- Anything that contains chlorpheniramine
- Anything that contains carbinoxamine
- Anything that contains doxylamine
- Anything that contains clemastine
- Anything that contains tripolidine
- Anything that contains tripelennamine
- Any “Allergy” or “Cold” Preparation (like Tylenol Cold & Sinus or Advil Cold & Sinus)

Other Types of Medications to Hold 5 Days Before Allergy Testing

Anti-Nausea Medications

- Dramamine (dimehydrinate)
- Doxylamine
- Antivert, Bonine (meclizine)
- Phenergan (promethazine)

Over-the-Counter Sleep Aids

- Any “PM’1 Product (Like Tylenol PM or Excedrin PM or Alka Seltzer PM or Doan’s PM)
- Simply Sleep Nighttime Sleep Aid
- Sominex
- Anything that contains diphenhydramine Nasal and Eye Drops to Hold 48 Hours Before Allergy Testing

Prescription Nasal Sprays

- Astelin Nasal Spray

All Over-the-Counter Eye Drops

- Visine A Eye Drops
- Op-Con A
- Naph-Con A
- Alomide Eye Drops

Prescription Eye Drops

- Patanol Eye Drops
- Zaditor Eye Drops
- Optivar Eye Drops
- Elestat Eye Drops

Medicines That You MAY CONTINUE & Should Not Interfere With Testing

- Saline Nose Spray
- Steroid Nose Sprays
- Afrin Nose Spray
- Singulair
- Asthma Inhalers
- Asthma Nebulizer Treatments
- Nasalcrom
- Crolom
- Zycam
- Mucinex (guaifenesin)
- Cough or Sinus Preparations that only contain dextromethorphan and/or guaifenesin and/or psudoephedrine
- Plain Sudafed (pseudoephedrine)
- “Non-Drowsy” Cold Preparations EXCEPT NO LORATIDINE

PLEASE DO NOT TAKE ANTIHISTAMINES 5 DAYS PRIOR TO YOUR APPOINTMENT

Patient Information

First Name: _____ Last Name: _____

Middle Name: _____ Suffix: _____

Mailing Address: _____

City, State, Zip: _____

Residential Address (If mailing address is a PO Box): _____

City, State, Zip: _____

Preferred Phone: _____ Alternate Phone: _____ Date of Birth: _____

Sex: ☐ Male ☐ Female ☐ Other Social Security #: _____

Marital Status (check one) ☐ Single ☐ Married ☐ Divorced ☐ Widowed Age: _____

Patient's Employer: _____

How did you hear about our practice? _____

E-Mail Address: _____

Race: _____ Ethnicity (check one): ☐ Not Hispanic ☐ Hispanic

Preferred Language: _____

Referring Physician's Name: _____ Telephone #: _____ Fax #: _____

Pharmacy Name: _____ Pharmacy Phone #: _____

Responsible Party Information

Name: _____ ☐ Spouse ☐ Parent ☐ Guardian's

Mailing Address: _____

City, State, Zip: _____

Preferred Phone: _____ Alternate Phone: _____ Date of Birth: _____

Social Security #: _____

Employer: _____

Emergency Information

Contact Name: _____ Relationship: _____

Phone Number: _____

Patient Account #: _____

Medical Insurance Information

Primary Coverage

Company Name: _____

Contract (ID) #: _____ Group #: _____

Name of Policyholder as it appears on card: _____ Relationship to Patient: _____

Address of Policyholder: _____

Date of Birth: _____ RX BIN #: _____

Secondary Coverage

Company Name: _____

Contract (ID) #: _____ Group #: _____

Name of Policyholder: _____ Relationship to Patient: _____

Address of Policyholder: _____

Date of Birth: _____

The undersigned agrees, whether he/she signs as agent or as patient, that in consideration of services to be rendered by AllerVie Health to the patient named above, he/she hereby obligates himself/herself, assumes financial responsibility, and agrees to pay upon demand to provider all charges for such services and incidentals incurred by said patient. Should the account be referred to an attorney/collection agency, the undersigned agrees to pay 33% of the unpaid balance for collection costs, or alternatively the maximum lawful fee, at such time my account is placed with a collection agency. I further understand that in the event the account is referred to an attorney for collection, I agree to be liable for such additional reasonable court costs and attorney's fees as may be determined by the court. The undersigned understands that all bills are payable upon service and that he/she, not the insurance company, is responsible for the payment of all services.

Until my accounts are finally settled, I give my direct consent to receive communications regarding my accounts from any services and any collectors of my accounts, through various means such as 1) any cell, landline, or text number that I provide, 2) any email address that I provide, 3) auto dialer systems, 4) voicemail messages, and other forms of communications.

I hereby authorize AllerVie Health to use "Signature on File" in lieu of an original signature for all medical claims submitted for services rendered on above patient.

Signature of Responsible Party: _____ Date: _____

Printed Name of Responsible Party: _____

Patient Name:_____ Date of Birth:_____

Medical History

1. Reason for visit: _____

_____

2. Medications

Name	Dose	Directions	Frequency

3. Pharmacy

Name: _____

Address: _____

Phone: _____

4. Please list all drug allergies. Include the drug name and type of reaction.

Drug Name	Type of Reaction

Allergy History

1. Have you ever had:

☐ Hay Fever/Seasonal Allergies ☐ Childhood Asthma ☐ Adult Onset Asthma

☐ Eczema ☐ Hives ☐ Allergic Eyes ☐ Insect Sting Reaction

☐ Food Allergies ☐ Swelling ☐ Latex Allergy ☐ Chemical Allergy

2. List all food allergies and describe the reaction and dates(s):

_____

_____

3. Have you ever been tested for allergies? ☐ Yes ☐ No When? _____

If yes, what type of testing did you have? ☐ Skin tests ☐ Blood tests

What were the test results? _____

4. Have you ever had allergy immunotherapy? ☐ Yes ☐ No

If yes, did they help? ☐ Yes ☐ No

If yes, please give provider name and year: _____

5. Have you ever had a severe reaction to an insect? ☐ Yes ☐ No

What insect? ☐ Honey Bee ☐ Yellow Jacket ☐ Wasp ☐ Hornet ☐ Fire Ant ☐ Other: _____

If yes, was reaction: ☐ local, generalized hives and/or swelling or ☐ anaphylaxis

6. How many sinus infections per year do you get?	☐ 1	☐ 2-3	☐ 3-4	☐ 5 or greater	☐ None
7. How many lung infections per year do you get?	☐ 1	☐ 2-3	☐ 3-4	☐ 5 or greater	☐ None
8. How many courses of antibiotics per year do you get?	☐ 1	☐ 2-3	☐ 3-4	☐ 5 or greater	☐ None
9. How many steroid courses per year do you get?	☐ 1	☐ 2-3	☐ 3-4	☐ 5 or greater	☐ None

For Children Under 15, Complete the Following

1. Birth Weight:_____

2. Were there any complications following delivery? ☐ Yes ☐ No
   If yes, was there an intensive care unit stay? ☐ Yes ☐ No

3. Were there any severe respiratory infections under age 8? ☐ Yes ☐ No
   Please specify: ☐ RSV ☐ Pneumonia ☐ Severe bronchitis ☐ Croup

4. Has growth and development been normal? ☐ Yes ☐ No
   If no, explain: _____

5. Are immunizations up to date? ☐ Yes ☐ No

Social History

1. Current Occupation: _____
   If a child, please indicate: ☐ Student-What Grade? ☐ Daycare/Preschool ☐ Not Applicable

2. Do your hobbies involve any of the following? ☐ Chemicals ☐ Particulates ☐ Animals ☐ Outdoor sports

Environmental History

1. Do you have pets? ☐ None
   ☐ Dogs If yes: ☐ 1-2 ☐ 2 + ☐ Inside ☐ Outside
   ☐ Cats If yes: ☐ 1-2 ☐ 2 + ☐ Inside ☐ Outside
   ☐ Other: _____

2. Do you have anyone that smokes living in your household? ☐ None ☐ Yes

Preventive Measures

1. Smoking Status: (please check) ☐ Never Smoked ☐ Current smoker: How often? _____
   ☐ Previous smoker: Year that you quit? _____

2. Have you received the Influenza vaccine within the past 12 months? ☐ Yes ☐ No
   If yes, when: _____

3. If you are age 40 or above, have you ever received the pneumonia vaccine? ☐ Yes ☐ No
   If yes, _____

Asthma Control Test

If you are being seen for asthma or asthma symptoms, please circle the best answer to the following questions below:

(For Age 12 years or older)

1. In the past 4 weeks, how much of the time did your asthma keep you from getting as much done at work, school or home?
   ☐ (1) All of the time ☐ (2) Most of the time ☐ (3) Some of the time ☐ (4) A little of the time ☐ (5) None of the time

2. In the past 4 weeks how often have you had shortness of breath?
   ☐ (1) More than once a day ☐ (2) Once a day ☐ (3) Three to six times a week ☐ (4) Once or twice a week ☐ (5) Not at all

3. In the past 4 weeks how often did your asthma symptoms wake you up at night or earlier than usual in the morning?
   ☐ (1) 4 or more nights a week ☐ (2) 2 or 3 nights a week ☐ (3) Once a week ☐ (4) Once or twice ☐ (5) Not at all

4. In the past 4 weeks how often have you used your rescue inhaler or nebulizer medication?
   ☐ (1) 3 or more times per day ☐ (2) 1 or 2 times a day ☐ (3) 2 or 3 times a week ☐ (4) Once a week or less ☐ (5) Not at all

5. How would you rate your asthma control in the past 4 weeks?
   ☐ (1) Not controlled at all ☐ (2) Poorly controlled ☐ (3) Somewhat controlled ☐ (4) Well controlled
   ☐ (5) Completely controlled

Total Score: _____

(For Ages 4 to 11 years)

1. (To the child) How is your asthma today?
   ☐ (0) Very Bad ☐ (1) Bad ☐ (2) Good ☐ (3) Very Good

2. (To the child) How much of a problem is your asthma when you run, exercise, or play sports?
   ☐ (0) It's a big problem, can't do what I want ☐ (1) It's a problem ☐ (2) It's a little problem, but okay ☐ (3) It is not a problem

3. (To the child) Do you cough because of your asthma?
   ☐ (O)Yes, all of the time ☐ (1)Yes, most of the time ☐ (2)Yes, sometimes ☐ (3) No, none of the time

4. (To the child) Do you wake up at night because of your asthma?
   ☐ (O)Yes, all of the time ☐ (1)Yes, most of the time ☐ (2)Yes, sometimes ☐ (3)No, none of the time

5. (To the parent) During the past 4 weeks, on average, how many days per month did your child have any daytime asthma symptoms?
   ☐ (0) Everyday ☐ (1) 19-24 days/month ☐ (2) 11-18 days/month ☐ (3) 4-10 days/month ☐ (4) 1-3 days/ month ☐ (5) Not at all

6. (To the parent) During the past 4 weeks how many days per month did your child wheeze during the day due to asthma?
   ☐ (0) Everyday ☐ (1) 19-24 days/month ☐ (2) 11-18 days/month ☐ (3) 4-10 days/month ☐ (4) 1-3 days/month ☐ (5) Not at all

7. (To the parent) During the last 4 weeks how many days per month did you child wake up during the night due to asthma?
   ☐ (0) Everyday ☐ (1) 19-24 days/month ☐ (2) 11-18 days/month ☐ (3) 4-10 days/month ☐ (4) 1-3 days/month ☐ (5) Not at all

Total Score: _____

Review of Systems

Are you currently experiencing any of the following:

General	Yes	No
Fever		
Chills or night sweats		
Weight loss		
Weight gain		
Tired/Weakness/Fatigue		

Skin/Hair	Yes	No
Rash		
Hives		
Itchiness		
Eczema		

Eyes	Yes	No
Worsening eyesight		
Cataracts		
Glaucoma		
Pain		
Infection		

Ears, Nose & Throat	Yes	No
Dizziness		
Loss of hearing		
Earache		
Ringing in ears		
Nose bleeds		
Sore throat		
Hoarseness		
Mouth sores		
Thrush		
Pain in neck		

Lungs	Yes	No
Cough up blood		
Pneumonia		
Shortness of breath		
Chronic bronchitis		

Heart/Blood Vessels	Yes	No
High blood pressure		
Pain/tightness in chest at rest or exercise		
Heart murmur		
Heart Palpitations		
Pace maker		

Gastrointestinal	Yes	No
Heartburn		
Nausea		
Vomiting		
Stomach pain		
Diarrhea		
Constipation		
Hemorrhoids		
Bloody stools		
Recent loss of appetite		
Jaundice		
Hepatitis		
Ulcer		

Endocrine	Yes	No
Goiter/Thyroid problems		
Diabetes mellitus		
Frequent thirst		
Frequent urination		
Heat intolerance		
Cold intolerance		

Musculoskeletal	Yes	No
Joint pain		
Arthritis		
Muscle aches/weakness		
Ulcers on legs or feet		

Genitourinary	Yes	No
Frequent urination		
Urine infections		
Pain/burning on urination		
Difficulty with urination		
Blood in urine		
Kidney stones		

Neurological	Yes	No
Seizures		
Tingling		
Numbness		
Poor balance		
Stroke/paralysis		
Difficulty with speech		
Tremors		
Headaches		

Psychiatric	Yes	No
Anxiety		
Memory loss		
Panic disorder		
Bipolar		
Schizophrenia		

Hematology	Yes	No
Anemia or low blood		
Bruise easily		
Swollen glands		
Blood clots		
Blood transfusions		

Women Only	Yes	No
Menstrual problems		
STD		

Men Only	Yes	No
Prostate trouble		
STD		
Discharge from penis		
Pain or lump in testicles or scrotum (sac)		

I acknowledge that all information regarding my medical history is correct and accurate to my knowledge. By signing this document I understand that I am held accountable for any false information which could impede proper treatment provided by the healthcare providers and staff of the AllerVie Health. I am aware that I am responsible for providing updated information to the physicians and staff of AllerVie Health as changes occur in my medical history.

Signature

Date

Patient Name:_____ Date of Birth:_____

Surgical History – Please check off any procedure or surgeries

Surgical Procedure	When	Explain
☐ None		
☐ Eye		
☐ Ear		
☐ Ear tubes		
☐ Thyroid		
☐ Tonsillectomy		
☐ Adenoidectomy		
☐ Appendectomy		
☐ Cholecystectomy		
☐ Hernia		
☐ Heart		
☐ Hysterectomy		
☐ Shoulder		
☐ Back		
☐ Hip		
☐ Ankle		
☐ Knee		
☐ Stomach		
☐ Breast		
☐ Removal of Ovaries Only		
☐ Tubal Ligation		
☐ C-Section		
☐ Other:		
☐ Other:		
☐ Other:		

Family History – Indicate which relative has had the following diseases:

Disease	Father	Mother	Brother	Sister	Son	Daughter	Other	No
Allergic Rhinitis								
Asthma								
Autoimmune Disorder								
Cystic Fibrosis								
Eczema/Atopic Dermatitis								
Food Allergy								
Hereditary Angioedema								
Immunodeficiancy								

Photography & Publicity Release Form

I, the undersigned, do hereby consent and agree that AllerVie Health and its Subsidiaries and Partners, its employees, or agents permission **to use my name, likeness, image, voice, and/or appearance as well as my health information** as such may be embodied in any pictures, photos, video recordings, audiotapes, digital images, and the like, taken or made on behalf of these entities or their activities.

I agree that AllerVie Health and its Subsidiaries and Partners may use these in any and all media, now or hereafter known, and exclusively for any purpose consistent with their missions. These uses include, but are not limited to illustrations, exhibitions, videos, reprints, reproductions, publications, advertisements, and any promotional, marketing, or educational materials in any medium now known or later developed, including the Internet. I further consent that my name and identity may be revealed therein or by descriptive text or commentary.

I do hereby release to AllerVie Health and its Subsidiaries and Partners, its agents, and employees all rights to exhibit this work in print and electronic form publicly or privately and to market and sell copies. I waive any rights, claims, or interest I may have to control the use of my identity or likeness in whatever media used. I understand that there will be no financial or other remuneration due to me as a result of this agreement or anything described herein.

I also understand that AllerVie Health and its Subsidiaries and Partners are not responsible for any expense or liability incurred as a result of my participation in this recording, including medical expenses due to any sickness or injury incurred as a result.

I represent that I am at least 18 years of age, or the legal guardian, have read and understand the foregoing statement, and am competent to execute this agreement.

Name: _____

Address: _____

Phone Number: _____

Parent or Legal Guardian: _____

_____ _____

Signature Date