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Parent Request for Psychiatric Evaluation

******THESE FORMS MUST BE COMPLETELY FILLED OUT (AND SIGNED WHERE INDICATED) PRIOR TO YOUR APPOINTMENT.**

Please FAX completed forms to_781-374-7552_ in advance of your appointment to the provider you will be seeing. If you do not have access to a fax machine, you can email your forms (but anything that goes over the internet is not HIPPA compliant).

Consent Statement: By submitting this form I attest that I am consenting to a psychiatric consultation.

Signature:_____ Date_____

Treatment Consultations: I understand that the information gathered for the consultation will be summarized in a report protected as a confidential medical record by the Health Insurance Portability and Accountability Act (HIPAA). Reports will only be forwarded to other providers in response to my signed written medical release of information, and only to those parties that I designate. I know I can read about HIPAA rights at the U.S. Department of Health and Human Services web site at www.hhs.gov/ocr/hipaa/. Initials: _____

Security of information: all reasonable precautions will be taken to maintain the confidentiality of the information to be submitted on this form.

Patient or Authorized person's signature: I authorize SSPS to submit insurance claims on my behalf. I authorize the release of any medical or other information necessary to process my insurance claims.
Signature _____Date_____

South Shore Psychiatric Services, PC. Medical Release of Information (Page 1 of 2)

Patient Name:

DOB:

Address:

Patient and Parent Telephone Contact: Day: Evening:
I, _____ do hereby authorize South Shore Psychiatric Services, PC to obtain health information and reports from providers below and to release health information including copies of my medical and mental health record of care received from South Shore Psychiatric Services, P.C. to :name of person(s), the locations/facilities listed for the purposes described.
****Please include phone and fax number. If you don't have this information, please contact your provider and provide it on this form prior to your appointment. If you would like a family member or your parents to be able to speak with your provider, you must include their name below as well.**
1._Primary Care Physician:__Name: Address:

_____

_____Phone:_____Fax:_____

2. Therapist: Name: Address:

_____

_____Phone:_____Fax:_____

3. Previous Prescriber/Other: Name: Address:

_____

_____Phone:_____ _Fax:_____

Treatment Dates: All Dates: _X_. Purpose Of Request: _X_.Coordination Of Care:_X_
Disability:_X__Insurance: _X__Legal _X_. Other: Specify_____
I authorize the disclosure of my complete record and the following information, which may be included in my record. (GENETIC TESTING, SEXUALLY TRANSMITTED DISEASES, HIV INFORMATION, AIDS OR AIDS RELATED CONDITIONS, ABORTION). ALCOHOL & DRUG ABUSE RECORDS PROTECTED BY FEDERAL CONFIDENTIALITY RULES 42 CFR PART 2. ***Patient Initials _____.
I understand that the provider of information disclosed cannot guarantee that the recipient will not redisclose my health information to a 3rd party. The recipient may not be subject to federal laws governing privacy of health information. However, if the disclosure consists of treatment information about a consumer in a federally-assisted alcohol or drug abuse program, the recipient is prohibited under the federal law from making any further disclosure of such information unless further disclosure is expressly permitted by written consent of the consumer or as otherwise permitted under federal law governing Confidentiality or Alcohol and Drug Abuse Patient Records (42 CFR, Part 2).
I may revoke this authorization in writing at any time, except that the revocation will not have any effect on any action taken by the provider before the provider received written notice of revocation. I further understand that I must provide any notice of revocation in writing to South Shore Psychiatric Services, PC at 160 Old Derby Street, Suite 457, Hingham MA 02043.

Unless otherwise revoked, this authorization will expire automatically within one year unless you insert a preferred date of expiration here_____.

I understand that authorizing the disclosure of health information is voluntary and that I do not need to sign this form to ensure treatment. However, SSPS strongly encourages that communication between our clinicians and your primary care physician be allowed in the event that any medical problems arise while being treated at SSPS.

Patient's Signature_____Date_____

PATIENT FULL NAME:

DATE OF BIRTH:

ADDRESS:

CELL PHONE: EMAIL:

EMERGENCY CONTACT: NAME: CELL PHONE:

IF USING INSURANCE, PLEASE PROVIDE THE FOLLOWING INFORMATION:

NAME OF INSURANCE COMPANY:

ID NUMBER:

GROUP NUMBER:

NAME OF SUBSCRIBER TO INSURANCE:
RELATIONSHIP TO PATIENT:
SUBSCRIBER'S ADDRESS AND PHONE:

SUBSCRIBER'S DATE OF BIRTH:
***Many insurance companies use other companies such as CVS caremark, Express scripts, Optum RX, etc to pay for their medications. PLEASE CHECK WITH YOUR INSURANCE COMPANY TO SEE WHO PAYS FOR PRESCRIPTIONS AND PROVIDE the name of the company and your ID number below so we can do prior authorizations (if needed) for medications that are prescribed.**

_____

_____

PLEASE BRING A COPY OF ALL INSURANCE CARDS TO YOUR FIRST VISIT OR COPY BOTH SIDES AND INCLUDE IN FAX.

Patient's Childhood History			
Developmental Milestones **Developmental milestones include crawling, walking, toilet training, speech and language, self care (dressing and bathing), social skills and self-control.**	Normal	Delayed	**If you had any delays or needed special services in childhood, please explain below:**

Temperament ***In Childhood/adolescence***

	YES	NO	Notes: Comment below on current temperament as an adult
Easy going	Y	N	
Tolerant of frustration	Y	N	
Confident	Y	N	
Tried new things	Y	N	
Social, outgoing	Y	N	
Quiet	Y	N	
Calm	Y	N	
Interactive, made good eye contact	Y	N	
Kind, sensitive to others	Y	N	
Flexible	Y	N	
Independent	Y	N	
Shy/Anxious	Y	N	
Separation Anxiety	Y	N	

Describe the relationships you have with friends, family, authority figures, bosses, etc.

Name	Relationship to you	How do you get along with this person?	Comments
Example: Tom	*Boss*	*We don't get along at all. He doesn't like me and it is evident. OR "We get along great."*	*He is always criticizing my work and I get defensive and argue with him. OR He really appreciates my hard work and we have fun working together.*

Please describe your ability to socialize and to make and keep friends. *Do you make and keep friends easily? Are you comfortable in social situations? OR Is it difficult to make friends? Do you feel nervous in social situations?*

_____

_____

_____

Are you currently working or in college?_____

If yes, where do you work or go to school?_____
What is your role/job title at work?

How are you doing in school/job currently?_____

Do you have any learning disabilities/problems that affect performance?_____

Have you had neuropsychological testing done? Yes No. If yes, please fax a copy to us or bring it to the evaluation with you.

Have you ever been abused or neglected as a child? Yes____ No_____
Are you currently being abused in any way? Yes____ No____. If yes, please explain:

Have you ever experienced a traumatic event that caused you nightmares and has caused you to avoid certain people or places? Yes ___ No___

TRAUMAS	YES	NO	NOTES
Victim of violence	Y	N	
Victim of sexual abuse	Y	N	
Witnessed violence	Y	N	
Separation from parent(s)	Y	N	
Death in family	Y	N	
Out of home placement	Y	N	
Divorce/separation	Y	N	
Other traumatic experience	Y	N	

Do you have a therapist currently? Yes___ No___. If yes, please provide name of therapist:

Date therapy started or ended:

Has therapy been helpful in the past or present? Yes___ No___.

How long have you been going to therapy?

Please describe the Behaviors/symptoms/experiences that brought you to therapy:

Describe your strengths:

Describe your weaknesses:

Do you:

Hit or punch others when angry	Never	Past	Sometimes	Often	Always
Threaten to hurt or kill others	Never	Past	Sometimes	Often	Always
Hurt yourself intentionally (cutting, head-banging)	Never	Past	Sometimes	Often	Always
Own or carry a weapon	Never	Past	Sometimes	Often	Always
Threaten suicide	Never	Past	Sometimes	Often	Always
Attempted suicide	Never	Past	Sometimes	Often	Always

Write your notes regarding dangerous behaviors here:

Challenge those in authority	Never	Past	Sometimes	Often	Always
Manipulate others so you can get what you want	Never	Past	Sometimes	Often	Always
Start Arguments with others	Never	Past	Sometimes	Often	Always
Have trouble getting along with family and/or friends	Never	Past	Sometimes	Often	Always
Are you easily frustrated?	Never	Past	Sometimes	Often	Always
Are you angry or resentful	Never	Past	Sometimes	Often	Always
Are you spiteful or vindictive	Never	Past	Sometimes	Often	Always
Do you annoy others deliberately	Never	Past	Sometimes	Often	Always
Do you blame others for your mistakes	Never	Past	Sometimes	Often	Always

Your notes regarding defiant and disruptive behaviors:

Do you have trouble:

Listening to directions or following through?	Never	Past	Sometimes	Often	Always
Focusing to complete tasks?	Never	Past	Sometimes	Often	Always
Organizing?	Never	Past	Sometimes	Often	Always
Staying seated?	Never	Past	Sometimes	Often	Always
Are you easily distracted?	Never	Past	Sometimes	Often	Always
Are you forgetful in daily activities?	Never	Past	Sometimes	Often	Always
Do you have trouble relaxing, sitting still? Are you Driven or hyperactive?	Never	Past	Sometimes	Often	Always
Do you fidget or squirm when you are seated?	Never	Past	Sometimes	Often	Always
Do you lose or misplace things that you need for your daily activities?	Never	Past	Sometimes	Often	Always
Do you talk too loud or too much?	Never	Past	Sometimes	Often	Always
Are you impatient? Have trouble standing in line or waiting?	Never	Past	Sometimes	Often	Always
Do you interrupt or intrude in conversations?	Never	Past	Sometimes	Often	Always
Do you blurts answers or finish other people's sentences for them?	Never	Past	Sometimes	Often	Always

Please describe problems with focus, concentration, and impulse control:

****If you suspect you have ADHD (or already have a diagnosis of ADHD), please fill out the ADHD rating scale on the website and fax it to the office or bring it with you to the visit.

Do you:

Feel sad	Never	Past	Sometimes	Often	Always
Talk or think about death	Never	Past	Sometimes	Often	Always
Enjoy things less or have you lost interest in things you used to enjoy	Never	Past	Sometimes	Often	Always
Cry	Never	Past	Sometimes	Often	Always
Feel guilty	Never	Past	Sometimes	Often	Always
Feel worthless	Never	Past	Sometimes	Often	Always
Feel hopeless like things will never improve	Never	Past	Sometimes	Often	Always
Feel helpless to make things better	Never	Past	Sometimes	Often	Always
Feel lethargic or lacking energy	Never	Past	Sometimes	Often	Always
Lack motivation	Never	Past	Sometimes	Often	Always
Feel Sick, tired, achy, or have a lot of physical complaints	Never	Past	Sometimes	Often	Always

Have trouble falling asleep	Never	Past	Sometimes	Often	Always
Have trouble staying asleep	Never	Past	Sometimes	Often	Always
Sleep too much	Never	Past	Sometimes	Often	Always
Eat too little (losing weight)	Never	Past	Sometimes	Often	Always
Eat too much (gaining weight)	Never	Past	Sometimes	Often	Always
Have excessive/distorted thoughts or concerns about your body weight	Never	Past	Sometimes	Often	Always
Binge-eat	Never	Past	Sometimes	Often	Always
Make yourself vomiting or using laxatives to lose weight	Never	Past	Sometimes	Often	Always
Go on starvation diets or exercise excessively	Never	Past	Sometimes	Often	Always
Have other depressive behaviors: (specify)	Never	Past	Sometimes	Often	Always
	Never	Past	Sometimes	Often	Always
	Never	Past	Sometimes	Often	Always
	Never	Past	Sometimes	Often	Always

*If you have depressive symptoms, please fill out the depression rating scale and the mood disorder scale on the website and fax or bring it to visit.
Write your notes regarding above symptoms here:

Do you have periods of time when you:

Havie odd or unusual bursts of energy	Never	Past	Sometimes	Often	Always
Shout at others and start fights	Never	Past	Sometimes	Often	Always
Feel unusually self-confident and socially outgoing	Never	Past	Sometimes	Often	Always
Have a decreased need for sleep (sleeping less but not feeling tired)	Never	Past	Sometimes	Often	Always
Are much more talkative than usual	Never	Past	Sometimes	Often	Always
Have pressured speak (talking faster and more)	Never	Past	Sometimes	Often	Always
Feel unusually distracted by things around you	Never	Past	Sometimes	Often	Always
Have trouble concentrating	Never	Past	Sometimes	Often	Always
Are eager to take on many more projects than usual	Never	Past	Sometimes	Often	Always
Feel unusually or excessively interested in sex	Never	Past	Sometimes	Often	Always
Do things that are extremely foolish or risky that are out of character for you	Never	Past	Sometimes	Often	Always

Spend excessive amounts of money	Never	Past	Sometimes	Often	Always
Have other odd mood shifts (specify):	Never	Past	Sometimes	Often	Always
	Never	Past	Sometimes	Often	Always
	Never	Past	Sometimes	Often	Always

Write your notes regarding above symptoms here:

Do you:

Have excessive worries or fears	Never	Past	Sometimes	Often	Always
Have difficulty separating from familiar people	Never	Past	Sometimes	Often	Always
Have panic attacks	Never	Past	Sometimes	Often	Always
Have trouble leaving home	Never	Past	Sometimes	Often	Always
Have checking rituals (checking things multiple times)	Never	Past	Sometimes	Often	Always
Have counting rituals (counting in your head over and over)	Never	Past	Sometimes	Often	Always
Have hand washing rituals (washing excessively due to fear of germs)	Never	Past	Sometimes	Often	Always
Have disturbing thoughts that pop into your head and won't go away	Never	Past	Sometimes	Often	Always
Panic around unfamiliar people	Never	Past	Sometimes	Often	Always
Have physical symptoms when you feel upset	Never	Past	Sometimes	Often	Always
Worry excessively about illness	Never	Past	Sometimes	Often	Always
Feel too nervous to go to school or work	Never	Past	Sometimes	Often	Always
Have nightmares	Never	Past	Sometimes	Often	Always
Feel like you are on a persistent look-out for dangers	Never	Past	Sometimes	Often	Always
List other things that make you anxious (specify):	Never	Past	Sometimes	Often	Always
	Never	Past	Sometimes	Often	Always
	Never	Past	Sometimes	Often	Always

*If you have anxiety symptoms, please fill out the anxiety rating scale on website and fax or bring to visit.
Write your notes regarding above symptoms here:

Do you:

Hears voices that no one else hears	Never	Past	Sometimes	Often	Always
See visions or things that no one else sees	Never	Past	Sometimes	Often	Always
Have odd ideas or beliefs that probably aren't true	Never	Past	Sometimes	Often	Always
Have imaginary friends	Never	Past	Sometimes	Often	Always
Behave in a way that others consider to be odd	Never	Past	Sometimes	Often	Always
Neglect your personal hygiene	Never	Past	Sometimes	Often	Always
Exhibit behaviors that others consider to be strange or bizarre (specify)	Never	Past	Sometimes	Often	Always
	Never	Past	Sometimes	Often	Always
	Never	Past	Sometimes	Often	Always
	Never	Past	Sometimes	Often	Always

Write your notes regarding above symptoms here:

What questions would you like to have answered at this evaluation?
1.
2.
3.

Please note areas of active concern (specifics will be recorded on later pages):

	YES	NO
Behavior dangerous to others	Y	N
Behavior dangerous to self	Y	N
Use of drugs or alcohol	Y	N
Defiance with authority figures	Y	N
Problems with focus and attention	Y	N
Depressed moods	Y	N
Elevated, irritable, or manic moods	Y	N
Anxieties, fears, phobias	Y	N
Confusion about what is real and what is not	Y	N

Duration of symptoms is an important diagnostic consideration. If mood disturbance is a concern, how long are the continuous periods when mood seems distinctly abnormal and you are not your usual self?

	MINUTES	HOURS	DAYS	WEEKS	MONTHS
Duration of continuous mood disturbance					

HOW DO/DID YOU DO IN SCHOOL (PAST OR CURRENT)

Check and note approximately when the problem started:

Reading	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
Math					
Written Expression					
Relationships with Peers					
Following Directions					
Disrupting Class					
Completing assignments					
Organizational skills					

Did/ Do you have an Individualized Education Plan (IEP) or have accommodations in school:

Nature of disability:

Services offered:

Your suggestions for improvement in plan:

Behavior and Consequences:
Do you often behave in a way that ends with consequences in your life, school, work, relationships, etc? If so, please explain. (Example: loss of temper, irritability, lying, lack of motivation, etc.)

What consequences have occurred due to these behaviors? (loss of job, suspension from school, break up of relationship, trouble with the law, etc.)

Are you currently working on these behaviors? If so, what are you doing and is this working for you?

MEDICAL HISTORY

It is important to provide a history of any psychiatric medications that you have taken in the past, including the dates they were taken, and your response to them. Please send a copy of this medical release of information to your previous prescriber with a request for them to fax or mail your medical and medication records. Please request records right away as it often takes time for offices to process.

SSPS CONFIDENTIAL FAX#: 781-374-7552

LIST OF PAST MEDICATIONS

Medication	Dates taken	Response Did it work?	Side Effects	Reason Stopped

LIST OF CURRENT MEDICATIONS (including supplements, vitamins, and medications for medical issues):

NAME OF MEDICATION	DOSE	TIMES TAKEN PER DAY	REASON FOR TAKING IT

MEDICAL HISTORY CONTINUED

PLEASE LIST ANY PAST OR CURRENT MEDICAL PROBLEMS: PLEASE CHECK YES OR NO

	YES	NO		YES	NO
Concussion			Asthma		
Concussion/Traumatic Brain Injury			Heart Problems		
Seizures			Lung Problems		
Blood Clots			Glaucoma		
Abnormal Bleeding			Liver Problems		
Stomach/Bowel Problems			Kidney Problems		

Any other medical problems? Please Describe:

Have you ever had surgery? If so, Please Provide type of surgery and dates:

Do you have any allergies?
Do you have any allergies to drugs? If so, please list:

Are you sexually active? Yes____ No____
If female, are you using a reliable form of birth control? Yes____ No____. If yes, please list name and dose: _____
Is there any chance that you could be pregnant? Yes____ No____

When was your last physical? _____. Date of last Blood Draw:_____

Please contact your primary care doctor and ask them to fax a copy of your last visit, that includes your medical history (including any previous diagnosis of medical or psychiatric disorder and a copy of your most recent labs) to your provider prior to your appt. This will save time during the evaluation process so that your can receive a prescription in a timely fashion (if needed). Without these records, your clinician may not be able to prescribe a medication for you.
FAX #: 781-374-7552

FAMILY HISTORY OF MEDICAL/PSYCHIATRIC DISORDERS

Family History	Yes	No	Who? (Relation to you). Please explain diagnosis or symptoms.
Heart disease	Y	N	
Sudden death (Someone's heart stopped out of the blue)	Y	N	
Diabetes	Y	N	
Psychosis, schizophrenia, or nervous breakdowns	Y	N	
Psychiatric Hospitalizations	Y	N	
Bipolar disorder (or manic-depressive disorder)	Y	N	
Explosive temper/violent behavior	Y	N	
Suicidal thoughts or suicide attempts	Y	N	
Alcohol or drug abuse or addiction	Y	N	
Severe depression	Y	N	
Severe anxiety or panic attacks	Y	N	
Attention-deficit Hyperactivity Disorder (ADHD)	Y	N	
Antisocial or criminal behavior	Y	N	
Other conditions (specify)	Y	N	

****It is important that you are honest with your provider about drug and alcohol use as mixing with certain medications may cause a serious medical problem.**

Has you ever used or abused drugs or alcohol? Yes ___ No___. Please list substance(s) with approximate use dates in the past along with any treatment received:

_____

_____

Has anyone ever been concerned about your alcohol use? Yes ___ No___. If yes, please explain:_____

_____

How often do you currently drink alcohol? #_____ drinks per event, #_____ times per week.

How often do you smoke marijuana? #____times per day, #____ times per week. How much do you smoke at each occurrence? _____

How often do you take other illicit drugs? #____times per day, #___ times per week. Please list drugs used.
Past:_____

Currently: _____

Have you ever had suicidal thoughts or attempted suicide? Yes ___ No___. If yes, When and what led up to this?
_____

Have you ever had homicidal thoughts or violent behavior? Yes ___ No___. Please explain: -
_____

Have you ever been hospitalized for emotional or behavioral problems? Yes ___ No___. If yes, please list:

Name of Hospital	Dates Hospitalized	Reason for Hospitalization

_____

Insurance and Payment Policies (page 1 of 2)

For Blue cross blue shield patients: We accept most Blue Cross Blue Shield plans. However, if you have an out of state BCBS plan or medicare or medicaid in addition to BCBS, they may not cover services at SSPS. You should call to verify if you are covered for services at SSPS. Give them NPI # 1588062244 to be sure you are covered at this office. **Co-payments must be made at the time of the visit by cash, check, credit card, debit or medical benefit card. An invoice of fees for services provided by SSPS will be sent directly to BCBS on your behalf but you are personally responsible for any fees that are not covered by your plan. If you have a high deductible, you will need to pay out of pocket at the time of the visit until your deductible is met. An invoice for services will be sent to BCBS so it will be applied to your deductible. If your insurance coverage changes at any time, it is your responsibility to provide the new insurance card to the clinician at the time of the visit. If this is not provided, the claim may be denied and you will be responsible for the payment.**

For all other patients: SSPS is not on any insurance panels (other than BCBS) so we are considered an "out of network provider". We do not bill insurances other than BCBS. Most PPO insurance plans will reimburse patients for out of network visits but rates vary so you should check with your company. **All fees for services must be paid at the time of the visit by cash, check, credit, debit or medical benefit card.** We will provide a receipt for you to submit to your insurance company for reimbursement. We advise you to check with your insurance about coverage and deductibles so you will not be surprised by fees that they don't cover.

All patients are responsible for payment at the time of the services that are not covered by insurance.

Office Cancellation and Overdue Balance Policy (2 of 2)

All appointments **must be cancelled 24 hours in advance** in order to avoid being charged for the missed appointment. (Insurance companies do not cover missed visits and our clinicians rely on income from scheduled appointments). **Due to the high number of patients not showing up for appointments, last minute cancelations and unpaid overdue balances, we are now forced to collect credit or debit card information to keep on file.** Your credit card will be charged ONLY FOR MISSED VISITS/ LAST MINUTE CANCELATIONS AND FOR OVERDUE BALANCES > 90 DAYS. You will have the option to use another method of payment should you choose. **In the event of a missed appointment, that has not been canceled at least 24 hours in advance, your card will be charged for the minimum cost of a 30-minute appointment ($150).** **We have a waiting list for patients who are anxious to get in for an appointment as soon as possible. If appointments are canceled at least 24 hours in advance, we can fill that slot with someone on the waiting list and you can avoid being charged.

We send out text reminders of appointments as a courtesy. However, you are responsible to keep track of your appointment. *Not receiving a text reminder does not absolve you from being financially responsible for a missed appointment.

Credit or Debit card information

Name on Credit or Debit Card:_____
Please circle: Master card Visa American Express Debit Card

Card number_____

3 DIGITS on back of card_____ (**4 DIGITS** FOR AMERICAN EXPRESS on front of card)_____

Expiration Date: _____ **Zip code:** _____

I acknowledge that I have read this policy and that I am responsible for fees that are not covered by my insurance company and I give permission for SSPS to charge my credit card for the fees noted above only.

Client Signature_____ **Date:**_____
****THIS PAGE MUST BE COMPLETELY FILLED OUT AND SIGNED PRIOR TO SEEING YOUR PROVIDER AT THE FIRST VISIT.**

SSPS Prescription Refill Policy

It is important to keep track of your prescriptions so that you do not run out of medications. At your visit, you will receive enough medication to last until your next scheduled visit. If you need to cancel an appointment, make sure to reschedule in a timely fashion so as not to run out of medication. In the event that you do run out, refill requests can be called in to 781-837-8833. **We require 7 days notice for any refill requests as we are not in the office every day and may not be available for non-emergencies during vacations, conferences, etc. Refills are not processed on Fridays, Saturdays or Sundays as the office is closed.** We do not accept refill requests from pharmacies so do not rely on them to call the office as they will not be filled. Refill requests are only accepted from our patients or their guardian directly by phone at 781-837-8833.

*****ALL PATIENTS MUST BE SEEN AT LEAST ONCE EVERY 3 MONTHS TO ENSURE PROPER MONITORING AND GUIDANCE AND TO OBTAIN PRESCRIPTION REFILLS.**

EMERGENCIES ONLY

For true medical or psychiatric emergencies, go to the nearest emergency room and have the ER doctor contact your provider: Dr. Mary Ann McDonnell at 781-424-5782.

**This number should not be used unless it is a true psychiatric/medical emergency! For non-emergency issues, please call the main office number at 781-837-8833 and someone will get back to you within 24 working hours on Mondays through Fridays. Messages are not routinely checked on the weekends. I have received a copy and I agree to comply with the office policies.

Signature_____Date_____