# INFORMATION/APPLICATION FOR CARE

**The following information is needed in order to better serve you. Please complete all questions. If you need help please ask the receptionist. PLEASE PRINT**

NAME_____________________________________________________________ MIDDLE __________________________NICK NAME_____________________

BIRTHDATE ___________________________ AGE____________________ MARITAL STATUS: S M W D GENDER: M F UNSPECIFIED

☐ HOME ___________________________ ☐ WORK ______________________________ ☐ CELL __________________________

ADDRESS_____________________________________________________ CITY___________________ STATE________________ ZIP_______________

EMAIL ADDRESS________________________________________ WORK EMAIL___________________________________________

EMPLOYMENT STATUS ☐ EMPLOYED ☐ FT STUDENT ☐ PT STUDENT ☐ OTHER ☐ RETIRED ☐ SELF EMPLOYED

PRIMARY CARE PHYSICIAN ______________________________________ REFERRED TO OUR OFFICE BY:_____________________________

**MULTI- RACIAL** ☐ YES ☐ NO **ETHNICITY** ☐ HISPANIC OR LATINO ☐ NOT HISPANIC OR LATINO ☐ I CHOOSE NOT TO SPECIFY

**RACE** (CHECK ONE)
☐ WHITE ☐ HISPANIC ☐ BLACK/AFRICAN AMERICAN ☐ I CHOOSE NOT TO SPECIFY
☐ ASIAN ☐ FILIPINO ☐ VIETNAMESE ☐ AMERICAN INDIAN/ ALASKAN NATIVE
☐ JAPANESE ☐ CHINESE ☐ OTHER_________________ ☐ G UAMANIAN OR CHAMORRO
☐ SAMOAN ☐ KOREAN ☐ ASIAN INDIA ☐ NATIVE HAWAIIAN OR OTHER PACIFIC ISLAND

**PREFERRED LANGUAGE**

☐ ENGLISH ☐ SPANISH ☐ CHINESE ☐ FRENCH ☐ GERMAN ☐ AMERICAN SIGN LANGUAGE
☐ TAGALOG ☐ ITALIAN ☐ KOREN ☐ RUSSIAN ☐ POLISH ☐ VIETNAMESE
☐ ARABIC ☐ GREEK ☐ HINDI ☐ PORTUGUESE ☐ JAPANESE ☐ FRENCH CREOLE
☐ PERSIAN ☐ URDU ☐ GUJARATI ☐ ARMENIAN ☐ I CHOOSE NOT TO SPECIFY

IS YOUR CONDITION DUE TO AN ACCIDENT? YES_____ NO______ DATE OF ACCIDENT__________________
TYPE OF ACCIDENT? AUTO_____ WORK/ON JOB_____ AT HOME_____ OTHER________________________
HAVE YOU EVER BEEN IN AN AUTO ACCIDENT? PAST YEAR___ PAST 5 YEARS ___ OVER 5 YEARS___ NEVER___

I (WE) AGREE TO PAY FOR SERVICES RENDERED TO ABOVE MENTIONED PATIENT AS THE CHARGE IS INCURRED. I UNDERSTAND AND AGREE THAT HEALTH & ACCIDENT INSURANCE POLICIES ARE AN ARRANGEMENT BETWEEN AN INSURANCE CARRIER AND MYSELF AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT OF ANY AND ALL SERVICES COVERED OR NOT COVERED. I ALSO UNDERSTAND IF I SUSPEND OR TERMINATE MY CARE AND TREATMENT, ANY FEE FOR PROFESSIONAL SERVICES RENDERED TO ME WILL BE IMMEDIATELY DUE AND PAYABLE.

**PATIENT'S SIGNATURE**_________________________________________________ DATE ___________________________

**OR GUARDIAN SIGNATURE**____________________________________________ DATE __________________________

**<u>NOTICE TO OUR NEW PATIENTS:</u>** FULL PAYMENT FOR SERVICES RENDERED IS DUE AT THE END OF EACH VISIT. IF FOR ANY REASON THIS REQUEST CANNOT BE MET, ARRANGEMENTS SHOULD BE MADE IN ADVANCE BEFORE SEEING THE DOCTOR.

## HISTORY OF PRESENT ILLNESS/CONCERN

CC# ________

**AS A NEW PATIENT, PLEASE COMPLETE THE FOLLOWING INFORMATION BELOW TO THE BEST OF YOUR ABILITY. SHOULD YOU HAVE MULTIPLE AREAS OF CONCERN (NECK, BACK, HEADACHES, TREMORS, VERTIGO...), PLEASE PRINT AND COMPLETE THIS SHEET FOR EACH AREA/CONCERN.**

DESCRIBE THE PROBLEMS/SYMPTOMS THAT YOU ARE EXPERIENCING. ________________________________

________________________________________________________________

WHEN DID THIS PROBLEM BEGIN? ________________________________

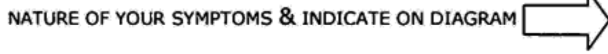
IF THIS A REOCCURRENCE OF AN EXISTING CONDITION, WHEN DID THE PROBLEM ORIGINALLY BEGIN? ________________

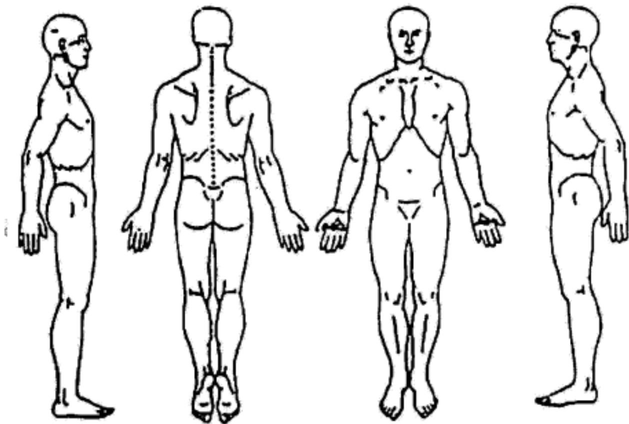
HOW DID YOUR SYMPTOMS START (IE...TRAUMA, UNKNOWN): ________________________________

HOW OFTEN ARE YOU EXPERIENCING SYMPTOMS? (CIRCLE ONE)

A. CONSTANTLY (76-100% OF THE DAY)
B. FREQUENTLY (51-75% OF THE DAY)
C. OCCASIONALLY (26-50% OF THE DAY)
D. INTERMITTENTLY (0-25% OF THE DAY)

NATURE OF YOUR SYMPTOMS & INDICATE ON DIAGRAM





A. SHARP
B. SHOOTING
C. DULL ACHE
D. NUMB
E. BURNING
F. TINGLING

INDICATE THE AVERAGE INTENSITY OF YOUR SYMPTOMS: NONE 1 2 3 4 5 6 7 8 9 10 UNBEARABLE

HOW ARE YOUR SYMPTOMS CHANGING?

A. GETTING BETTER
B. NOT CHANGING
C. GETTING WORSE

WHAT TESTING HAVE YOU HAD FOR THIS CONDITION?

- ☐ MRI
- ☐ CT SCAN
- ☐ EKG
- ☐ X-RAYS
- ☐ LABORATORY WORK
- ☐ OTHER: ________________

WHAT MAKES YOUR CONDITION BETTER? ________________________________

WHAT MAKES IT WORSE? ________________________________

DOES IT AFFECT YOUR ABILITY TO SLEEP OR WAKE YOU AT NIGHT? YES NO

HOW MUCH HAS THIS CONDITION INTERFERED WITH YOUR ACTIVITIES OF DAILY LIVING (INCLUDING WORK, SOCIAL, SELF/FAMILY CARE)

A. NOT AT ALL B. A LITTLE BIT C. MODERATELY D. QUITE A BIT E. EXTREMELY

PLEASE LIST ANY OTHER PROVIDERS (MEDICAL DOCTOR, PHYSICAL THERAPIST, CHIROPRACTOR, ETC...) THAT YOU HAVE CONSULTED FOR THIS CONDITION. LIST THE APPROXIMATE DATE OF THE LAST VISIT, DIAGNOSIS AND THEIR CONTACT INFORMATION. (USE BACK IF NECESSARY)

1. ________________________________

2. ________________________________

PLEASE INCLUDE ANY OTHER RELEVANT HISTORY/INFORMATION REGARDING THIS COMPLAINT. ________________

________________________________________________________________

## PAST MEDICAL HISTORY (PLEASE CIRCLE ALL THAT APPLY)

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| MEASLES | NO | YES | ARTHRITIS | NO | YES | NECK PAIN | NO | YES | HEPATITIS (A, B, C, D) | NO | YES |
| MUMPS | NO | YES | ANEMIA | NO | YES | BACK PAIN | NO | YES | ULCER | NO | YES |
| CHICKENPOX | NO | YES | VENEREAL DISEASE | NO | YES | HIGH BLOOD PRESSURE | NO | YES | MITRAL VALVE PROLAPSE | NO | YES |
| WHOOPING COUGH | NO | YES | EPILEPSY | NO | YES | LOW BLOOD PRESSURE | NO | YES | AUTOIMMUNE DISEASE | NO | YES |
| SCARLET FEVER | NO | YES | HERNIA | NO | YES | MULTIPLE SCLEROSIS | NO | YES | THYROID DISEASE | NO | YES |
| DIPHTHERIA | NO | YES | TUBERCULOSIS | NO | YES | HIVES/ECZEMA | NO | YES | MIGRAINE HEADACHES | NO | YES |
| SMALL POX | NO | YES | DIABETES | NO | YES | AIDS/HIV+ | NO | YES | STROKE | NO | YES |
| PNEUMONIA | NO | YES | CANCER | NO | YES | FIBROMYALGIA | NO | YES | TIA | NO | YES |
| RHEUMATIC FEVER | NO | YES | POLIO | NO | YES | BRONCHITIS | NO | YES | ASTHMA | NO | YES |
| HEART DISEASE | NO | YES | GLAUCOMA | NO | YES | HEMORRHOIDS | NO | YES | DIVERTICULITIS | NO | YES |
| PERSISTENT COUGH > 3 WKS | NO | YES | IRREGULAR HEART BEAT | NO | YES | BLOOD / PLASMA TRANSFUSION | NO | YES | KIDNEY DISEASE | NO | YES |
| BLADDER INFECTION | NO | YES | RESTLESS LEG SYNDROME | NO | YES | INFECTIOUS MONONUCLEOSIS | NO | YES | BLEEDING TENDENCY | NO | YES |

## PREVIOUS HOSPITALIZATIONS/SURGERIES/SERIOUS ILLNESSES

| PROCEDURE | DATE | HOSPITAL, CITY, STATE |
|---|---|---|
| | | |
| | | |
| | | |

## MEDICATIONS (*INCLUDE NON-PRESCRIPTION*) – USE BACK SIDE IF NECESSARY

| DRUG NAME | DOSE | CONDITION/REASON |
|---|---|---|
| | | |
| | | |
| | | |

## PATIENT SOCIAL HISTORY

MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

USE OF ALCOHOL ☐ NEVER ☐ RARELY ☐ MODERATELY ☐ DAILY

USE OF TOBACCO ☐ NEVER ☐ PREVIOUSLY _____ YRS, BUT QUIT: ____________ ☐ CURRENT PACK/DAY/YR:______________

USE OF DRUGS ☐ NEVER ☐ TYPE/FREQUENCY/YRS: ______________________________________________

USE OF CAFFEINE ☐ NEVER ☐ RARELY MODERATELY ☐ DAILY

EXPOSURE TO: ☐ FUMES ☐ DUST ☐ SOLVENTS ☐ AIRBORNE PARTICLES ☐ NOISE

## FAMILY HISTORY

| | AGE | DISEASE | IF DECEASED, CAUSE OF DEATH |
|---|---|---|---|
| FATHER | | | |
| MOTHER | | | |
| SIBLINGS | | | |
| SIBLINGS | | | |
| SPOUSE | | | |
| CHILDREN | | | |

☐ PLEASE CHECK HERE IF PATIENT IS ADOPTED, AND FAMILY HISTORY IS UNKNOWN.

## REVIEW OF SYSTEMS: *PLEASE INDICATE ANY PERSONAL HISTORY BELOW*

### CONSTITUTIONAL

| | | |
|---|---|---|
| GENERAL GOOD HEALTH | NO | YES |
| RECENT WEIGHT CHANGE | NO | YES |
| FEVER | NO | YES |
| FATIGUE | NO | YES |
| HEADACHES | NO | YES |

### EYES

| | | |
|---|---|---|
| EYE DISEASE OR INJURY | NO | YES |
| WEAR GLASSES/CONTACTS | NO | YES |
| BLURRED/DOUBLE VISION | NO | YES |
| VISUALIZE SPOTS OR COLORS | NO | YES |

### EARS/NOSE/THROAT

| | | |
|---|---|---|
| HEARING LOSS/RINGING | NO | YES |
| EARACHES OR DRAINAGE | NO | YES |
| MUCUS MEMBRANE DRYNESS | NO | YES |
| NOSE BLEEDS | NO | YES |
| MOUTH SORES | NO | YES |
| BLEEDING GUMS | NO | YES |
| BAD BREATH/BAD TASTE | NO | YES |
| SORE THROAT/VOICE CHANGE | NO | YES |
| SWOLLEN GLANDS | NO | YES |

### CARDIOVASCULAR

| | | |
|---|---|---|
| HEART TROUBLE | NO | YES |
| CHEST PAIN / ANGINA PECTORIS | NO | YES |
| PALPITATIONS/ARRHYTHMIAS | NO | YES |
| SHORTNESS OF BREATH W/ EX. | NO | YES |
| SWOLLEN FEET, ANKLES, HANDS | NO | YES |

### RESPIRATORY

| | | |
|---|---|---|
| CHRONIC OR FREQUENT COUGH | NO | YES |
| SPITTING UP BLOOD | NO | YES |
| SHORTNESS OF BREATH | NO | YES |
| WHEEZING | NO | YES |

### GASTROINTESTINAL

| | | |
|---|---|---|
| LOSS OF APPETITE | NO | YES |
| CHANGE IN BOWEL MOVEMENTS | NO | YES |
| NAUSEA OR VOMITING | NO | YES |
| DIARRHEA OR CONSTIPATION | NO | YES |
| PAINFUL BOWEL MOVEMENTS | NO | YES |
| BLOOD IN STOOL | NO | YES |
| ABDOMINAL PAIN | NO | YES |
| RECTAL BLEEDING | NO | YES |
| STOOL THAT FLOATS | NO | YES |
| HEMORRHOIDS | | |

### GENITOURINARY

| | | |
|---|---|---|
| FREQUENT URINATION | NO | YES |
| BURNING/PAINFUL URINATION | NO | YES |
| BLOOD IN URINE | NO | YES |
| CHANGE IN FORCE OF STREAM | NO | YES |
| INCONTINENCE OR DRIBBLING | NO | YES |
| KIDNEY STONES | NO | YES |
| SEXUAL DIFFICULTY | NO | YES |
| MALE – TESTICLE PAIN | NO | YES |
| FEMALE- PAINFUL PERIODS | NO | YES |
| FEMALE- IRREGULAR PERIODS | NO | YES |
| FEMALE-VAGINAL DRYNESS | NO | YES |
| FEMALE – # OF PREGNANCIES: | ________ | |
| FEMALE - # OF MISCARRIAGES | ________ | |
| FEMALE – DATE OF LAST PAP | ________ | |

### MUSCULOSKELTAL

| | | |
|---|---|---|
| JOINT PAIN | NO | YES |
| JOINT STIFFNESS/SWELLING | NO | YES |
| MUSCLE/JOINT WEAKNESS | NO | YES |
| MUSCLE PAIN OR CRAMPS | NO | YES |
| BACK PAIN | NO | YES |
| COLD EXTREMITIES | NO | YES |
| DIFFICULTY WALKING | NO | YES |

### INTEGUMENTARY (SKIN)

| | | |
|---|---|---|
| RASH OR ITCHING | NO | YES |
| CHANGE IN SKIN COLOR | NO | YES |
| CHANGE IN HAIR OR NAILS | NO | YES |
| VARICOSE VEINS | NO | YES |
| BREAST PAIN | NO | YES |
| BREAST LUMP | NO | YES |
| BREAST DISCHARGE | NO | YES |

### NEUROLOGICAL

| | | |
|---|---|---|
| FREQUENT HEADACHES | NO | YES |
| LIGHTHEADED OR DIZZY | NO | YES |
| CONVULSIONS OR SEIZURES | NO | YES |
| NUMBNESS OR TINGLING | NO | YES |
| TREMORS OR TICS | NO | YES |
| PARALYSIS | NO | YES |
| HEAD INJURY | NO | YES |
| LOSS OF CONSCIOUSNESS | NO | YES |
| FACIAL DROOPING/WEAKNESS | NO | YES |
| SPONTANEOUS MOVEMENT | NO | YES |
| MOVEMENT DISORDER | NO | YES |

### PSYCHIATRIC

| | | |
|---|---|---|
| MEMORY LOSS/CONFUSION | NO | YES |
| NERVOUS OR ANXIOUS | NO | YES |
| DEPRESSION | NO | YES |
| INSOMNIA | NO | YES |
| LOSS OF MOTIVATION | NO | YES |

### ENDOCRINE

| | | |
|---|---|---|
| GLANDULAR PROBLEM | NO | YES |
| HORMONE PROBLEM | NO | YES |
| HEAT/COLD INTOLERANCE | NO | YES |
| SKIN BECOMING DRYER | NO | YES |
| CHANGE IN HAT/GLOVE SIZE | NO | YES |
| UNUSUAL HAIR GROWTH | NO | YES |

### HEMATOLOGIC/LYMPHATIC

| | | |
|---|---|---|
| SLOW TO HEAL AFTER CUTS | NO | YES |
| BLEEDING OR BRUISING TENDENCY | NO | YES |
| ANEMIA | NO | YES |
| PHLEBITIS | NO | YES |
| PAST TRANSFUSION | NO | YES |
| ENLARGED GLANDS | NO | YES |
| ANEMIA | NO | YES |

### ALLERGIC/IMMUNOLOGIC

| | | |
|---|---|---|
| HISTORY OF ADVERSE REACTION TO: | NO | YES |
| PENICILLIN OR OTHER ANTIBIOTICS | NO | YES |
| MORPHINE, DEMEROL, NARCOTICS | NO | YES |
| NOVOCAIN OR OTHER ANESTHETICS | NO | YES |
| ASPIRIN OR OTHER PAIN REMEDIES | NO | YES |
| TETANUS ANTITOXIN OR SERUMS | NO | YES |
| IODINE, MERTHIOLATE, ANTISEPTICS | NO | YES |

OTHER DRUGS AND MEDICATIONS: ____________

________________________________________

________________________________________

KNOWN FOOD ALLERGIES: ____________

________________________________________

________________________________________

ENVIRONMENTAL ALLERGIES: ____________

________________________________________

________________________________________

# Consent for Chiropractic Treatment & Acknowledgment of Receipt of Information

To the patient: Every type of health care is associated with some risk of potential problem. Health care providers, including chiropractors, are required, by law, to tell you the nature of your condition, the general nature of treatment, the risks involved, and the reasonable therapeutic alternatives.

In keeping with the Florida law of informed consent, you are being asked to sign a confirmation that we have discussed all these matters. We have already discussed with you the common problems and risks. Please read carefully. Ask about anything you don't understand, and we will explain it.

In general, chiropractic treatment includes examination, taking of x-rays, manipulation/adjustment, and application of physical therapy modalities. Although their occurrence is extremely remote, some risks are known to be associated with these procedures. These include:

1) Stroke: is the most serious problem associated with spinal manipulation. The results can be temporary or permanent dysfunction of the brain, with a very rare complication of death (1 in 20 million). Spinal manipulations have been associated with strokes that arise from the vertebral artery (located in the neck vertebrae). (This problem occurs so rarely that there is no conclusive data to quantify probability.)

2) Disc Herniations: that create pressure on the spinal nerve or spinal cord are frequently successfully treated by chiropractors. Rarely, treatment may aggravate the problem, resulting in increased low back pain, radicular pain and numbness of a transient nature, Residuals may last for a few days but seldom for longer periods of time.

3) Soft tissue injury: Soft tissue primarily refers to muscles and ligaments. Muscles move bones and ligaments limit joint movement. Rarely, treatment may injure some muscle and ligament fibers. The result is temporary increase in pain and necessary treatments for resolution, but there are no long term affects for the patient.

4) Rib fractures: The ribs are found only in the thoracic spine or middle back. Rarely, a manipulation will fracture a rib bone. This occurs only on patients who have weakened bones from such things as osteoporosis. Osteoporosis can be noted on your x-rays. We adjust all patients carefully, especially those who have indications of osteoporosis on their x-rays.

I hereby authorize and direct Rob Thomson DC, together with associates and assistants of his choice, to provide chiropractic treatment including examination/diagnostics, spinal manipulation/adjustment, carious modes of physical therapy, x-rays and any additional procedures or services that may be deemed necessary or reasonable. This treatment has been explained to me, and alternative methods of treatment (if any) have also been addressed. I have read and understand all information set forth in this document, including any attachments. I acknowledge that I have had the opportunity to ask any questions about the contemplated procedure and that my questions have been answered to my satisfaction. This authorization for and consent to chiropractic treatment is and shall remain valid until revoked.

**Patient's name**______________________________ **Date**________________________
**Signature of patient / guardian**____________________________________________

**Relationship to patient**________________________________

**Client/Patient Testimonial Solicitation and Release Authorization Form**

As part of our ongoing effort to bring the best care to Pensacola and surrounding communities we use several avenues to market to the region including but not limited to; Facebook, Google, Yelp, Instagram, Nearby Now, Twitter etc. We truly appreciate your help in taking the time to honestly review the service you've received here and in helping the community discover the same health benefits as you.

**Purpose of Authorization:** By signing this authorization form, I am providing Robert Thomson Jr DC to solicit, distribute, and share my client testimonial that I provided. Sharing my client testimonial may include posting the information on the company website, posting the testimonial information on Robert Thomson Jr DC's social media pages, and including my testimonial on printed advertisements and promotions. I agree that I am voluntarily sharing my testimonial about services from Robert Thomson Jr DC and I am receiving no financial remuneration from Robert Thomson Jr DC for providing my testimonial and allowing them to use my protected health information for marketing purposes.

**Right to Revoke:** I understand that I have the right to revoke this authorization at any time by providing a written request to the Privacy Officer at Robert Thomson Jr DC I understand that if I choose to revoke this authorization, it will become effective on the day of the revocation of the authorization. Any prior uses and disclosures of my testimonial with my protected health information will not be subject to the revocation of the authorization. I understand that Robert Thomson Jr DC will make it best effort to remove my testimonial and protected health information from the Robert Thomson Jr DC's website and other social media pages.

**Components of my Testimonial:** I understand that the client testimonial for Robert Thomson Jr DC will only include my name, location, photograph, and information provided to the organization in my testimonial. I understand that all other protected health information that Robert Thomson Jr DC creates and maintains for purposes of my care will not be used in my testimonial or for marketing purposes without prior authorization per privacy regulations of the state and Health Insurance Portability and Accountability Act (HIPAA).

NearbyNow – I understand that Robert Thomson Jr, DC will use generic, obfuscated information about my home address for location marketing purposes and may include my first name, and a generic description of the condition treated. For the purposes of NearbyNow posts no other personal information will be utilized including but not limited to last name, age, sex, etc.

By signing below, I agree and acknowledge that I have read and understood all of the elements of this authorization for use of my client testimonial. This authorization will expire 24 months after the date of the signature. After the expiration, I understand that Robert Thomson Jr DC will not be allowed to use my testimonial for any future marketing purposes. It does not require Robert Thomson Jr DC to remove my testimonial from the website or other social media pages unless I specifically request a revocation of this authorization.

Signature: _______________________________________________ Date: _______________

If not patient, Relationship to Patient: _____________________________________________

Name (Printed):______________________________________ `

**Dr. Rob Thomson Jr, DC**
280 N Palafox St
Pensacola, FL 32502
Telephone (850) 637-5281

APPOINTMENT REMINDERS AND HEALTH CARE INFORMATION AUTHORIZATION

Your chiropractor and members of the practice staff may need to use your name, address, phone number, and clinical records to contact you with appointment reminders, information concerning treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not at home or work, a message will be left on your answering machine, with a family member, friend, co-worker or employer. In addition, by signing this form you are giving us authorization to contact you with these reminders and information.

You may restrict the individuals or organizations to which your health care information is released or you may revoke authorization to us at anytime; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Information that we use or disclose based on authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at anytime. (164.524)

This authorization will expire seven years after the date on which you last received services from us.

I authorize you to use or disclose my health information in the manner described above.

| | |
|---|---|
| ______________________________ Patient name printed | ______________________________ Date |
| ______________________________ Patient signature | ______________________________ Authorized provider representative |
| ______________________________ Personal representative printed | ______________________________ Personal representative signature |

________________________________________________________________________

Description of personal representative’s authority to act for patient.