



(404) 267-5566 FAX: (404) 267-5565
 SCHEDULING@GAINTERVENTIONALMEDICINE.COM
 WWW.GAINTERVENTIONALMEDICINE.COM
 CHAMBLEE - 3286 BUCKEYE RD., ATLANTA, GA 30341

LETTER OF PROTECTION AND NOTICE MEDICAL LIEN

Patient Name:	
First Date of Service:	
County in which legal case is pending:	
<p>I do hereby authorize you _____ (name of attorney) as my attorney to pay Georgia Interventional Medicine, LLC (hereinafter "GIM") for medical services out of any proceeds that I receive as a settlement, judgment or verdict from my pending legal case.</p> <p>I understand that the settlement or award amount may not cover part or all of the medical services rendered by GIM. I fully understand that I am financially responsible for and agree to pay all charges which are not paid by the settlement, judgment or verdict in the case, if not settled with attorney.</p> <p>I hereby authorize and direct you as my attorney to pay directly to GIM such sums as may be due and owed to GIM for medical services rendered. I hereby further give a lien on my case to GIM against any and all proceeds of my settlement, judgment or verdict which may be paid to you, my attorney or myself, as a result of the injuries for which I have been treated or injuries in connection therewith.</p> <p>I understand that I am directly and fully responsible to GIM for all medical bills submitted by GIM for services rendered to me. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.</p> <p>I agree to promptly notify GIM of any charge or additional of attorney(s) used by me in connection with this accident and I instruct my attorney to do the same and to promptly deliver a copy of this lien to any such substituted or added attorney(s). I have been advised that if my attorney does not wish to cooperate in protecting GIM's interest, GIM will not await payment, but will declare the entire balance due and payable. I have had an opportunity to review the terms and conditions of this lien and have had the opportunity to obtain advise of counsel. I enter into this agreement knowingly and willingly.</p>	
Patient's Signature:	Date:
Attorney's Signature:	Date:



X-RAY CONSENT FORM

Patient Name _____ Date _____

During your examination, the doctor may feel that x-rays will be needed in order to diagnose your condition. In addition, they may be required in order to administer treatment.

By signing below, I consent to having the diagnostic x-rays performed, which the doctor determines is clinically necessary.

Patients Signature _____ Date _____

FOR WOMEN ONLY:

I understand that if I am pregnant and have x-rays taken which expose my lower torso to radiation, it is possible to injure the fetus.

I am aware that the ten (10) days following the onset of a menstrual period are generally considered to be safe for x-ray exams.

With those factors in mind, I am advising my doctor that:

I am pregnant. Yes No

I could be pregnant. Yes No

I am late with my menstrual period. Yes No

I am taking contraceptives. Yes No

I have had a tubal ligation. Yes No

I have had a hysterectomy. Yes No

I have irregular menstrual periods. Yes No

My last menstrual period began on _____

With full understanding of the above, and believing that I am currently not as risk, I wish to have an x-ray examination performed today if requested by the doctor.

Signature _____ Date: _____

THIS FORM IS FOR EVERYONE; PLEASE SEE TOP PORTION.

PATIENT REGISTRATION INFORMATION		
Name:	Date of Birth:	Sex:
Preferred language (if not specified, English will be chosen as your preferred language):		
Email:		
Home Address:	Zip Code:	Mailing Address (if different):
Home Phone:	Mobile Phone:	Work Phone:
Reason for visit/Diagnosis:		
Primary Care Physician:		Referring Physician:
Pharmacy:		
Name	Address:	
Guarantor/Responsible Party		
Name:	Date of Birth:	
Relationship to patient: <input type="checkbox"/> Parent <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Family Member <input type="checkbox"/> Other _____		
Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Other _____		
Home Address:	Mailing Address (if different):	
Home Phone:	Mobile Phone:	Work Phone:
Emergency Contact(s)		
Name:	Phone:	Date of Birth:
Relationship to patient: <input type="checkbox"/> Parent <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Family Member <input type="checkbox"/> Other _____		
Home Address:	City:	State: Zip:
Name:	Phone:	Date of Birth:
Relationship to patient: <input type="checkbox"/> Parent <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Family Member <input type="checkbox"/> Other _____		
Home Address:	City:	State: Zip:
Insurance		
PRIMARY INSURANCE Name:		Attorney:
Subscriber/Member ID#:		Case Manager:
Group#:		Phone:
Subscribe Name:		
Address:		
Employer:		
Date of Birth:		
Relationship to Patient:		

- I hereby authorize Georgia Interventional Medicine to obtain records from other sources as may be needed in the treatment of this patient.
- I hereby authorize the release of information concerning this patient's treatment to other physicians involved in the care and treatment of this patient.
- I hereby authorize payment of insurance benefits otherwise due to me to be made directly to Georgia Interventional Medicine or hospital. I understand that I am responsible for any amount not covered by the insurance company.

A copy of this information shall be as valid as the original.

Signature of parent or responsible party

Date

Patient Name:

Date of Birth:

CHIEF COMPLAINTS:

Since the accident, have you experienced pain in any of the following areas?

Neck	<input type="checkbox"/> Left	<input type="checkbox"/> Right	Feet	<input type="checkbox"/> Left	<input type="checkbox"/> Right
Shoulders	<input type="checkbox"/> Left	<input type="checkbox"/> Right	Muscle Cramps	<input type="checkbox"/> Left	<input type="checkbox"/> Right
Upper Arms	<input type="checkbox"/> Left	<input type="checkbox"/> Right	Headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Elbows	<input type="checkbox"/> Left	<input type="checkbox"/> Right	Visual Disturbances	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Forearms	<input type="checkbox"/> Left	<input type="checkbox"/> Right	Light Sensitivity	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Wrists	<input type="checkbox"/> Left	<input type="checkbox"/> Right	Nausea	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hands	<input type="checkbox"/> Left	<input type="checkbox"/> Right	Chest Pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Mid-Back	<input type="checkbox"/> Left	<input type="checkbox"/> Right	Shortness of Breath	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Rib Pain	<input type="checkbox"/> Left	<input type="checkbox"/> Right	Shoulder Muscle Tension	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Low Back Pain	<input type="checkbox"/> Left	<input type="checkbox"/> Right	Back Muscle Tension	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hips	<input type="checkbox"/> Left	<input type="checkbox"/> Right	Muscle Weakness	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Buttocks	<input type="checkbox"/> Left	<input type="checkbox"/> Right	Radiating Pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Legs	<input type="checkbox"/> Left	<input type="checkbox"/> Right	Numbness	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Knees	<input type="checkbox"/> Left	<input type="checkbox"/> Right	Tingling	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Ankles	<input type="checkbox"/> Left	<input type="checkbox"/> Right		<input type="checkbox"/> Yes	<input type="checkbox"/> No

ALLERGIES: Include Food Allergies

Yes None If Yes, please list:

Immunizations up to date: Yes No Decline

PAST HISTORY:

Hospitalizations, Surgeries, Major Illnesses:

Problem:

Problem:

Problem:

Problem:

PATIENT MEDICAL HISTORY:

TREATING OFFICE:

ADHD	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Spine Surgery	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Schizophrenia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Major Depression	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Chronic Lung Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Epilepsy (seizures)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Congenital Heart Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart Issues	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	ALS	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Multiple Sclerosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Mental Illness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Parkinson's Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Hypertension	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Kidney Failure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Neuropathy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Deep Vein Thrombosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
High Cholesterol	<input type="checkbox"/> Yes	<input type="checkbox"/> No				

Patient Name:

Date of Birth:

CURRENT MEDICATIONS: (list all medications including over the counter medications/vitamins)

1.	2.
3.	4.
5.	6.
7.	8.
9.	10.
11.	12.

Do you take antibiotics prior to any procedures, operations or appointments? Yes No

SOCIAL HISTORY: Check all that apply to the patient

Exercise: Occasionally Daily Competitive Athlete Recreational

Diet: Usual American Low Fat Low Salt Vegetarian Other _____

Smoking: N/A No. of packs a day Age started _____

Alcohol: N/A Type: _____ Amount: _____ day/week/month

Sexual Activity: N/A Yes No Currently pregnant

FAMILY HISTORY

Relationship	Name	Age/ Staus	Hypertension	Heart Surgery	Heart Attack	High Blood Pressure	Stroke	Dyslipidemia	Diabetes	Obesity	Cardiomyopathy	Pacemaker	Sudden Death	Long QT Syndrome	Drowning	Passing Out	Seizures	Marfan's Syndrome	Deafness at Birth	Other
Mother																				
Father																				
Sister																				
Brother																				
Maternal Grandmother																				
Maternal GrandFather																				
Paternal Grandmother																				
Paternal GrandFather																				
Other																				

WARNING! IF YOU HAVE A PACEMAKER, DEFIBRILLATOR OR ANEURYSM CLIP, DO NOT PROCEED WITH YOUR SCAN. PLEASE NOTIFY A STAFF MEMBER IMMEDIATELY.

Patient Name _____ DOB _____ Appt. Date _____

Please indicate if you have any of the following implants or metal inside your body:

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N | Cardiac pacemaker or defibrillator – DON'T SCAN | <input type="checkbox"/> Y <input type="checkbox"/> N | Coronary artery stent – OK |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Brain aneurysm clip – DON'T SCAN | <input type="checkbox"/> Y <input type="checkbox"/> N | Cardiac valve replacement – OK |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Cochlear, ear or eye/lid implant; Internal hearing aid – DON'T SCAN | <input type="checkbox"/> Y <input type="checkbox"/> N | External hearing aid(s) – REMOVE |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Joint replacement, metal rod, plates, screws, anchors – OK | <input type="checkbox"/> Y <input type="checkbox"/> N | Internal drug infusion pump – DON'T SCAN |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Breast tissue expander – DON'T SCAN (breast implants OK) | <input type="checkbox"/> Y <input type="checkbox"/> N | External drug infusion device – REMOVE |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Non-coronary metallic stent, filter, or coil – ASK RADIOLOGIST | <input type="checkbox"/> Y <input type="checkbox"/> N | Prosthetic device – REMOVE |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Surgical staples, clips, temporary wire or pin – ASK RADIOLOGIST | <input type="checkbox"/> Y <input type="checkbox"/> N | Penile implant – DON'T SCAN |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Shrapnel, bullet or other foreign body – ASK RADIOLOGIST | <input type="checkbox"/> Y <input type="checkbox"/> N | IUD, diaphragm or pessary – ASK RAD |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Spinal cord/neurostimulator or bone growth/fusion stimulator – DON'T SCAN | <input type="checkbox"/> Y <input type="checkbox"/> N | Spinal or brain shunt – ASK RAD |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Other implant/prosthesis – _____ | | |

Please indicate if any of the following apply to you:

- Y N Pregnant or trying to get pregnant? – FILL OUT FORM
- Y N History of metallic foreign body in eye for which you sought medical attention, or work with metal on the job? – X-RAY ORBITS
- Y N Tattoos – OK Y N Cosmetic colored contact lenses – REMOVE
- Y N Body piercings –
Low-Field Extremity MRI (e.g. O- Scan): REMOVE if metal on/near extremity of interest, and if can be easily removed by patient. *If can't be easily removed, test with a strong handheld magnet. If attracted to magnet, REMOVE prior to scanning.*
Low-Field Whole Body MRI (e.g. S/G Scan): REMOVE if metal and if can be easily removed by patient. *If can't be easily removed, test with a strong handheld magnet. If attracted to magnet, REMOVE prior to scanning.*
- Y N Fainting, dizzy spells (syncope), breathing problem, or motion disorder
- Y N Known Allergies list: _____
- Y N Any surgeries of the Heart, Brain, Spine or Abdomen?
 If yes, what was done and when? _____
- Y N Prior MRI of this same body part?
 If yes, at what facility and when was it performed? _____

IMPORTANT INSTRUCTIONS! Before entering the MRI environment or MRI system room, you must remove ALL metallic objects, including hearing aids, dentures, partial plates, keys, pagers, cell phones, eyeglasses, hairpins, barrettes, jewelry, body-piercing jewelry, watch, safety pins, paper clips, money clip, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knife, nail clipper, and tools.

Please consult the MRI technologist or radiologist if you have any questions or concerns before you enter the MRI system room.

NOTE: You may be advised or required to wear earplugs or other hearing protection during the MRI procedure to prevent possible problems or hazards related to acoustic noise.

I attest that the above information is correct to the best of my knowledge. I read and understand the contents of this form, and had the opportunity to ask questions regarding the information on this form and the MR procedure that I am about to undergo.

Signature of Person Completing Form: _____ Date ____/____/____
Signature

Form Completed by: Patient Other _____
Print name Relationship to patient

Form Reviewed by: MRI Tech. _____
 Tech. Assist. Coordinator Signature

I have reviewed this form. All positive responses have been discussed, investigated and cleared.

Signature of Technologist: _____ Date ____/____/____



(404) 267-5566 FAX: (404) 267-5565
SCHEDULING@GAINTERVENTIONALMEDICINE.COM
WWW.GAINTERVENTIONALMEDICINE.COM
CHAMBLEE - 3286 BUCKEYE RD., ATLANTA, GA 30341

MEDICATION AGREEMENT

The purpose of this Agreement is to prevent misunderstandings about certain medications you will be taking for pain management. This is to help both you and your physician to comply with the law regarding pain-control medications. I understand that this Agreement is essential to the trust and confidence necessary in a physician/patient relationship and that my physician undertakes treatment based on this Agreement.

I understand that if I breach this Agreement my physician will be forced to stop prescribing pain-control medications.

I will communicate fully with my physician about the character and intensity of my pain, the effect of the pain on my daily life and how well the medication is helping to relieve the pain.

I will not share, sell or trade my medication with anyone.

I will safeguard my medication from loss or theft. Lost or stolen medications cannot be replaced.

I agree that only one physician may prescribe pain medications. If pain medications are received from other physician practices, our clinic will be unable to prescribe pain medications thereafter.

I agree that refills of my prescriptions for pain medication will be made only at the time of an office visit or during regular office hours.

I authorize my physician and my pharmacy to cooperate fully with any city, state or federal law enforcement agency including this state's Board of Pharmacy, in the investigation of any possible misuse, sale or other diversion of my medications.

I authorize my physician to provide a copy of this Agreement to my pharmacy if necessary.

I agree to waive any applicable privilege or right of privacy or confidentiality with respect to this Agreement and the medications presented for pain management.

I agree that I will use my medication as prescribed and that use of my medication at a greater rate will result in my being without medication for a period of time.

I agree to follow these procedures that have been fully explained to me. All of my questions and concerns regarding my medications have been adequately answered.

A copy of this Agreement has been given to me. Nothing herein shall be deemed to alter the discretion of my physician to use his best judgment in recommending treatment and medication options.

This Agreement is entered into on this _____ day of _____, _____.

Patient Signature: _____

Witnessed by: _____

Physician Signature: _____

1.) Date of accident: _____

Visit to the ER Yes No Transported by EMS Yes No
 Imaging performed Yes No X-Ray Yes No

2.) Did either driver receive a citation or ticket from the police? If so, who received the citation/ticket?

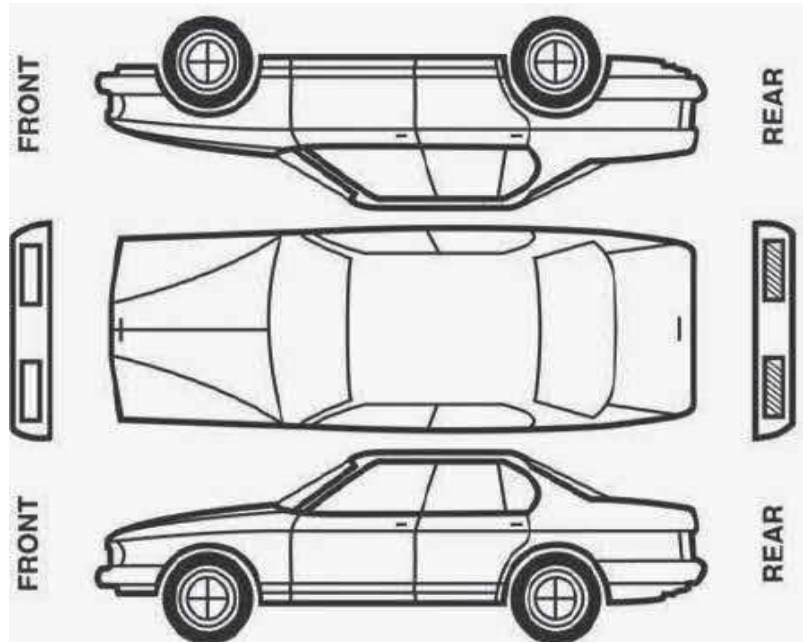
3.) Do you have MEDPAY with your car insurance? If so, please provide MEDPAY information:

4.) Who was the at fault driver? You? Driver of the other vehicle? Unsure? _____

5.) Vehicle Damage:

- ___ None
- ___ Scratch
- ___ Dent
- ___ Total Loss

What area and percentage of your car was damaged? Indicate on the picture shown.



6.) Are you treating at another clinic for this Motor Vehicle Accident ? If so where?

Signature _____ Date: _____



(404) 267-5566 FAX: (404) 267-5565
 SCHEDULING@GAINTERVENTIONALMEDICINE.COM
 WWW.GAINTERVENTIONALMEDICINE.COM
 CHAMBLEE - 3286 BUCKEYE RD., ATLANTA, GA 30341

AUTHORIZATION TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION

Patient Name: _____ DOB: _____
 Address: _____ Phone: _____

I _____ authorize representatives from the following facility(s)
 to disclose health information as directed below to release records by mail or fax copies to:
 _____ release to: Georgia Interventional Medicine – 3286 Buckeye Road, Atlanta, GA 30341
 _____ obtain from: _____
 _____ exchange with: _____

the following information pertaining to myself: _____
 _____ treatment summary
 _____ history/intake
 _____ diagnosis
 _____ medication history
 _____ other (specify) _____

for the purpose of:
 _____ evaluation/assessment and/or coordinating treatment efforts
 _____ other (specify) _____

I understand I have the right to refuse to sign this form, and that I may revoke my consent at any time (except to the extent that the information has already been released).

Signature of Client

Date

Signature of Witness

Date



 (404) 267-5566  FAX: (404) 267-5565
 SCHEDULING@GAINTERVENTIONALMEDICINE.COM
 WWW.GAINTERVENTIONALMEDICINE.COM
 CHAMBLEE - 3286 BUCKEYE RD., ATLANTA, GA 30341

TRANSPORTATION FEES

Please sign that you understand the fees below will be added to your account paid by your attorney, should you fall into one or more of the below categories.

UBER CHARGES for each way:
\$10.00 CANCELLED UBER
\$20.00 0-10 MILES
\$30.00 10-20 MILES
\$40.00+ 20 MILESS AND UP

For multiple passengers or large UBER premium vehicles there will be an additional charge.(That charge is what UBER charges us).

Print Name

Sign Name

Date



(404) 267-5566 FAX: (404) 267-5565
SCHEDULING@GAINTERVENTIONALMEDICINE.COM
WWW.GAINTERVENTIONALMEDICINE.COM
CHAMBLEE - 3286 BUCKEYE RD., ATLANTA, GA 30341

NO SHOW / CANCELLATION POLICY

Our goal is to meet the needs of our patients and we will make every effort to efficiently schedule your appointments. In return, it is your responsibility to make every effort to keep your scheduled appointments and arrive promptly at the time instructed. However, we realize that unanticipated events may prevent you from keeping your appointment. In fairness and consideration to our other patients, we hereby request that you notify our office immediately when you realize you will not be able to keep your appointment. If you need to cancel or reschedule your appointment, you must do so at least 24 hours before your scheduled office appointment and 48 hours before your scheduled procedure time to avoid paying a fee. In an effort to see patients promptly at the scheduled time, this office does not double-book appointments; therefore, the 24 / 48-hour notification is necessary so that we may schedule other patients needing immediate appointments.

The fees are as follows:

Missed office appointment is \$50.00
Missed physical therapy appointment is \$50.00
Missed MRI appointment is \$100.00
Missed procedure appointment is \$100.00

Sign Name

Date



Our office is able to complete FMLA/Disability forms ONLY at our Chamblee Tucker location. Due to high demands and limited availability it is recommended you plan to have a scheduled appointment as soon as you have forms available. Once you have been discharged our office will **NO** longer complete any medical forms and your primary care physician will have to continue them. Your primary care is able to request your medical records if needed.

Charges:

1-3 pages \$30.00 anything after that will be \$40.00.

If you have two separate set of forms to be completed you will be required to schedule another appointment and the same charges above will be required. If an update on forms is required the same charges will be applied. You can make the payment with exact cash or card.

Please sign below that you have acknowledged the above terms, in the case you are required to have forms completed.

Signature:

Date:

TECHNOLOGY & RECORDING POLICY ACKNOWLEDGMENT

COMMITMENT TO PRIVACY

GA Interventional Medicine (GIM) is committed to protecting the privacy and confidentiality of all patients, staff, and Protected Health Information (PHI) in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and all applicable federal and state privacy regulations.

As wearable and personal technology becomes increasingly common, this policy outlines expectations regarding its use within our facility.

WEARABLE & PERSONAL TECHNOLOGY USE

Patients and visitors are permitted to wear personal electronic devices, including but not limited to:

- Smart glasses (e.g., Meta glasses or similar devices)
- Smart watches
- Smartphones
- Tablets
- Fitness trackers or other wearable technology

However: **Audio, Video, or Live Recording Is Strictly Prohibited**

PERSONAL DEVICES MAY NOT BE USED TO:

- Record audio or video
- Capture images
- Live stream
- Broadcast via social media
- Record conversations (including provider discussions)
- Capture computer screens, documents, or clinical activity

This restriction applies in all areas of the facility, including waiting rooms, hallways, and exam rooms.

PROTECTION OF PROTECTED HEALTH INFORMATION (PHI)

Unauthorized recording may inadvertently capture:

- Other patients
- Clinical staff
- Medical records or computer screens
- Verbal discussions containing PHI

Such activity may constitute a violation of HIPAA privacy standards and patient confidentiality laws. To ensure compliance and protect all individuals within the facility, GIM reserves the right to request that any recording-enabled device be turned off or removed if there is concern that recording is occurring.

REQUESTS TO RECORD PERSONAL MEDICAL DISCUSSIONS

If a patient wishes to record a portion of their own clinical discussion for personal medical reference:

- The request must be made in advance
- Explicit approval must be granted by the provider or clinic leadership
- No other individuals or PHI may be captured

GIM reserves the right to deny recording requests to maintain privacy, safety, and operational integrity.

NON-COMPLIANCE

If unauthorized recording is observed or suspected, GIM may:

- Request the recording be stopped immediately
- Request deletion of the recording
- Reschedule or terminate the visit
- Initiate discharge from the practice in accordance with clinic policy

PATIENT ACKNOWLEDGMENT

By signing below, I acknowledge that I have read and understand GA Interventional Medicine's Technology & Recording Policy. I agree to comply with these guidelines while on GIM premises.

Patient Name: _____

Signature: _____

Date: _____