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Advanced Practice
— MENTAL HEALTH AND WELLNESS —

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4325 Dick Pond Rd.
Myrtle Beach, SC 29588

Little River
4360 Big Barn Dr.
Little River, SC 29566

Consent for Treatment, Notice of Privacy, & Policies Acknowledgement

I have read The Informed Consent for Assessment and Treatment and Office Policies and Notice of Privacy Practices, and I understand and accept the policies contained therein. Having read that information, I hereby agree to assessment and treatment. I acknowledge that this consent is truly voluntary and is valid until revoked. I hereby consent for my provider to release information to the billing agent/funding source and for the billing agent/funding source to release information to your provider. I understand that I am responsible for any fee not covered by insurance and agree to pay for sessions or co-pays at time of service. I authorize the release of any information relating to all claims and benefits submitted on my behalf or on behalf of my child or minor in my legal custody. I further acknowledge that my signature here authorizes the clinician or his/her billing specialist to submit claims for services rendered without obtaining my signature on every claim. I understand that I am responsible for paying the co- pay, coinsurance or deductible amount at the time of service. If the claim is denied, I agree to pay for the service. I authorize payment of medical benefits for assessment or psychotherapy to the providing clinician, for services rendered. I acknowledge that I have reviewed and understood the Consent for Treatment and Practice Policies. I voluntarily consent to evaluation and treatment, including telehealth services when applicable, and understand that results are not guaranteed and that I may withdraw consent at any time. I acknowledge receipt of the Notice of Privacy Practices and understand how my health information may be used and disclosed.

_____ _____

Patient Name

Patient Signature
(If signed by other than Patient, indicate relationship)

_____ _____

Date of Birth

Todays Date

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Telehealth Services Consent & Acknowledgement

I understand that privacy and confidentiality laws apply to telehealth services, and that no information obtained through telehealth will be disclosed to researchers or other entities without my written consent, except as otherwise permitted or required by law.

1. I understand that telehealth services will be provided through videoconferencing technology and that, unlike an in-person visit, I will not be in the same physical location as my healthcare provider during the session.
2. I understand that telehealth services involve the use of electronic communication technology, which may include potential risks such as interruptions, technical difficulties, unauthorized access, or other security-related issues. I understand that either my healthcare provider or I may discontinue the telehealth session if the technology is not adequate for the situation.
3. I understand that telehealth may involve the electronic transmission of my personal health information to other healthcare professionals or consultants who may be located in different geographic areas, including outside the state.
4. I understand that telehealth services are not appropriate for emergencies or crisis situations. If I am experiencing a medical or mental health emergency, I should immediately call 911 or seek assistance from the nearest emergency room, hospital, or crisis service provider in my area.
5. I understand that I do not need to download any software or receive a link in advance for my appointment. My provider will send the telehealth link at my scheduled appointment date and time. By clicking the link, I will be connected directly to my provider.
6. I understand that all patients must have a completed Payment Authorization Form and a valid payment card on file in order to schedule and attend telehealth appointments. The form is available through the patient portal and must be updated as needed. Telehealth appointments cannot be conducted without a completed authorization form and valid payment method on file. If a payment method is declined, the office will make one attempt to contact me for updated payment information. Payment must be received by 10:00 AM on the day of the appointment or the appointment may be considered a no-show.

By signing below, I acknowledge that I have read and understand this Telehealth Consent and Acknowledgment form, including the risks and benefits of telehealth services, and I voluntarily consent to participate in telehealth treatment.

Patient Name: _____ **Patient Signature:** _____

Todays Date: _____ **Parent/Guardian (if applicable):** _____

Relationship to Patient: _____

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—MENTAL HEALTH AND WELLNESS—

CHILD (3-13) MENTAL HEALTH INTAKE FORM

NAME _____ DATE OF BIRTH _____

PRIMARY CARE PHYSCIAN (IF APPLICABLE): _____

What are the problems with which you are seeking help?

1. _____
2. _____
3. _____

What are your treatment goals?

_____

Current symptoms checklist:

- Depressed mood
- Sleep disturbance
- Change in appetite
- Excessive guilt
- Forgetfulness
- Fatigue
- Decreased libido
- Racing thoughts
- Impulsivity
- Increased libido
- Decrease need for sleep
- Excessive energy
- Increased irritability
- Crying spells
- Excessive worry
- Anxiety attacks
- Avoidance
- Hallucinations
- Lack of Concentration

Suicide Risk Assessment

Have you **ever** had feelings or thoughts that you did not want to live? _____

If YES, please answer the following. If **NO**, please skip to the next section

Do you **currently** feel that you don't want to live? _____

How often have you had these thoughts? _____

When was the last time you had thoughts of dying? _____

Has anything happened to make you feel this way? _____

Have you ever thought about how you would kill yourself? YES NO

Have you ever tried to kill or harm yourself before? YES NO

Past Psychiatric History:

Outpatient treatment

Reason: _____

Dates Treated: _____ By Whom: _____

Psychiatric Hospitalizations

Reason: _____

Dates Hospitalized: _____ Where: _____

Family Psychiatric History:

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Has anyone in your family been diagnosed with or treated for: (Please Circle)

Bipolar YES NO	Anger YES NO	PTSD YES NO
Depression YES NO	Suicide YES NO	Alcohol abuse YES NO
Anxiety YES NO	Schizophrenia YES NO	Substance abuse YES NO

If yes, who had each problem? Were they treated with psychiatric medication?

_____

Alcohol/Substance Use:

Do you think you may have a problem with alcohol or drug use? _____

Have you ever abused prescription medication? If yes, which ones and for how long? _____

_____

Check if you have ever tried the following:

- ○ Methamphetamine
- ○ Cocaine
- ○ Stimulants (pills)
- ○ Heroin
- ○ Marijuana
- ○ Pain killers (not as prescribed)
- ○ Methadone
- ○ Tranquilizer/ sleeping pills
- ○ Alcohol
- ○ Ecstasy

If yes, how long and when did you last use?

_____

Tobacco History

How you ever smoked cigarettes YES NO Currently Smoking? YES NO

Family Background and Childhood History:

Were you adopted? YES NO Where did you grow up? _____

What was/is your fathers occupation? _____

What was/is your mothers occupation? _____

Did your parents divorce? YES NO

If so, how old were you when they divorced? _____

If your parents divorced, who do you live with? _____

Trauma History:

Do you have a history of being abused emotionally, sexually, physically, or by neglect? If yes, please describe when, where, and by whom:

_____

_____

ADVANCED PRACTICE MENTAL HEALTH AND WELLNESS

NAME: _____ **DOB:** _____

CHECK BOX IF YOU HAVEN EVER TAKEN ANY OF THE MEDICATIONS LISTED BELOW

Antidepressants

- ☐ Marplan (isocarboxazid)
- ☐ Nardil (phenelzine)
- ☐ Parnate (tranylcypromine)
- ☐ Emsam patch (Selegiline)
- ☐ Tofranil (imipramine)
- ☐ Elavil (amitriptyline)
- ☐ Vivactil (protriptyline)
- ☐ Pamelor (nortriptyline)
- ☐ Anafranil (clomipramine)
- ☐ Norpramin (desipramine)
- ☐ Sinequan / Silenor (doxepin)
- ☐ Surmontil (trimipramine)
- ☐ Ludiomil (maprotiline)
- ☐ Prozac (fluoxetine)
- ☐ Zoloft (sertraline)
- ☐ Paxil (paroxetine)
- ☐ Luvox (fluvoxamine)
- ☐ Celexa (citalopram)
- ☐ Lexapro (escitalopram)
- ☐ Effexor XR (venlafaxine ER)
- ☐ Cymbalta (duloxetine DR)
- ☐ Pristiq (desvenlafaxine ER)
- ☐ Savella (milnacipran)
- ☐ Fetzima (levomilnacipran ER)
- ☐ Wellbutrin/Aplenzin/ Zyban (bupropion)
- ☐ Serzone (nefazodone)
- ☐ Remeron (mirtazapine)
- ☐ Symbyax (fluoxetine+olanzepine)
- ☐ Viibyrd (vilazodone)
- ☐ Trintellix / Brintellix (vortioxetine)
- ☐ Ketamine (IV/IM)
- ☐ Spravato (intranasal esketamine)
- ☐ Zulresso (brexanolone)

Sleep disorders

- ☐ Ambien (zolpidem)
- ☐ Belsomra (suvorexant)
- ☐ Dayvigo (lemborexant)
- ☐ Doral (quazepam)
- ☐ Hetlioz (tasimelteon)
- ☐ Lunesta (eszopiclone)
- ☐ Prazosin (Minipress)
- ☐ Restoril (temazepam)
- ☐ Rozerem (ramelteon)
- ☐ Sonata
- ☐ Trazodone
- ☐ Sunosi (solriamfetol)

Mood Disorders

- ☐ Haldol (haloperidol)
- ☐ Loxitane (loxapine)
- ☐ Navane (thiothixene)
- ☐ Prolixin (fluphenazine)
- ☐ Stelazine (trifluoperazine)
- ☐ Thorazine (chlorpromazine)
- ☐ Trilafon (perphenazine)
- ☐ Clozaril (clozapine)
- ☐ Fanapt (iloperidone)
- ☐ Geodon (ziprasidone)
- ☐ Invega (paliperidone)
- ☐ Latuda (lurasidone)
- ☐ Risperdal (risperidone)
- ☐ Saphris (asenapine)
- ☐ Seroquel (quetiapine)
- ☐ Zyprexa (olanzepine)
- ☐ Abilify (aripiprazole)
- ☐ Rexulti (brexpiprazole)
- ☐ Vraylar (cariprazine)
- ☐ Caplyta (lumateperone)
- ☐ Nuplazid (pimvanserin)
- ☐ Haldol Decanoate (haloperidol)
- ☐ Prolixin Decanoate (fluphenazine)
- ☐ Zyprexa Relprevv (olanzepine)
- ☐ Abilify Maintena (aripiprazole)
- ☐ Aristada (aripiprazole lauroxil)
- ☐ Risperdal Consta (risperidone)
- ☐ Invega Sustenna (paliperidone 1 mo)
- ☐ Invega Trinza (paliperidone 3 month)
- ☐ Perseris (subcutaneous risperidone)
- ☐ Nuedexta (dextromethoprhan&quinidine)

Sedatives

- ☐ Ativan (lorazepam)
- ☐ BuSpar (buspirone)
- ☐ Inderal (propranolol)
- ☐ Klonopin (clonazepam)
- ☐ Librium (chlordiazepoxide)
- ☐ Valium (diazepam)
- ☐ Vistaril / Atarax (hydroxyzine)
- ☐ Xanax(alprazolam)

Seizures

- ☐ Depakene (valproic acid)
- ☐ Depakote (divalproex)
- ☐ Dilantin (phenytoin)
- ☐ Keppra (levetiracetam)
- ☐Lamictal (lamotrigine)
- ☐Lithium / Lithobid
- ☐Neurontin (gabapentin)
- ☐Phenobarbital
- ☐Tegretol (carbamazepine)
- ☐Topamax (topiramate)
- ☐Trileptal (oxcarbazepine)
- ☐Zonegran (zonisamide)

Stimulants

- ☐ Adderall
- ☐ Evekeo
- ☐ Procentra (liquid)
- ☐ Zenzedi
- ☐ Adderall XR
- ☐ Adzenys
- ☐ Dexedrine Spansule
- ☐ Dyanavel XR (liquid)
- ☐ Mydayis
- ☐ Vyvanse
- ☐ Ritalin
- ☐ Focalin
- ☐ Adhansia
- ☐ Aptensio
- ☐ Concerta
- ☐ Cotempla XR-ODT
- ☐ Daytrana (patch)
- ☐ Focalin XR
- ☐ Jornay PM
- ☐ Metadate CD
- ☐ Metadate ER
- ☐ Ritalin LA
- ☐ Quillichew ER
- ☐ Quillivant XR (liquid)
- ☐ Provigil (modafinil)
- ☐ Nuvigil (armodafinil)
- ☐ Wakix (pitolisant)
- ☐ Xyrem (sodium oxybate)

Movement disorders

- ☐ Artane (trihexyphenidyl)
- ☐ Austedo (deutetrabenazine)
- ☐ Cogentin (benztropine)
- ☐ Gralise (gabapentin once daily)
- ☐ Horizant (gabapentin enacarbil)
- ☐ Ingrezza (valbenazine)
- ☐ Primidone
- ☐ Symmetrel / Osmolex (amantadine)
- ☐ Xenazine (tetrabenzene)
- ☐ Aricept (donepezil)
- ☐ Exelon patch (rivastigmine)
- ☐ Namenda [XR] (memantine)
- ☐ Namzaric (donepezil/memantine)
- ☐ Razadyne ER (galantamine)
- ☐ Apokyn (apomorphine)
- ☐ Azilect (rasagiline)
- ☐ Comtan (entacapone)
- ☐ Gocovri (amantadine ER)
- ☐ Mirapex [☐ER] (pramipexole)
- ☐ Neupro patch (rotigone)
- ☐ Northera (droxidopa)
- ☐ Nourianz (istradefylline)
- ☐ Requip [☐XL] (ropinirole)
- ☐ Rytary (carbidopa/levodopa ER)
- ☐ Sinemet [☐CR] (carbidopa/levodopa)
- ☐ Xadago (safinamide)

Weight loss

- ☐ Belviq [XR] (Lorcaserin)
- ☐ Chantix (varenicline)
- ☐ Contrave (bupropion/naltrexone)
- ☐ Phentermine (Adipex)
- ☐ Qsymia (phentermine/topamax)
- ☐ Saxenda / ☐Victoza (liraglutide)

Opioid/alcohol/ substance abuse

- ☐ Antabuse (disulfiram)
- ☐ Campral (acamprosate)
- ☐ Lyrica [☐CR] (pregabalin)
- ☐ Methadone
- ☐ Nucynta [ER] (tapentadol)
- ☐ Suboxone/subutex (buprenorphine)
- ☐ Vivitrol injection (naltrexone)

D4 NICHQ Vanderbilt Assessment Scale - PARENT Informant

Today's Date: _____ Child's Name _____ Date of Birth: _____

Parent's Name: _____ Parent's Phone Number: _____

Directions: Each rating should be considered in the context of what is appropriate for the age of your child. Please think about your child's behaviors since the last assessment scale was filled out when rating his/her behaviors.

Is this evaluation based on a time when the child ○ was on medicatio ○ was not on medication ○ not sure?

Symptoms	Never	Occasionally	Often	Very Often
1. Does not pay attention to details or makes careless mistakes with, for example, homework	○ 0	○ 1	○ 2	○ 3
2. Has difficulty keeping attention to what needs to be done	○ 0	○ 1	○ 2	○ 3
3. Does not seem to listen when spoken to directly	○ 0	○ 1	○ 2	○ 3
4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)	○ 0	○ 1	○ 2	○ 3
5. Has difficulty organizing tasks and activities	○ 0	○ 1	○ 2	○ 3
6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort	○ 0	○ 1	○ 2	○ 3
7. Loses things necessary for tasks or activities (toys, assignments, pencils, or books)	○ 0	○ 1	○ 2	○ 3
8. Is easily distracted by noises or other stimuli	○ 0	○ 1	○ 2	○ 3
9. Is forgetful in daily activities	○ 0	○ 1	○ 2	○ 3
10. Fidgets with hands or feet or squirms in seat	○ 0	○ 1	○ 2	○ 3
11. Leaves seat when remaining seated is expected	○ 0	○ 1	○ 2	○ 3
12. Runs about or climbs too much when remaining seated is expected	○ 0	○ 1	○ 2	○ 3
13. Has difficulty playing or beginning quiet play activities	○ 0	○ 1	○ 2	○ 3
14. Is "on the go" or often acts as if "driven by a motor"	○ 0	○ 1	○ 2	○ 3
15. Talks too much	○ 0	○ 1	○ 2	○ 3
16. Blurts out answers before questions have been completed	○ 0	○ 1	○ 2	○ 3
17. Has difficulty waiting his or her turn	○ 0	○ 1	○ 2	○ 3
18. Interrupts or intrudes in on others' conversations and/or activities	○ 0	○ 1	○ 2	○ 3
19. Argues with adults	○ 0	○ 1	○ 2	○ 3
20. Loses temper	○ 0	○ 1	○ 2	○ 3
21. Actively defies or refuses to go along with adults' requests or rules	○ 0	○ 1	○ 2	○ 3
22. Deliberately annoys people	○ 0	○ 1	○ 2	○ 3
23. Blames others for his or her mistakes or misbehaviors	○ 0	○ 1	○ 2	○ 3
24. Is touchy or easily annoyed by others	○ 0	○ 1	○ 2	○ 3
25. Is angry or resentful	○ 0	○ 1	○ 2	○ 3
26. Is spiteful and wants to get even	○ 0	○ 1	○ 2	○ 3
27. Bullies, threatens, or intimidates others	○ 0	○ 1	○ 2	○ 3
28. Starts physical fights	○ 0	○ 1	○ 2	○ 3
29. Lies to get out of trouble or to avoid obligations (ie,"cons" others)	○ 0	○ 1	○ 2	○ 3
30. Is truant from school (skips school) without permission	○ 0	○ 1	○ 2	○ 3
31. Is physically cruel to people	○ 0	○ 1	○ 2	○ 3
32. Has stolen things that have value	○ 0	○ 1	○ 2	○ 3

Adapted from the Vanderbilt Rating Scales developed by Mark L. Wolraich, Revised - 1102

Symptoms (continued)	Never	Occasionally	Often	Very Often
33. Deliberately destroys others' property	O	O	O	O
34. Has used a weapon that can cause serious harm (bat, knife, brick, gun	O	O	O	O
35. Is physically cruel to animals	O	O	O	O
36. Has deliberately set fires to cause damage	O	O	O	O
37. Has broken into someone else's home, business, or car	O	O	O	O
38. Has stayed out at night without permission	O	O	O	O
39. Has run away from home overnight	O	O	O	O
40. Has forced someone into sexual activity	O	O	O	O
41. Is fearful, anxious, or worried	O	O	O	O
42. Is afraid to try new things for fear of making mistakes	O	O	O	O
43. Feels worthless or inferior	O	O	O	O
44. Blames self for problems, feels guilty	O	O	O	O
45. Feels lonely, unwanted, or unloved; complains that "no one loves him or her"	O	O	O	O
46. Is sad, unhappy, or depressed	O	O	O	O
47. Is self-conscious or easily embarrassed	O	O	O	O

Performance	Excellent	Above Average	Average	Somewhat of a problem	Problematic
48. Overall school performance	O 1	O 2	O 3	O 4	O 5
49. Reading	O 1	O 2	O 3	O 4	O 5
50. Writing	O 1	O 2	O 3	O 4	O 5
51. Mathematics	O 1	O 2	O 3	O 4	O 5
52. Relationship with parents	O 1	O 2	O 3	O 4	O 5
53. Relationship with siblings	O 1	O 2	O 3	O 4	O 5
54. Relationship with peers	O 1	O 2	O 3	O 4	O 5
55. Participation in organized activities (e.g., teams)	O 1	O 2	O 3	O 4	O 5

Explain/Comments

For Office Use Only

Total number of questions scored 2 or 3 in questions 1–9: _____

Total number of questions scored 2 or 3 in questions 10–18: _____

Total Symptom Score for questions 1–18: _____

Total number of questions scored 2 or 3 in questions 19–26: _____

Total number of questions scored 2 or 3 in questions 27–40: _____

Total number of questions scored 2 or 3 in questions 41–47: _____

Total number of questions scored 4 or 5 in questions 48–55: _____

Average Performance Score: _____

Advanced Practice
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NAME: _____ **DOB:** _____ **TODAYS DATE:** _____

GAD-7 ASSESMENT

Over the last 2 weeks, how often have you been bothered by any of the following problems?

		NOT AT ALL	SEVERAL DAYS	MORE THAN HALF OF DAYS	NEARLY EVERY DAY
1.	Feeling nervous, anxious, or on edge	0	1	2	3
2.	Not being able to stop or control worrying	0	1	2	3
3.	Worrying too much about different things	0	1	2	3
4.	Trouble relaxing	0	1	2	3
5.	Being so restless that it is hard to sit still	0	1	2	3
6.	Becoming easily annoyed or irritable	0	1	2	3
7.	Feeling afraid as if something awful might happen	0	1	2	3

PHQ-9 ASSESSMENT

Over the last 2 weeks, how often have you been bothered by any of the following problems?

		NOT AT ALL	SEVERAL DAYS	MORE THAN HALF OF DAYS	NEARLY EVERY DAY
1.	Little interest or pleasure in doing things	0	1	2	3
2.	Feeling down, depressed, or hopeless	0	1	2	3
3.	Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4.	Feeling tired or having little energy	0	1	2	3
5.	Poor appetite or overeating	0	1	2	3
6.	Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7.	Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8.	Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9.	Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

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PATIENT NAME: _____ **DOB:** _____

The ACE questionnaire (AGES 3-17)

Finding Your ACE Score The ACE questionnaire is a simple scoring system that attributes one point for each category of adverse childhood experience. The 10 questions below each cover a different domain of trauma, and refer to experiences that occurred prior to the age of 18. Higher scores indicate increased exposure to trauma, which have been associated with a greater risk of negative consequences.

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household often or very often... Swear at you, insult you, put you down, or humiliate you? or Act in a way that made you afraid that you might be physically hurt? **YES NO**

2. Did a parent or other adult in the household often or very often... Push, grab, slap, or throw something at you? or Ever hit you so hard that you had marks or were injured? **YES NO**

3. Did an adult or person at least five years older than you ever... Touch or fondle you or have you touch their body in a sexual way? or Attempt or actually have oral, anal, or vaginal intercourse with you?

YES NO

4. Did you often or very often feel that... No one in your family loved you or thought you were important or special? or Your family didn't look out for each other, feel close to each other, or support each other? **YES NO**

5. Did you often or very often feel that ... You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? or Your parents were too drunk or high to take care of you or take you to the doctor if you needed it? **YES NO**

6. Were your parents ever separated or divorced? **YES NO**

7. Was your mother or stepmother: Often or very often pushed, grabbed, slapped, or had something thrown at her? or Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? or Ever repeatedly hit at least a few minutes or threatened with a gun or knife? **YES NO**

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs? **YES NO**

9. Was a household member depressed or mentally ill, or did a household member attempt suicide?

YES NO

10. Did a household member go to prison? **YES NO**

Now add up your "Yes" answers: _____. This is your ACE Score.

Advanced Practice Mental Health and Wellness

Phone: 843-945-1452 Fax: 843-945-1489 Email: info@apmhofsc.com

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Payment Authorization Form

I, the undersigned patient (or responsible party), authorize Advanced Practice Mental Health and Wellness to securely keep my preferred payment method on file (credit card, debit card, or HSA/FSA card). I understand and agree to the following terms:

- **Authorization for Charges**

I authorize Advanced Practice Mental Health and Wellness to charge the payment method on file for any patient balances, including but not limited to co-pays, deductibles, co-insurance, outstanding account balances, and fees related to services provided. I authorize charges for any **late cancellation fees** and **no-show fees** in accordance with the practice's policies, without the need for additional written or verbal authorization. **Late Cancellation Fee:** $25.00 (applies when an appointment is canceled less than 24 hours before the scheduled time). **No-Show Fee:** $50.00 (applies when an appointment is missed without notice).

- **Timing of Charges**

Payment will be processed **the day before my scheduled appointment**. If payment is declined, I understand it is my responsibility to update my payment information before services can be provided.

- **Ongoing Authorization**

This authorization will remain in effect until I provide and updated card on file with a new form filled out I agree to maintain a valid payment method on file at all times while receiving services from Advanced Practice Mental Health and Wellness.

- **Acknowledgement**

I understand that it is my responsibility to review and understand the financial policies of Advanced Practice Mental Health and Wellness. I acknowledge that any fees charged are consistent with the practice's published policies.

Patient Name: _____ Date of Birth: _____

CARD NUMBER: _____

CARD EXPIRATION: _____CVV SECURITY CODE: _____

BILLING ZIP CODE: _____

Signature: _____ **Date:** _____

Thank you for helping us maintain efficient billing practices. If you have questions about this authorization, please contact our office staff prior to signing.