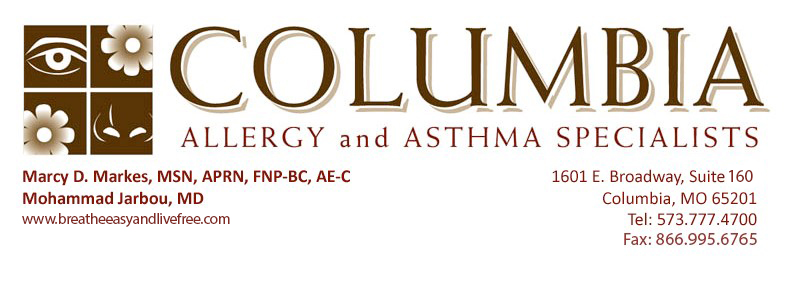
**New Patient Form**

Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Birth Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security #\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ST\_\_\_\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status: \_\_single \_\_married \_\_divorced \_\_widowed/widower \_\_domestic partner

Home # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency**

**Contact:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home #\_\_\_\_\_\_\_\_\_\_\_\_Work #\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell/Other #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Responsible Party or Bill to Information:**

Full Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date\_\_\_\_\_\_\_\_\_\_

Address if different from above \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell \_\_\_\_\_\_\_\_\_\_\_\_\_\_SS#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Insurance:**

Insurance Carrier \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Policy #\_\_\_\_\_\_\_\_\_\_\_\_\_Group#\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CoPay amount $\_\_\_\_\_\_\_\_\_\_\_\_**

**Secondary Insurance:**

Insurance Carrier \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Policy #\_\_\_\_\_\_\_\_\_\_\_\_\_Group#\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Physician:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**How did you learn about us**: \_\_Friend \_\_Relative \_\_ Physician \_\_ Insurance

\_\_Website \_\_Facebook \_\_Radio

**Chief Complaint**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long has this been a problem?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Past Medical and surgical history:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Medications**: Prescription, Inhalers, over the counter, supplements etc.

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 6.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

COLUMBIA ALLERGY and ASTHMA SPECIALISTS PAGE 2

Patient Name and DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What is your preferred pharmacy?**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any medication allergies? \_\_\_Y \_\_\_N

What medications and reaction?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any food allergies? \_\_\_Y\_\_\_N What foods?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any insect allergies?\_\_\_Y\_\_\_N

**Have you ever had allergy testing before**?\_\_\_Yes \_\_\_No

If yes, name of previous allergist and when?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been on allergy shots before?\_\_\_Y\_\_\_N If yes, how long?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family history**: Please mark any family members that have experienced any of the following conditions: asthma, allergies, sinusitis, bronchitis, COPD, emphysema, migraines, eczema or hives

\_\_ mother \_\_father \_\_brother \_\_sister \_\_aunt \_\_uncle

\_\_grandmother \_\_grandfather N/A adopted\_\_\_

**Living/Work Environment:**

Do you have any pets? \_\_Y \_\_N If yes, what kind and how many? Inside the home? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home or apartment?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Type of heat?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Air condition? \_\_\_\_\_

Any filters inside the home? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Floor types? \_\_carpet \_\_hard wood \_\_vinyl \_\_tile

Do you have curtains? \_\_\_\_ Blinds? \_\_\_ Cleaning frequency\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are there any smokers in the home? \_\_\_\_\_ If yes, how many? \_\_\_\_

Plants? \_\_ How many? \_\_\_

Do you have hypoallergenic mattress covers and pillows on your bedding? \_\_Y \_\_N

Work/School Environment?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your worst time of year? \_\_\_Spring \_\_\_Summer \_\_\_Fall \_\_\_ Winter

**Triggering factors**:

\_\_heat \_\_cold \_\_night \_\_day \_\_foods \_\_cleaning agents \_\_laughter

\_\_candles \_\_cats \_\_dogs \_\_trees \_\_grass \_\_lawn mowing \_\_dust

\_\_metals \_\_weeds \_\_smoke \_\_illness \_\_weather changes \_\_wind

\_\_other please list \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you smoke?** \_\_Y \_\_N If yes, how many years? \_\_\_\_ How much per day?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Review of systems**:

Ears Eyes Nose Throat Sinus

Popping Tearing Runny Pain Pain

Fullness Itch Itch Itch Drainage

Recurrent Infection Redness Sneeze Redness Pressure

Tubes Change in vision Bleeding Hoarseness Infection

Hearing Loss Other Blockage Tonsillectomy Other

Other Polyps Adenoidectomy

Loss of smell Other

Other

Skin Respiratory Gastrointestinal

Itch Cough Nausea

Burn Wheeze Vomiting

Rashes Shortness of breath Reflux/heartburn

Hives Exercise Food Intolerance

Eczema Night cough Other

Dryness Day cough

Other Other

COLUMBIA ALLERGY and ASTHMA SPECIALISTS PAGE 3

Patient Name and DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***CONSENT FOR CARE AND TREATMENT***

I, the undersigned, do hereby agree and give my consent and authorization for COLUMBIA ALLERGY and ASTHMA SPECIALISTS, to provide examination, treatments, and services by a licensed provider to myself/designee. I realize and certify that no guarantee or assurance has been made as to the results that may be obtained for such examinations, treatments, and services.

***ASSIGNMENT AND RELEASE***

I hereby authorize my insurance company to pay benefits directly to COLUMBIA ALLERGY and ASTHMA SPECIALISTS, or its designee, for services rendered, and agree that I am financially responsible for non-covered services. I also authorize COLUMBIA ALLERGY and ASTHMA SPECIALISTS, to release any and all requested information pertaining to treatment necessary to process claim(s) benefits. (Physician, Insurance company, Attorney, etc)

***PATIENT ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES***

***AND PATIENT RIGHTS AND RESPONSIBILITES***

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, have been provided access to, and have been offered a copy of, the notice of privacy practices followed by COLUMBIA ALLERGY and ASTHMA SPECIALISTS, and I was also provided with a copy of the summary of the Privacy Practices and Patient Rights and Responsibilities followed by COLUMBIA ALLERGY and ASTHMA SPECIALISTS. I have read and understand Assignment and Release and Financial Policy Statement as set forth above. I have had an opportunity to read all these documents and ask questions.

I consent and agree to all the terms and conditions as set forth in these documents.

**Signature of Patient**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If patient is a minor, Signed for Patient by:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Today’s Date:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Witness:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***FINANCIAL POLICY AND AGREEMENT***

I authorize direct payment from my insurance/Medicare benefits be made directly to the provider of Columbia Allergy and Asthma Specialists who rendered medical services to me. I authorize any holder of medical information about me to release to the insurance carrier or the Centers for Medicare and Medicaid Services any information needed to determine these benefits. I also understand I am financially responsible for the charges regardless of my insurance coverage.

I recognize that any third-party medical coverage I may have (through either an insurance policy or governmental program) is a contract between myself and the third-party payor. However, I understand that the staff of Columbia Allergy and Asthma Specialist will make reasonable effort to collect all appropriate benefits from my third-party payor(s).

In recognition of the above, I agree and promise to pay all charges identified as patient responsibility incurred for services provided to the patient. I agree to pay all cost incurred in the collection of any unpaid balance, including reasonable attorney fees if necessary. I agree that any court actions relating to this account may be brought in Boone County, Missouri.

We make payment as convenient as possible by accepting (cash, money order, MasterCard, Visa and in-state

checks). A $35.00 service fee will be charged for all returned checks. Additionally, you may authorize us to

keep your credit card on file for your convenience knowing that we adhere to the highest level of

information security.

I have read and understand the above financial policy. I agree, in addition to the amount owed, I will also be responsible for fees/interest charged by the collection agency for costs of collections if such action becomes necessary.

Signature of Insured or Authorized Representative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

COLUMBIA ALLERGY and ASTHMA SPECIALISTS PAGE 4

Patient Name and DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Interest**

Interest of 1.5% will incur if a balance remains unpaid after 60 days.

**Payments**

We realize that temporary financial problems may affect timely payment of your account. If this should

occur, please contact us for assistance in the management of your account. Our goal is to provide quality

care and service. Please let us know immediately if you require any assistance or clarification from anyone

within our business.

**Insurance**

***Please remember that your insurance policy is a contract between*** ***you and your insurance carrier***. ***We will, as a courtesy, bill your insurance and help you receive the maximum allowable benefit under your policy***.

It is the patient’s responsibility to know if our office is participating or non-participating with their insurance

plan. Failure to provide all required information may necessitate patient payment for all charges. When

insurance is involved, we are contractually obligated to collect co-payments, co-insurance and deductibles, as

outlined by your insurance carrier. Please be aware that out-of-network insurance carriers often prohibit assignment of benefits and may try to limit their financial liability with arbitrary limits, exclusions or reductions such as reasonable and customary

or usual and prevailing reductions. Our fees are well within such ranges and although we will assist in the

filing of an appeal if these limitations are imposed, you as the guarantor are responsible for all out of network

fees. If we are not contracted with your carrier we will not negotiate reduced fees with your carrier.

**Miscellaneous Forms, Additional Information and Authorizations**

We will provide all necessary information to have your benefits released. However, if it becomes necessary

to submit redundant or unnecessary information for the completion of claim forms for school, sports or

extra-curricular activities there will be an administrative fee, not to exceed $35.00, for the additional

information.

**Missed Appointments**

We require notice of cancellations 24 hours in advance. This allows us to offer the appointment to another

patient. If you fail to keep your appointments without notifying us in advance: a missed appointment fee

will apply. These fees are typically $50.00 but not to exceed half of the cost of your scheduled appointment.

Repeated missed appointments without notification may cause you to be discharged from the practice so

that we can provide care to other patients.

**Medical Records Fees**

Patients are entitled under federal law to have access to their protected health information and we follow all

rules, guidelines and exceptions to ensure compliance to patient rights. However, providers also have the

right to compensation for records and our fees are a reasonable cost-based fee for copies including the

copying, supplies, labor and postage of the files and or summaries.

**Timeliness of Appointments**

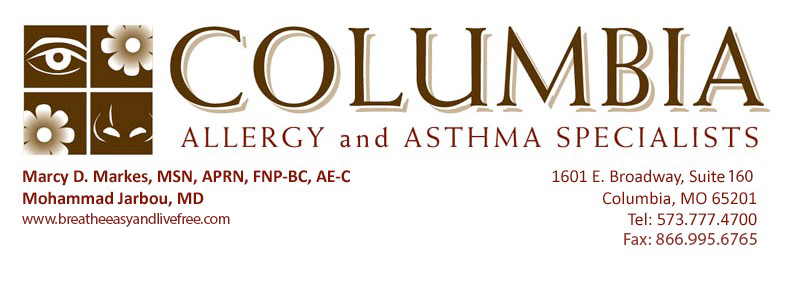
We try to see everyone in a timely manner but if we are taking too long, please let our receptionist know so

we can best serve your needs and reschedule you if necessary.

I have read and understand the above policies for Interest, Payments, Insurance, Miscellaneous Forms, Additional Information and Authorizations, Missed Appointments, Medical Record Fees and Timeliness of appointments. By signing below, I agree to abide by the above policies.

Signature of Insured or Authorized Representative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



**Alpha-1 Antitrypsin Testing**

Alpha-1 Antitrypsin Deficiency is a hereditary condition that is passed on from parents to their children genetically. This condition may result in serious lung disease in adults and/or liver disease in infants, children, and adults.

Alpha-1 occurs when there is a severe lack of a protein in the blood called alpha-1 antitrypsin (AAT) that is mainly produced by the liver. The main function of AAT is to protect the lungs from inflammation caused by infection and inhaled irritants such as tobacco smoke. The low level of AAT in the blood occurs because the AAT is abnormal and cannot be released from the liver at the normal rate. This leads to a buildup of abnormal AAT in the liver that can cause liver disease.

Testing for Alpha-1 is fairly simple, quick, highly accurate, and free to our patients. We encourage all of our patients to participate in this preventative testing. Upon consent, testing will be performed in our clinic by collecting a small blood sample via finger stick. The testing is mailed to a lab and takes up to 2 weeks for results to be received.

**I consent to AAT testing being performed:**

Patient/Guardian Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I decline to have AAT testing performed at this time:**

Patient/Guardian Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***For office use only:***

Testing performed (date and initials):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Specimen mailed (date and initials):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



**HIPAA Consent and Acknowledgement**

I give CAAS my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations like quality reviews.

I have been informed that I may review CAAS’s Notice of Privacy Practices (for more complete

descriptions of uses and disclosures) before signing this consent.

I understand that this clinic has the right to change their privacy practices and that I may obtain any revised notices at the clinic.

I understand that I have the right to request a restriction of how my protected health information is used.

However, I also understand that CAAS is not required to agree to the request. If CAAS agrees to my requested restriction, they must follow the restriction.

I also understand that I may revoke this consent at anytime, by making a request in writing except for information already used or disclosed.

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

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Patient, Parent or Legal Guardian)

If signed by patient representative, state relationship to patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize CAAS to discuss my protected health information with the following:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and privileged information for the use of the designated recipients named above. The designated recipients are prohibited from redistributing this information to any other party without authorization and are required to destroy the information after its stated need had been fulfilled. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited by federal or state law. If you have received this communication in error, please notify me immediately by telephone at 573.777.4700, and destroy all copies of this communication and any attachments.