NDCARE, Inc.

Acupuncture & Alternative Medicine

Celisha Gerber, ND, LAc (473)

138 Chamberlain Blvd, Knoxville, TN 37920 / Phone: 541.499.9722 / Fax: 541.292.5128

At NDCARE, Inc. we are able to offer a "Time Of Service Reduction Cost" for services by not contracting with insurance companies. We pass these savings to you! To keep these costs low, we have a strict No Show/Late Cancellation Policy of $100 (Please cancel 24 hours before visit to avoid this charge). Thank you for your understanding.

Type of Visit	Details	Cost
Acupuncture	Initial Acupuncture	$ 165
	Follow-up Acupuncture	$ 115
	Add-on Manual Therapy	$ 50
	Community Auricular Acupuncture	$ 85
	Package of 6 Acupuncture Visits	$625
ND Visit	ND Visit	$ 335
	Package of 3 ND Visits	$ 935
	1 Year Budget: ND visit every 3 months	$ 125/month
	Email Recommendation	$115
Zyto Scan	Initial Chief Complaint Scan	$ 175
	Follow up of Chief Complaint Scan	$ 125
EVOX	1 Topic EVOX Reframe	$125
	Multitopic EVOX Reframe	$100/session
	Transgenerational Perception Reframing (8 sessions)	$750

- Initial Acupuncture visit includes assessment and treatment...$165
- Follow-up Acupuncture includes treatment…$115
- Community Auricular Acupuncture includes needles placed on the cartilage of the ear...$85
- Add-on Focused Massage, Tui-Na, or Trigger point therapy…$50/unit (1 unit: 8-15 minutes)
- Initial ND visit (Nutrient & Dietary Counseling): includes comprehensive health history, exam, review of records, discussion of labs and plan of action…$335
- Follow-up ND visit: includes review of past/current labs, update on symptoms and treatment regimen, and plan of action…$335
- Initial Chief Complaint Zyto Scan (Galvanic Skin Response Scan)...$175
- Follow-up focused Zyto Scan of previous chief complaint...$125
- EVOX: 1 topic: $125, Multitopic: $100/session, Transgenerational Perception Reframing: $750
- Budget ND Membership $125/month for 12 months (Available after the Initial ND Visit)
  - 4 Nutrient and Dietary Counseling visits a year at once every 3 months
- Acupuncture package:
  - 6 sessions: $625...($65 savings) ($100/tx)
- ND Visit package (Nutrient and Dietary Counseling):
  - 3 sessions: $935...($70 savings) ($300/visit)
- Special Discounts for Veterans/Military, Students, First Responders: $20 off ND visits, $10 off all other services (not to be combined with other discounts).

**Prices do not include lab fees, supplements, nor required check-ins with Dr. Runne should he order labs.

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Informed Consent to Treat

I understand Acupuncture services are not intended to substitute for diagnosis or treatment by medical doctors or to be used as an alternative to necessary medical care. It is expected that you are under the care of a primary care physician or medical specialist and that patients seeking adjunctive cancer support are under the care of an oncologist.

I understand that currently the State of Tennessee does not regulate or license Naturopathic Doctors or the practice of Naturopathic Medicine. As such, Dr. Gerber will provide information and education to me in the form of health consultations but will not diagnose, treat, or cure any diseases. I authorize Dr. Gerber to provide services to me in such a manner.

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible).

I understand that methods of treatment may include, but are not limited to nutritional counseling, acupuncture, cupping, electrical stimulation, massage, Guasha/Graston Technique, herbal medicine. I appreciate that it is not possible to consider every possible complication to care. I have been informed that acupuncture is a generally safe method of treatment, but, as with all types of healthcare interventions, there are some risks to care, including, but not limited to: bruising, numbness or tingling near the needling sites that may last a few days; dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping or when the treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements that have been recommended are traditionally considered safe, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy or nursing and that I will notify a clinical staff member if I become pregnant or am nursing. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, liver/kidney damage, headache, diarrhea, rashes, hives.

I understand that, as with all healthcare approaches, results are not guaranteed, and there is no promise to cure. I understand that I must inform, and continue to fully inform, this office of any medical history, family history, medications, and or supplements being taken currently (prescription and over-the-counter). I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

I understand that Zyto and Evox technology is not intended to be used in the diagnosis, cure, treatment, mitigation, or prevention of any disease or medical condition. The diagnosis and treatment of medical conditions should only be undertaken by qualified medical professionals. Zyto and EVOX provides general wellness information, including information about biological coherence and should not be used without the involvement of licensed healthcare professionals.

By voluntarily signing below, I confirm that I have read, or have had read to me, the above consent to treatment, have been told about the risk s and benefits of acupuncture and other procedures, and have had an opportunity to ask questions I agree with the current or future recommendations for care. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

Acupuncturist Name: Celisha Gerber, ND, LAc (License number: 473)

Today's Date: _________

Patient name: ______________________________

Signature of Patient or Patient Representative (note relationship if signing for patient): ______________________

Patient Rights Under HIPPA

Using and Disclosing Health Information

This information is intended to help you understand your rights under federal privacy regulation, the Health Insurance Portability and Accountability Act, or HIPPA. This page focuses on helping you understand how NDCARE INC will use your health information for treatment, payment, and health care operations as described in the Notice of Privacy Practices.

Confidential Information

Your confidential patient information includes verbal, written, photographs and other images, and/or electronic information about your health, medical, or psychological care and treatment. Your information may include information generated by NDCARE INC and information received from other health care providers.

How we may use and disclose information about you:

Treatment

Here are some examples of how we use your information for treatment purposes. Your health care provider may share your health information with other health care providers to perform such services as lab work, x-rays, and prescriptions for your medications. WE may also disclose information to health care providers who will be involved in your care during or after your treatment.

Payment

We may use and disclose health information about you to your insurer to obtain payment for your treatment you receive at NDCARE INC. For example, we may need to give you health plan information about treatment you received at NDCARE INC. We may also tell your health plan about a treatment that you are going to receive to obtain prior approval or to determine whether or not your plan will cover the treatment.

Appointment reminders

We may use and disclose health information to contact you as a reminder that you have an appointment for treatment or care at NDCARE INC.

Special situations in which we may release medical or health information:

Public Health—These activities generally include: preventing or controlling disease, injury or disability; reporting births and deaths; reporting child abuse or neglect; reporting reactions to medications or problems with products; notifying people of recalls of products they may be using; notifying a person who may have been exposed to a disease, or may be at risk for contracting or spreading a disease or condition; notifying the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required by law.

Health Oversight—Activities authorized by law such as audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Law enforcement—To a law enforcement official in response to a court order or similar process; to identify or locate a suspect, fugitive, material witness, or missing person, but only if limited information is disclosed; about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement; about a death we believe may be the result of criminal conduct; about criminal conduct we believed occurred on the premises of the institution; and in emergency circumstances to report a crime, the location of the crime or victims, or the identity, description, or location of the person who committed the crime.

Coroners, medical examiners, funeral directors—To a coroner or medical examiner to identify a deceased person or to identify the cause of death. We may release information about patients to funeral directors as necessary to carry out their duties.

Prevent serious threat to health or safety—When necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone who is able to help prevent the threat.

Armed forces and foreign military personnel—if you are a member of the armed forces, as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

National security—To authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Worker's Compensation—For worker's compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.

Alcohol and Drug Abuse—Alcohol and drug abuse information has special privacy protections. We will not disclose any information identifying an individual as being a patient or provide any medical information relating to the patient's substance abuse treatment unless: the patient consents in writing; a court order requires disclosure of the information; medical personnel need the information to meet a medical emergency; qualifies personnel use the information for the purpose of conducting scientific research, management audits, financial audits, or program evaluation; or, it is necessary to report a crime or a threat to commit a crime, or to report abuse or neglect as required by law.

Authorizations

Your authorization is required for other disclosures. Except as described above, we will not use or disclose your health information, unless you allow NDCARE INC in writing to do so. For example, if you want us to send your information to an outside doctor not involved with your treatment, you would need to sign an authorization allowing us to do that.

Revoking authorizations

You have the right to withdraw, or revoke your authorization. If you revoke your authorization, it is effective only after the date of your written revocation, or withdrawal. You must use a designated form to revoke and authorization.

Signature of Patient/Guardian Date

CC: Patient refused on: _______________

NDCARE, INC
Celisha Gerber, ND, LAc
www.ND-CARE.com
(541) 499-9722 Fax (541)292-5128

e-mail: ______________________

PATIENT INFORMATION:

Date:__________

Cell Phone: ______________________

Patient's Name:______________________________ Home Phone:______________________

Patient's Address:____

Patient's Birth date:__________ Age_____yrs Patient's SS#:________-______-________

Height ___ft.___in. Weight____lbs Marital Status: M____ S___ D___W____

Number of Children and ages:____

Patient's Employer Name & Address:____

______________________________________Work Phone______________________

Spouse's Name:__________________________ Spouse's Employer:______________________

Responsible Party's Name, Address & Phone (if different from patient)______________________

____

Responsible Party's SS#:________-______-________

Nearest Relative:__________________________ Relative:______________________

Address & Phone:____

Referred by:____

OFFICE POLICY: Our office policy is to collect payment in full at the time of service. Patient is responsible for all services deemed Non-Covered or not Medically Necessary by their insurance provider.

Responsible Party's Signature:__________________________ Date:______________________

PERSONAL INJURY CLAIMS: (Auto Accidents)

Date of Accident:__________________________ Claim #:______________________

Insurance Co. Name & Address:____

Insurance agent/Claim rep:__________________________Phone:______________________

Attorney's Name & Address (if applicable): ______________________________________

____Phone:______________________

Please remember this is a confidential report. Your honest evaluation is both pertinent and necessary to better enable the doctor to accurately assess your health status and effectively work with you to improve your general well being.

PRESENT COMPLAINTS:

Describe symptoms or conditions for which you are seeking care:____________________________

What brought it about?____________________________

How long has this been a problem?____________________________

Has this become progressively [ ] worse [ ] better [ ] up and down [ ] no change

When or what makes it feel better?____________________________

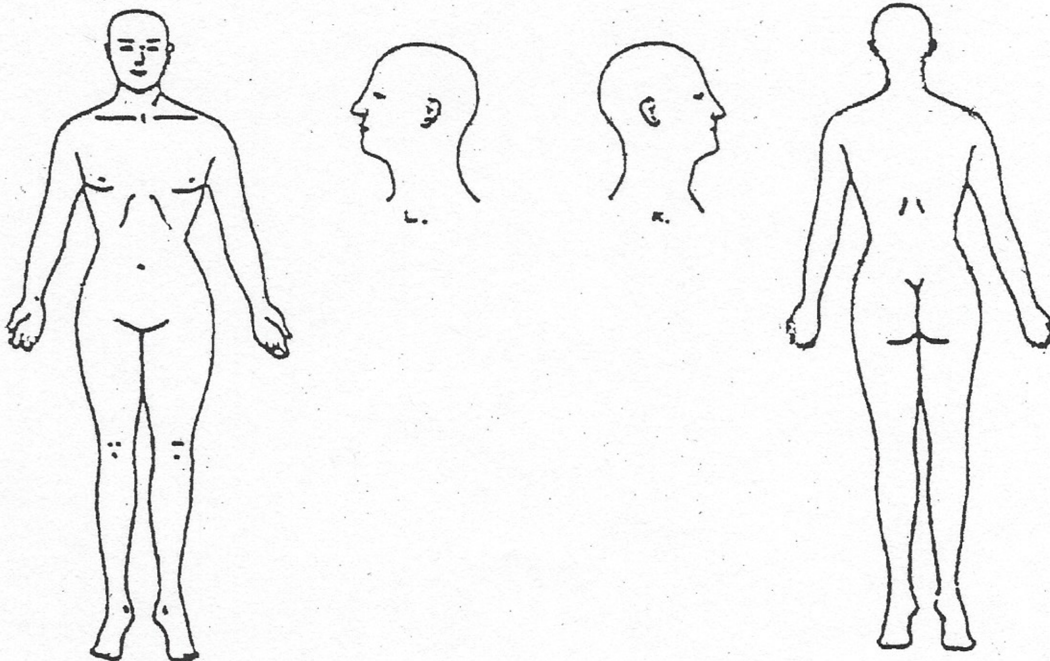
When or what makes it feel worse?____________________________

Describe previous care you have received for this:

Date	Doctor	Findings	Treatment	Your response

Mark the areas on your body where you feel the described sensations. Use the appropriate symbol. Include all affected areas.

Numbness	Pins & Needles	Burning	Aching	Stabbing
- - - -	o o o o	x x x x	* * * *	/ / / /
- - - -	o o o o	x x x x	* * * *	/ / / /
- - - -	o o o o	x x x x	* * * *	/ / / /



HEALTH HISTORY

SUPPLEMENTS & MEDICATIONS: List vitamin & mineral supplements you are now taking:
____
____

List drugs, hormones & medications you are now taking (prescription or over the counter):
[ ] anti-inflammatory drugs [ ] painkillers [ ] sleeping pills [ ] anti-depressants [ ] diet pills [ ] laxatives
[ ] birth control pills [ ] narcotics [ ] blood pressure drugs [ ] diuretics [ ] other____________
____
____

List any medications previously taken:______________________________________
____

ALLERGIES: (Food, Drug, Environmental)______________________________________
____

SURGERIES: (Give year or age): [ ] Tonsil ______ [ ] Appendix ______ [ ] Kidney ____ [ ] Gall Bladder ______
[ ] Heart ______ [ ] Spine ______ [ ] Prostate _____ [ ] Cyst ________ [ ] Hernia ____ [ ] Cancer ______
[ ] Other ____

PREVIOUS TREATMENTS: (Give year or age)
Hospitalizations:____
____
Dental/Orthodontic/Extractions/Fillings:____
____
Physiotherapy/Rehabilitation:____
Radiation therapy/chemotherapy/transfusions:_____________________________________
Other:____

BIRTH HISTORY:
Defects/Deformities:____
Mother's health during pregnancy with you: (chemical/physical/emotional stresses):______________
____
Difficulties/traumas during labor/delivery/infancy: (Mother's position, anesthesia, your birthing position, assisted delivery):____
____

Birth [ ] At home [ ] Birthing Center [ ] Hospital
Were you [ ] Bottle fed [ ] Nursed

PHYSICAL & CHEMICAL TRAUMAS: (Give year of trauma and body part involved)
Vehicle accidents:____
Work injuries:____
Sports injuries:____
Slip and fall injuries:____
Lifting injuries:____
Concussions:____
Fractures/Dislocations:____
Persistent and stressful body positions: (working, reading, playing musical instruments, watching TV)
____
Poisoning/Adverse chemical exposure:_______________________________________
____

ILLNESSES: (Give year or age)

[ ] Measles
[ ] Mumps
[ ] Chickenpox
[ ] Diphtheria
[ ] Whooping Cough
[ ] Rheumatic Fever
[ ] High Fevers
[ ] Polio
[ ] Epilepsy
[ ] Frequent Colds
[ ] Hay Fever
[ ] Asthma
[ ] Bronchitis
[ ] Pneumonia
[ ] TB
[ ] Hemorrhoids
[ ] Mononucleosis
[ ] VD
[ ] Herpes II
[ ] Hepatitis
[ ] Hypoglycemia
[ ] Diabetes
[ ] Hypothyroid
[ ] Ulcers
[ ] Colitis
[ ] Rheumatoid arthritis
[ ] Gall Stones
[ ] Kidney Stones
[ ] High Blood Pressure
[ ] Heart Attack
[ ] Stroke
[ ] Paralysis
[ ] Gout
[ ] Osteoarthritis
[ ] Emphysema
[ ] Cancer
[ ] Other____________
____
____
____

FAMILY HISTORY: (Living (L), give age. Deceased (D), give year and age at death)

Mother L_____Health Status____________________D_____Cause____________
Father L_____Health Status____________________D_____Cause____________
Sisters #__ L_____Health Status____________________D_____Cause____________
Brother #__ L_____Health Status____________________D_____Cause____________
Children #__ L_____Health Status____________________D_____Cause____________

Give any history of cancer or diabetes in your immediate family?____________
____

Give any history of your specific illness or condition in your family?____________
____

SYMPTOMS: Have you ever had, or do you now have:
Past symptoms, please check **[ ]**
Current symptoms, please check **{ }**

Musculo-skeletal system
[ ]{ } neck pain
[ ]{ } pain between shoulder blades
[ ]{ } low back pain
[ ]{ } sciatica
[ ]{ } pain/numbness
  [ ]{ } hip/leg/foot
  [ ]{ } shoulder/arm/hand
[ ]{ } pain/stiffness/swelling of joints
[ ]{ } torn muscles/ligaments

Nervous system
[ ]{ } tremors
[ ]{ } muscle atrophy
[ ]{ } muscle jerking
[ ]{ } fainting
[ ]{ } dizziness
[ ]{ } paralysis
[ ]{ } convulsions
[ ]{ } headaches

Eyes
[ ]{ } vision problems
[ ]{ } cataracts
[ ]{ } glaucoma

Circulatory system
[ ]{ } cold hands/feet
[ ]{ } phlebitis
[ ]{ } hardening of the arteries
[ ]{ } cold/heat intolerance
[ ]{ } fluid retention

Heart/Lungs
[ ]{ } chest pains
[ ]{ } palpitations/irregular heartbeat
[ ]{ } difficulty breathing
[ ]{ } persistent cough
[ ]{ } symp. from chemicals/fumes/odors

Digestive system
[ ]{ } heartburn
[ ]{ } excessive gas/bloating
[ ]{ } parasites
[ ]{ } blood in stools
[ ]{ } chronic constipation
[ ]{ } chronic diarrhea
[ ]{ } excess/sudden wt gain/loss
[ ]{ } symptoms from delays eating

SYMPTOMS: Have you ever had, or do you now have:
Past symptoms, please check **[ ]**
Current symptoms, please check **{ }**

Urinary system
[ ]{ } difficult/painful/frequent urination
[ ]{ } blood or pus in urine
[ ]{ } loss of bladder control

Male
[ ]{ } prostate problems
[ ]{ } discharge/sores
[ ]{ } impotence/sterility

Female
[ ]{ } PMS
[ ]{ } tipped uterus
[ ]{ } endometriosis
[ ]{ } intense menstrual cramps
[ ]{ } irregular menstrual cycle
[ ]{ } breast lumps/pain
[ ]{ } vaginal discharge/infection
[ ]{ } menopausal problems
[ ]{ } births: live __ still ______
[ ]{ } miscarriages
[ ]{ } surgical abortions
[ ]{ } are you now pregnant?
[ ]{ } date of last menstrual period ________________

General
[ ]{ } excessively worried/anxious
[ ]{ } irritable
[ ]{ } fearful
[ ]{ } depressed
[ ]{ } poor memory/concentration
[ ]{ } lonely
[ ]{ } grief/loss/excessive stress
[ ]{ } loss of sex drive
[ ]{ } insomnia
[ ]{ } chronic fatigue

Ears
[ ]{ } loss of hearing
[ ]{ } ear infections
[ ]{ } ringing in the ears

Sinus/Nose
[ ]{ } post nasal drip
[ ]{ } chronic nasal congestion
[ ]{ } recurrent nose bleeds

Throat/Mouth
[ ]{ } excessive tooth decay
[ ]{ } missing teeth/dentures
[ ]{ } braces on your teeth
[ ]{ } clicking jaw/grinding teeth
[ ]{ } crowding of/spaces between teeth

Skin
[ ]{ } hives
[ ]{ } acne/boils
[ ]{ } sebaceous cysts
[ ]{ } bruise easily
[ ]{ } slow wound healing
[ ]{ } low or absent sweating
[ ]{ } dry skin/eczema/psoriasis

Nails
[ ]{ } ridged/split/thickened

Activity level
[ ]{ } inactive
[ ]{ } moderately active
[ ]{ } very active

Rate your overall energy level: (low) 1 2 3 4 5 6 7 8 9 10 (high) *Circle one.*

Rate your overall sense of well being: (low) 1 2 3 4 5 6 7 8 9 10 (high) *Circle one.*

Current blood pressure: (within one month)______________________________Pulse rate:_________________

EXERCISE: (Type and frequency)____
____
____
____

DIET:

D=daily, F=frequently, O=occasionally, R=rarely, N=never.

D F O R N

[] [] [] [] [] Fresh fruits
[] [] [] [] [] Fresh vegetables
[] [] [] [] [] Sprouted foods
[] [] [] [] [] Whole grains/cereals
[] [] [] [] [] White flour products
[] [] [] [] [] Legumes/beans
[] [] [] [] [] Nuts/seeds
[] [] [] [] [] Dairy products
[] [] [] [] [] Milk (raw, pasteurized)
[] [] [] [] [] Peanut butter
[] [] [] [] [] Honey/molasses
[] [] [] [] [] Eggs
[] [] [] [] [] Fish
[] [] [] [] [] Fowl
[] [] [] [] [] Red meat/cold cuts
[] [] [] [] [] Salt (table/sea)
[] [] [] [] [] Salsa & chips
[] [] [] [] [] Spicy foods

D F O R N

[] [] [] [] [] Canned fruits
[] [] [] [] [] Canned vegetables
[] [] [] [] [] Margarine
[] [] [] [] [] Shortening/lard
[] [] [] [] [] White rice/pasta
[] [] [] [] [] Artificial sweeteners
[] [] [] [] [] Deep fat fried foods
[] [] [] [] [] Fast foods/pre-packaged
[] [] [] [] [] Food w/preservatives
[] [] [] [] [] Soda pop
[] [] [] [] [] Chocolate
[] [] [] [] [] Black tea
[] [] [] [] [] Coffee ________ cups/day
[] [] [] [] [] Cigarettes ________ per day
[] [] [] [] [] Alcohol
[] [] [] [] [] Marijuana/Cocaine
[] [] [] [] [] Ice cream
[] [] [] [] [] Refined sugar

List food cravings:____

____

Are you currently dieting? [] yes [] no

How many pounds have you lost throughout your life dieting, and when did you lose them?________________

____

Types of diets you have been on:

[] Elimination/rotation
[] Candida
[] Low fat
[] Vegetarian
[] Macrobiotic
[] Vegan
[] High protein
[] Low salt
[] Other________________

Using the D, F, O, R, N columns as above, do you currently:

D F O R N

[] [] [] [] [] Eat regular meals
[] [] [] [] [] Skip meals
[] [] [] [] [] Eat snacks
[] [] [] [] [] Over indulge foods

D F O R N

[] [] [] [] [] Eat out
[] [] [] [] [] Eat fast foods
[] [] [] [] [] Cook from scratch

List the amount and types of fluids/beverages you drink each day on the average:________________

____

____

EMOTIONAL STRESS: Please check either "**P**" for in the past or "**C**" for currently.

	Mild		Mod		Extreme	
	P	C	P	C	P	C
Childhood stress	[]	[]	[]	[]	[]	[]
School stress	[]	[]	[]	[]	[]	[]
Play/recreation	[]	[]	[]	[]	[]	[]
Family stress	[]	[]	[]	[]	[]	[]
Personal Relationships	[]	[]	[]	[]	[]	[]
Stress of illness	[]	[]	[]	[]	[]	[]

	Mild		Mod		Extreme	
	P	C	P	C	P	C
Work related stress	[]	[]	[]	[]	[]	[]
Stress of commuting	[]	[]	[]	[]	[]	[]
Loss of loved one	[]	[]	[]	[]	[]	[]
Change in lifestyle	[]	[]	[]	[]	[]	[]
Change in vocation	[]	[]	[]	[]	[]	[]
Abuse	[]	[]	[]	[]	[]	[]

How do you rate your physical health?
[ ]Excellent [ ]Good [ ]Fair [ ]Poor. Are you [ ]Improving or [ ]Worsening?

How do you rate your emotional/mental health?
[ ]Excellent [ ]Good [ ]Fair [ ]Poor. Are you [ ]Improving or [ ]Worsening?

If you consider yourself ill, why do you feel you are ill?____________________

If you consider yourself well, why do you feel you are well?____________________

PSYCHOLOGIC HISTORY:
Please list significant fears and emotional traumas, including death, divorce, problems with spouse, children, or job:

MILITARY HISTORY:
Branch of service:____________________ Years served:__________
Date and type of discharge:____________________

EDUCATION AND SOCIAL HISTORY:
Highest level of education completed:____________________ Degree(s)__________
Type of work done in the past:____________________

Places you have lived:____________________

Sports/hobbies:____________________

Comments:

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AUTHORIZATION TO DISCLOSE MEDICAL RECORDS

Print Name: ____ DOB:______________

Information to be released from:

Facility and/or Provider: ____

Phone:________________________ Fax:________________________________

Information to be sent to:
Dr. Celisha Gerber
NDCARE, Inc
138 Chamberlain Blvd
Knoxville, TN 37920
Phone: 541-499-9722
Fax: 541-292-5128

Purpose of disclosure: Establish/Continuity of Care

Information to be released:

By **initialing** the spaces below, I specifically authorize the release of the following medical records, if such records exist:

____ Laboratory Reports/Films/Diagnostic Imaging Reports from ___________ to _____________

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, or my eligibility of benefits. I understand if the person(s) or entity(ies) that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and is no longer protected by those regulations.

This authorization may be revoked at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the following address at the top of this form. The only exception is when action has been taken in reliance on the authorization. Unless revoked earlier, the consent will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

____ ______________________

Signature of Patient or Person Authorized by Law Date