PATIENT INFORMATION SHEET

Patient Name_____ Date of Birth_____ Sex_____

Address_____ City _____ State_____ Zip Code_____

Patient Cell # _____ Religion_____ Race _____ Ethnicity_____
*ONLY IF 16 OR OLDER

Pharmacy Name _____ **Phone #**_____

Mother's Name_____ Date of Birth_____

Address_____ City _____ State_____ Zip Code_____

Employer_____ Job Title_____ Work Phone #_____

Cell # _____ **Email**_____ **Home #** _____

Father's Name_____ Date of Birth_____

Address_____ City _____ State_____ Zip Code_____

Employer_____ Job Title_____ Work Phone #_____

Cell # _____ **Email**_____ **Home #** _____

Primary Insurance Name_____ Subscriber's Name_____

Member ID #_____ Group # _____

Claim Address_____ City _____ Zip Code_____

Secondary Insurance Name_____ Subscriber's Name_____

Member ID #_____ Group # _____

Claim Address_____ City _____ Zip Code_____

Please Read and Sign Below

I will be financially responsible for any medical services not covered by my health insurance company. I authorize the payment of medical benefits to Westchester Pediatrics LLC. I authorize the release of any information needed to provide documentation for the amount billed.

SIGNATURE_____ **DATE**_____

HOJA DE INFORMACION DEL PACIENTE

Nombre del Paciente_____ Fecha de Nacimiento_____ Sexo____

Dirección_____ Ciudad _____ Estado____ Código Postal_____

Celular del Paciente # _____ Religión_____ Rasa _____ Étnico_____

*SOLO PARA PACIENTES MAYORES DE 16 AÑOS

Nombre del Farmacia_____ **Teléfono**_____

Nombre del Madre_____ Fecha de Nacimiento_____

Dirección_____ Ciudad _____ Estado____ Código Postal_____

Empleador_____ Título_____ Teléfono de Trabajo_____

Celular _____**Correo Electrónico**_____ **Teléfono de Casa** _____

Nombre del Padre_____ Fecha de Nacimiento_____

Dirección_____ Ciudad _____ Estado____ Código Postal_____

Empleador_____ Título_____ Teléfono de Trabajo_____

Celular _____**Correo Electrónico**_____ **Teléfono de Casa** _____

Nombre del Seguro Primario_____ Nombre de Titular_____

Numero de Miembro_____ Numero de Grupo _____

Dirección del Reclamante_____ Ciudad _____Código Postal_____

Nombre del Seguro Secundario_____ Nombre de Titular_____

Numero de Miembro_____ Numero de Grupo _____

Dirección del Reclamante_____ Ciudad _____Código Postal_____

Por favor Lea y Firme Abajo

Seré financieramente responsable por los servicios médicos no cubiertos por seguros de salud. Autorizo el pago de las prestaciones médicas a Westchester Pediatrics LLC. Autorizo la publicación de cualquier información necesaria para presentar documentación para la cantidad facturada.

FIRMA_____ **FECHA**_____

Medical/Family History Questionnaire

MEDICAL HISTORY

Does your child have allergies to foods or medications? No ☐ Yes ☐

If yes, please specify: _____

_____

Has your child had any surgeries? No ☐ Yes ☐

If yes, please specify: _____

_____

Has your child ever been hospitalized? No ☐ Yes ☐

If yes, please specify: _____

_____

Has your child had any serious injuries? No ☐ Yes ☐

If yes, please specify: _____

_____

Has your child had a severe reaction to an insect bite? (e.g. shortness of breath, tongue swelling) No ☐ Yes ☐

If yes, please specify: _____

_____

Any reactions to immunizations? No ☐ Yes ☐

If yes, please specify: _____

_____

Are your child's immunizations up to date? No ☐ Yes ☐

Do you have an immunization record? No ☐ Yes ☐

Has your child ever had:

Asthma No ☐ Yes ☐

Chicken Pox (Year) _____ No ☐ Yes ☐

Frequent Ear Infections No ☐ Yes ☐

Vision/Hearing Problems No ☐ Yes ☐

Skin Problems/Eczema No ☐ Yes ☐

TB/Lung Disease No ☐ Yes ☐

Seizures/Epilepsy No ☐ Yes ☐

High Blood Pressure No ☐ Yes ☐

Heart Defects/Disease No ☐ Yes ☐

Liver Disease/Hepatitis No ☐ Yes ☐

Diabetes No ☐ Yes ☐

Kidney Disease/Bladder Infections No ☐ Yes ☐

Physical or Learning Disabilities No ☐ Yes ☐

Bleeding Disorders/Hemophilia No ☐ Yes ☐

Sexually Transmitted Diseases No ☐ Yes ☐

Emotional or Behavioral Problems No ☐ Yes ☐

Depression/Suicidal Thoughts No ☐ Yes ☐

Physical/Emotional/Sexual Abuse No ☐ Yes ☐

Bone or Joint Injuries No ☐ Yes ☐

Obesity/Eating Disorders No ☐ Yes ☐

Has your child had pneumonia? No ☐ Yes ☐

Does your child have a frequent cough? No ☐ Yes ☐

Do you own an aerosol machine? No ☐ Yes ☐

Problems with diarrhea or constipation? No ☐ Yes ☐

If yes, please explain: _____

_____

_____

FAMILY HISTORY

Has anyone in the family (parents, grand-parents, aunts/uncles, sisters/brothers) had:

			Who?
Asthma	No ☐	Yes ☐	
TB/Lung Disease	No ☐	Yes ☐	
HIV/AIDS	No ☐	Yes ☐	
Suicide Attempts	No ☐	Yes ☐	
Heart Disease	No ☐	Yes ☐	
High Blood Pressure/Stroke	No ☐	Yes ☐	
High Cholesterol	No ☐	Yes ☐	
Blood Disorders/Sickle Cell	No ☐	Yes ☐	
Diabetes	No ☐	Yes ☐	
Seizures	No ☐	Yes ☐	
Cancer	No ☐	Yes ☐	
Birth Defects	No ☐	Yes ☐	
Hearing Loss	No ☐	Yes ☐	
Speech Problems	No ☐	Yes ☐	
Kidney Disease	No ☐	Yes ☐	
Alcohol/Drug Abuse	No ☐	Yes ☐	
Hepatitis/Liver Disease	No ☐	Yes ☐	
Thyroid Disease	No ☐	Yes ☐	
Learning Problems/Attention	No ☐	Yes ☐	
Family Violence	No ☐	Yes ☐	
Mental Illness	No ☐	Yes ☐	

Allergies (please specify whom/what?) _____

_____

_____

_____

10300 SW 72ND STREET
SUITE 351
MIAMI,FL 33175
305-273-1200

Medical/Family History Questionnaire

Patient Name:	Date of Birth:	Sex: (circle) Male Female
Form Completed By: / Today's Date	Relationship:	

Mother's Name: _____
Occupation: _____
Mother's Health: _____
Marital Status: _____

Father's Name: _____
Occupation: _____
Father's Health: _____
Marital Status: _____

Do the child's parents live together? **No** ☐ **Yes** ☐
Does the patient have any siblings? **No** ☐ **Yes** ☐

If so, please give siblings' names, ages, and health status:

_____

_____

Whom does the child live with? _____

_____

Have any of your children died? **No** ☐ **Yes** ☐

Housing status?
☐ **Renting** ☐ **Owns a House** ☐ **Living with relatives**

☐ **Shelter** ☐ **Homeless**

Who cares for the child while you are at work? _____

_____

Is the patient in Foster care? **No** ☐ **Yes** ☐

What languages are used at home? _____

_____

Any assistive communication devices needed? (for vision, hearing, and/or cognitive issues) **No** ☐ **Yes** ☐

If yes, please specify: _____

_____

PREGNANCY AND BIRTH HISTORY

Mother's age at time of birth: _____
Name of Hospital: _____
Gestational Age: _____

Illnesses during pregnancy? **No** ☐ **Yes** ☐
Medications during pregnancy? **No** ☐ **Yes** ☐
Alcohol/Drug Abuse? **No** ☐ **Yes** ☐
Problems at birth? **No** ☐ **Yes** ☐
If yes, what kind? _____

_____

Type of delivery? ☐ **Vaginal** ☐ **C-Section**
Baby's birth weight _____

Feeding and Nutrition

Was this child breast fed or formula fed? _____
If still on formula, which one? _____
Does your child take vitamins? **No** ☐ **Yes** ☐
Were there any unusual feeding issues in the first 6 months of life? **No** ☐ **Yes** ☐
Does your child have any food allergies? **No** ☐ **Yes** ☐
If yes, what kinds? _____

_____

Development and Behavior

Does your child enjoy playing with others? **No** ☐ **Yes** ☐
Does your child have any problems with bed wetting or speech? **No** ☐ **Yes** ☐
At what age did your child walk alone? _____
What school does your child attend? _____

Safety and Environment

Do you know the hottest temperature of the water in your pipes? **No** ☐ **Yes** ☐
Is there a working smoke alarm on each floor of the house? **No** ☐ **Yes** ☐
Does your child always use a car seat or seat belt when riding a car? **No** ☐ **Yes** ☐
Are there any smokers in the house? **No** ☐ **Yes** ☐
Are there any problems with the condition of your house? (peeling paint, rats, or mice) **No** ☐ **Yes** ☐
Does your child always wear a helmet when riding a bicycle? **No** ☐ **Yes** ☐
Does your child know how to swim? **No** ☐ **Yes** ☐

SECONDARY INSURANCE

Name_____

Claim Address_____

City_____ State_____ Zip_____ Phone_____

Insured's Name_____ ID/Policy #_____ Group# _____

CONSENT

I give permission for my child _____ to receive medical service by the physicians at Westchester Pediatrics, LLC in the event that I am not available to bring my child to the office and he or she is brought in by a relative, medical services may be performed.

RELEASE OF MEDICAL RECORDS

I authorize payment of medical benefits to the physicians of Westchester Pediatrics, LLC, for any medical services rendered.

ASSIGNMENT OF BENEFITS

I authorize payment of medical benefits to the physicians of Westchester Pediatrics, LLC, for any medical services rendered.

OFFICE BILLING POLICIES

This office is willing to bill your insurance company for you, once benefits have been verified. You will be responsible for any deductibles, co-insurance, co-payment, or non-covered benefits due.

In the event that benefits or member edibility cannot be verified, you will be responsible for all charges and balances incurred.

If my child is a newborn, I understand that I have to contact my insurance company to enroll the baby (most insurance companies will give you thirty days to enroll your newborn, check with your carrier). If enrollment is not completed within thirty days, I will be responsible for any charges incurred since birth.

If contracted with an HMO I must give them the name of the patient's primary care physician at Westchester Pediatrics, LLC. If Westchester Pediatrics, LLC physician was not chosen, I am aware that I will be responsible for all charges incurred.

I HAVE READ, UNDERSTAND AND AGREE TO ALL OF THE ABOVE MENTIONED INFORMATION.

SIGNATURE_____ DATE_____

PRINT NAME_____

Bad Check / Bounced Check Policy

PARENTS OR LEGAL GUARDIANS ARE RESPONSIBLE FOR THE FULL AMOUNT OF ANY CHECK RETURNED FOR INSUFFICIENT FUNDS PLUS A SERVICE CHARGE DEPENDING ON THE CHECK AMOUNT.

PAYMENT FOR A BAD CHECK IS DUE WITHIN 15 DAYS OF NOTIFICATION. IF PAYMENT IS NOT RECEIVED, THE UNPAID CHECK WILL BE REPORTED TO THE STATE ATTORNEY'S OFFICE.

I AM AWARE OF THE ABOVE STATED OFFICE POLICY.

Signature: _____ Name: _____

Patient's Name: _____ Date Signed: _____

Notice of Privacy Acknowledgement

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Policy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

_____ _____

Patient Name or Legal Guardian (print) Date

_____

Signature

Office Use Only

We have made the following attempt to obtain the patient's signature acknowledging receipt of Notice of Privacy Practices:

Date:_____ Attempt: _____

Staff Name: _____

Aviso De Privacidad Reconocimiento

Entiendo que bajo el Health Insurance Portability and Accountability Act (HIPAA), tengo ciertos derechos a la privacidad con respecto a mi información de salud protegida.Reconozco que han recibido o han tenido la oportunidad de recibir una copia de su aviso de prácticas de privacidad. También entiendo que esta práctica tiene el derecho de cambiar su aviso de prácticas de privacidad y que puedo contactar con la práctica en cualquier momento para obtener una copia actual de la notificación de prácticas de privacidad.

_____ _____

Nombre del paciente o la Legal de Guarda (impresión) Fecha

_____

Firma

Uso de oficina solamente:

Hemos hecho el siguiente intento de obtener la firma del paciente reconoce el recibo de la notificación de prácticas de privacidad:

Fecha: _____ Intento: _____

Nombre De Empleado: _____

Westchester Pediatrics L.L.C. Office Charges

Dear Parents:

These charges are **not** "Covered Services" by your child's insurance company. Therefore, these fees are not reimbursable by your insurance company.

Form(s) to be completed by a physician	$25
Letters	$25
Duplicate copy of School Entry Health Exam Form (DH3040)	$25
Duplicate of controlled substance prescription	$10
Bounced Check	$30 and up
Copy of the 1st 25 pages of a medical record Each additional page	$1/page .25¢/page
Ear Piercing	$55
Repeat of PPD test due to parent failure to return to recheck test within 48hrs-72hrs	$30
Refusal of a prepared vaccine(s) or injectable medication after parent/legal guardian consent	charge depends on vaccine/injectable
Aerosol mask	$15
Notary service (only for office related services)	$25
Cancellation or rescheduling of an appointment on day of/No Show Fee	$25
Split of vaccines as per parent(s) request	$30
Convenience Fee~ *Westchester Pediatrics Lab Order(s)* Convenience Fee~ *Specialist/ Other Lab Order(s)*	$10 $30
Parent/patient who desires Westchester Pediatrics, LLC to draw blood understands that they will be charged a convenience fee. It is understood that this convenience fee is not for the drawing and handling of the patient's blood, but rather for the convenience of performing it in our office.	

By means of my signature, I acknowledge that I have read, understand, and agree with each office charge.

_____ _____

Signature of Parent or Legal Guardian **Date**

_____

Signature of 18yr and over Patient

_____ _____

Name of Patient **DOB**

Revised 03/29/2021

GENERAL CONSENTS

I give permission for my child _____ to receive medical service by the physicians at Westchester Pediatrics, LLC. I understand that a complete medical examination may include the external examination of the external genitalia and rectum. In the event that I am not available to bring my child to the office and he/she is brought in by a relative, medical services may be performed.

RELEASE OF MEDICAL RECORDS

I authorize payment of medical benefits to the physicians of Westchester Pediatrics, LLC, for any medical services rendered.

ASSIGNMENT OF BENEFITS

I authorize payment of medical benefits to the physicians of Westchester Pediatrics, LLC, for any medical services rendered.

OFFICE BILLING POLICIES

This office is willing to bill your insurance company for you, once benefits have been verified. You will be responsible for any deductibles, co-insurance, co-payment, or non-covered benefits due.

In the event that benefits or member edibility cannot be verified, you will be responsible for all charges and balances incurred.

If my child is a newborn, I understand that I have to contact my insurance company to enroll the baby (most insurance companies will give you thirty days to enroll your newborn, check with your carrier). If enrollment is not completed within thirty days, I will be responsible for any charges incurred since birth.

If contracted with an HMO I must give them the name of the patient's primary care physician at Westchester Pediatrics, LLC. If Westchester Pediatrics, LLC physician was not chosen, I am aware that I will be responsible for all charges incurred.

I HAVE READ, UNDERSTAND AND AGREE TO ALL OF THE ABOVE MENTIONED INFORMATION.

SIGNATURE _____ DATE _____

PRINT NAME _____

WESTCHESTER PEDIATRICS, LLC
Telehealth Informed Consent

Telehealth involves the use of secure electronic communications, information technology, or other means to enable a healthcare provider at one location, and a patient in another location to share individual patient clinical information for the purpose of consulting with, diagnosing, treating, prescribing, and/or referring the patient to in-person care, as determined clinically appropriate. This "**Telehealth Informed Consent**" informs the patient ("**patient,**" "**you,**" or "**your**") concerning the treatment methods, risks, and limitations of using a telehealth platform.

Services Provided:

Telehealth services offered by Westchester Pediatrics, LLC ("**Practice**"), and the Practice's engaged providers ("**Providers**") may include a patient consultation, diagnosis, treatment recommendation, prescription, and/or a referral to in-person care, as determined clinically appropriate (the "**Services**"). Your Provider will be licensed in the state where you are located at the time of your consultation, or otherwise meet a professional licensure exception under applicable state law.

Electronic Transmissions:

The types of electronic transmissions that may occur using the telehealth platform include, but are not limited to:

- Completion of medical intake forms;
- Exchange and review of patient medical intake forms, patient health records, images, diagnostic and/or lab test results
- Two-way interactive audio-video interaction between you and your Provider;
- Other electronic transmissions for the purpose of rendering clinical care to you.

Expected Benefits:

- Improved access to care by enabling you to remain in your preferred location while your Provider consults with you. Our telehealth services are available **during office hours**
- Easy access for follow-up care. If you need to receive non-emergent follow-up care related to your treatment, please contact your Provider by **calling the office at 305 273-1200**.

Service Limitations:

- The primary difference between telehealth and direct in-person service delivery is the inability to have direct, physical contact with the patient. Accordingly, some clinical needs may not be appropriate for a telehealth visit and your Provider will make that determination.
- **OUR PROVIDERS DO NOT ADDRESS MEDICAL EMERGENCIES. IF YOU BELIEVE YOU ARE EXPERIENCING A MEDICAL EMERGENCY, YOU SHOULD DIAL 9-1-1 AND/OR GO TO THE NEAREST EMERGENCY ROOM. AFTER RECEIVING EMERGENCY HEALTHCARE TREATMENT, YOU SHOULD CALL THE OFFICE FOR A FOLLOW UP APPPOINTMENT.**
- If it is determined during the initial screening of the telehealth visit that you should be seen in person, either in your Provider's office or in a recommended facility, you **will not** be charged for the telehealth visit. Appropriate emergency questions will be asked at the beginning of the telehealth visit that will determine what will be the best place for you to receive care.

Security Measures:

The electronic communication systems we use will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption. All the Services delivered to the patient through telehealth will be delivered over a secure connection that complies with the requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

Possible Risks:

- Delays in evaluation and treatment could occur due to deficiencies or failures of the equipment and technologies, or provider availability.
- In the event of an inability to communicate as a result of a technological or equipment failure, please contact the Practice at 305 273 1200.
- The quality of transmitted data may affect the quality of services provided by your Provider. Changes in the environment and test conditions

could be impossible to make during delivery of telehealth services.
- In rare events, your Provider may determine that the transmitted information is of inadequate quality, thus necessitating a rescheduled telehealth consult or an in-person office visit.
- In very rare events, security protocols could fail, causing a breach of privacy of personal medical information.

Patient Acknowledgments:

By checking the box associated with "Telehealth Informed Consent," you acknowledge that you understand and agree to the contents above and further agree with the following:

1. I understand that if I am experiencing a medical emergency, that I will be directed to dial 9-1-1 immediately and that our Providers are not able to connect me directly to any local emergency services.

2. I understand there is a risk of technical failures during the telehealth encounter beyond the control of the Practice. I agree to hold harmless the Practice for delays in evaluation or for information lost due to such technical failures.

3. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment. I understand that I may suspend or terminate use of the telehealth services at any time for any reason or for no reason.

4. I understand that alternatives to telehealth consultation, such as in-person services are available to me.
5. I understand that I may expect the anticipated benefits from the use of telehealth in my care, but that no results can be guaranteed or assured.

6. I understand that it is necessary to provide a complete and accurate medical history and will update my medical health records periodically, but no less than once a year.

7. I understand persons may be present during the consultation other than my Provider in order to operate the telehealth technologies. I further understand that I will be informed of their presence in the consultation, and their role, and thus will have the right to request the following: (1) omit specific details of my medical history/examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telehealth examination; and/or (3) terminate the consultation at any time.

8. I understand I have the right to object to the videotaping of the telehealth consultation.

9. Our Providers reserve the right to deny care for potential misuse of the Services or for any other reason if, in the professional judgment of our Providers, the provision of the Service is not medically or ethically appropriate.

10. I understand that I will not be prescribed any narcotics for pain, nor is there any guarantee that I will be given a prescription at all.

11. I understand that federal and state law requires health care providers to protect the privacy and the security of health information. I understand that Practice will take steps to make sure my health information is not seen by anyone who should not see it.

12. I understand that if I participate in a consultation, that I have the right to request a copy of my medical records and/or consultation report, which will be provided to me at reasonable cost of preparation, shipping and delivery.

13. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes.

14. I understand that I may not be covered under my current health insurance plan for telehealth services.

WESTCHESTER PEDIATRICS, LLC
Telehealth Informed Consent

Patient Informed Consent

I have carefully read this form and fully understand its contents, including the risks and benefits of the telehealth services. I hereby give my informed consent to participate in a telehealth consultation under the terms described herein. By checking the box associated with "Telehealth Informed Consent", I acknowledge that I understand and agree with the above and hereby consent to receive Practice's telehealth services:

□ ACCEPT. By checking the Box for this "**TELEHEALTH INFORMED CONSENT**" I hereby state that I have read, understood, and agree to the terms of this document.

PATIENT'S NAME:

PATIENT'S DATE OF BIRTH:

PATIENT'S SIGNATURE:

DATE:

If signing on behalf of a minor:

PARENT/LEGAL GUARDIAN'S NAME:

PARENT/LEGAL GUARDIAN'S SIGNATURE:

DATE:

Authorization to Release Medical Information

Patient's Name: _____ Date of Birth: _____

Patient's Address: _____ Phone #: _____

_____

I request and authorize _____ to release healthcare information of the patient named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

This request and authorization applies to:

- ☐ Healthcare information relating to the following treatment, condition or dates: _____

  _____
- ☐ All healthcare information
- ☐ Other: _____

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment, blood results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No I understand and agree that I am financially responsible for the following fees associated with my request, the charges for this service is: $1.00 per page for the first 25 pages, then $0.25 for each page thereafter.

Patient Signature: _____ Date Signed: _____

Legal Guardian: _____ Date Signed: _____

Prohibition of Re-disclosure: This information has been disclosed to you from records whose confidentiality is protected by law. Any further disclosure is strictly prohibited unless the patient/guardian provides specific written consent for subsequent disclosure of this information. These records may be protected by federal regulations (42CFR, Part 2)

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.

NEWBORN MEDICAL INSURANCE ENROLLMENT REQUIREMENT NOTICE

Congratulations on your newborn!

We would like to take this opportunity to inform you of the newborn enrollment process.

Parent or legal guardian must enroll newborn under the selected subscriber's medical insurance policy within 30 days of date of birth in order to obtain medical coverage. If after the first 30 days, you choose to change your newborn's medical insurance carrier, you must notify the office in writing of such change and provide all pertaining information including copy of new insurance card.

All insurance companies require prior notification **(30 days)** for newborn enrollment to the insurance policy. Failure to notify your health insurance carrier within the allotted time frame will prompt insurance denials thus leaving the parents or legal guardian responsible for all medical charges.

We are currently contracted with most HMO and PPO health insurance plans. Also, we are currently contracted with Aetna Better Health, CMS T19 and T21, and Staywell, under the Medicaid Managed Medical Assistance (MMA) plan. **Straight Medicaid (gold card) is NOT currently accepted**. Parents are responsible to contact their health insurance carrier to insure our current participation with the plan.

_____
Patient Name

_____
Patient Date of Birth

_____
Parent/Legal Guardian

_____
Date