Riverchase Dermatology And Cosmetic Surgery

Patient Information Form

Please complete both sides of this form in ink and sign where indicated.

Spa Blue MD AT RIVERCHASE

PATIENT INFORMATION

Patient Name (last, first, middle initial) _____ Date ____ / ____ / _____

Date of Birth: ____ / ____ /_____ Social Sec. # _____ Gender: Male Female

Race _____ Ethnicity _____ Language _____ ☐ Decline

Mailing Address: Street _____

City _____ State _____ ZIP _____

Alternate Address: _____

Primary Phone (_____) _____ Alternative Phone (_____) _____

Email Address: _____

(We will never give out your email address or send personal medical information via email without your permission.)

Please check yes or no to authorize Riverchase Dermatology to contact you via email for appointment reminders, practice updates and informational promotions.

Yes _____ No _____

Preferred method of contact: ☐ Phone ☐ Email ☐ Letter

Primary Care Physician: _____ Referring Physician: _____

Marital Status: (Circle one) Single Married Divorced Widowed Separated

Parent, Spouse or Responsible Party (If different from patient)

Name (last, first, middle initial) _____

Date of Birth ____ / ____ / _____ Social Sec. # _____ Gender: Male Female

Mailing Address: Street _____

City: _____ State: _____ ZIP: _____

Alternate Address _____

Primary Phone (_____) _____ Alternative Phone (_____) _____

Email Address _____

INSURANCE INFORMATION

Insurance Coverage – Primary

Insurance Company Name _____

Name of Policy Holder (Insured) _____ Date of Birth ____ / ____ / ____

Relationship to Insured: Self Spouse Child Other _____

Employer _____ Employer Address _____

Insurance Coverage – Secondary (if applicable)

Insurance Company Name _____

Name of Policy Holder (Insured) _____ Date of Birth ____ / ____ / ____

Relationship to Insured: Self Spouse Child Other _____

Employer _____ Employer Address _____

Office use only: Office Location: _____ Acct Number: _____ Attach a copy of Patient's insurance card(s) (front & back) Staff Initials: _____

Verify Form is completely filled out Staff Initials: _____

Emergency Contact Information

Name of Friend or Relative: _____

Relationship to Patient: _____

Address: _____

_____

Daytime Phone: (___) _____

Evening Phone: (___) _____

Pharmacy Information

Pharmacy Name: _____

Address/cross roads: _____ zip code: _____

Phone: (___) _____ Fax: (___) _____

RIVERCHASE DERMATOLOGY
AND COSMETIC SURGERY

How did you learn about Riverchase?

- ☐ Newspaper (specify) _____
- ☐ Magazine (specify) _____
- ☐ Physician Referral (specify) _____
- ☐ Family/Friend (specify) _____
- ☐ Phone Book (specify) _____
- ☐ TV Network (specify) _____
- ☐ Website/Search Engine (specify) _____
- ☐ Other (specify) _____

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize the release of medical information to my primary care or referring Physician, to Consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the Riverchase Physician/Provider if applicable.

Responsible Party Signature: _____ **Date** ____ / ____ / _____

FOR MEDICARE PATIENTS ONLY

Medicare Authorization

I request that payment for authorized Medicare benefits be made on my behalf to Riverchase Dermatology (RCD) for any services furnished to me by providers of RCD. I authorize RCD to release to the CMS and its agents any information needed to determine these benefits payable for related services.

Medicare is not always the Primary insurance. Federal regulations REQUIRE that we obtain information to determine if another insurer may be primary to Medicare;

Yes	No	
☐	☐	Do you or your spouse work in a company which has more than 20 employees and have coverage through the insurance at the job?
☐	☐	Are you covered by an HMO/PPO which makes Medicare secondary?
☐	☐	Is this illness/injury covered by the VA (Veterans Administration)?
☐	☐	Is this illness/injury covered by the Federal Black Lung or End Stage Renal Disease Program?
☐	☐	Is this illness/injury due to an automobile accident?
☐	☐	Is this illness/injury due to work related causes?

Patient Signature: _____ **Date** ___ / ___ / ____

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Patient Name:_____ Date:_____ DOB:_____

Past Medical History: (please circle all that apply)

Anxiety	Depression	Hyperthyroid
Arthritis	Diabetes	Leukemia
Asthma	End Stage Renal Disease	Lung Cancer
Atrial fibrillation	GERD	Lymphoma
Bone Marrow Transplant	Hearing Loss	Prostate Cancer
BPH	Hepatitis	Radiation Treatment
Breast Cancer	Hypertension	Seizures
Colon Cancer	HIV/AIDS	Stroke
COPD	High Cholesterol	
Coronary Artery Disease	Hypothyroid	**NONE**

Other: _____

Past Surgical History: (please circle all that apply)

Appendix Removed: (Appendectomy)	Liver: Hepatectomy
Bladder Removed (Cystectomy)	Liver: Liver Transplant
Mastectomy (Right, Left, Bilateral)	Liver: Shunt
Lumpectomy (Right, Left, Bilateral)	Ovaries Removed: Endometriosis
Breast Biopsy (Right, Left, Bilateral)	Ovaries Removed: Ovarian Cancer
Colon/Colectomy: Colon Cancer Resection	Ovaries Removed: Cyst
Colon/Colectomy: Diverticulitis	Ovaries: Tubal Ligation
Colectomy: IBD	Pancreas: Pancreatectomy
Colectomy: Colostomy	Prostate: Biopsy
Gallbladder Removed: (Cholecystectomy)	Prostate: Cancer
Heart: Biological Valve Replacement	Prostate: TURP (Prostate Removal)
Heart: CABG (Bypass)	Rectum: APR
Heart: Transplant	Rectum: Low Anterior Resection
Heart: Mechanical Valve Replacement	Skin: Basal Cell Carcinoma
Heart: PTCA (Angioplasty)	Skin: Melanoma
Joint Replacement, Knee: (Right, Left, Bilateral)	Skin: Skin Biopsy
	Skin: Squamous Cell Carcinoma
Joint Replacement, Hip: (Right, Left, Bilateral)	Spleen
	Testicles Removed (Right, Left, Bilateral)
Kidney: Biopsy	Uterus: (Hysterectomy) Fibroids
Kidney Stone Removal	Uterus: (Hysterectomy) Uterine Cancer
Kidney Transplant	Uterus: (Hysterectomy) Cervical Cancer
Kidney: Nephrectomy (Right, Left)	**None**

Other: _____

_____

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Skin Disease History: (please circle all that apply)

Acne	Dry Skin	Poison Ivy
Actinic Keratoses	Eczema	Precancerous Moles
Asthma	Flaking or Itchy Scalp	Psoriasis
Basal Cell Skin Cancer	Hay Fever/Allergies	Squamous Skin Cancer
Blistering Sunburns	Melanoma	**NONE**

Other: _____

Do you wear Sunscreen? Yes No
If yes, what SPF? _____
Do you tan in a tanning salon? Yes No
Do you have a family history of Melanoma? Yes No
If yes, which relative(s)? _____

Medications: (Please enter all current medications & dosage)

Allergies: (Please enter all drug allergies)

Social History: (Please circle all that apply)

Cigarette Smoking:

Never smoked
Currently Smokes
Has smoked in the past
Former Smoker

Alcohol Use:

None
Less than 1 drink per day
1-2 drinks per day
3 or more drinks per day

Family History: Significant disease & illness, skin or otherwise. Only first degree biological relatives- Mother, Father, Brother, Sister and Children)

CONDITION	RELATIVE

RIVERCHASE DERMATOLOGY
AND COSMETIC SURGERY

Review of Systems: Are you currently experiencing any of the following? (Please check "YES" or "NO")

SYMPTOM	YES	NO	SYMPTOM	YES	NO
Abdominal Pain			**Muscle Weakness**		
Anxiety			**Neck Stiffness**		
Bloody Stool			**Night Sweats**		
Bloody Urine			**Problems with bleeding**		
Blurred Vision			**Problems with healing**		
Chest Pain			**Scarring (Hypertrophic/Keloids)**		
Depression			**Seizures**		
Fever or Chills			**Shortness of breath**		
Hay Fever			**Thyroid problems**		
Headaches			**Unintentional weight loss**		
Immunosuppression			**Wheezing**		
Joint Aches			**Other:**		

Alerts: (please check all that apply)

- ☐ Allergy to Adhesive
- ☐ Blood Thinners
- ☐ Defibrillator
- ☐ Hepatitis B/C
- ☐ History of Melanoma
- ☐ HIV/AIDS
- ☐ Iodine Allergy
- ☐ Lactating/Breastfeeding
- ☐ Latex Allergy
- ☐ Lidocaine Allergy
- ☐ Medication Allergy- PLEASE MAKE SURE ALL ALLERGIES ARE LISTING ON PREVIOUS SHEET
- ☐ Pacemaker
- ☐ Polysporin Allergy
- ☐ Pregnant or Planning Pregnancy
- ☐ Preoperative Antibiotics

RIVERCHASE DERMATOLOGY

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RIVERCHASE DERMATOLOGY FINANCIAL POLICY

Understanding your financial responsibility is an essential component in establishing and maintaining a strong patient/practice relationship. In order to achieve this, we offer the following information regarding our insurance and financial policies.

Your insurance is a contract between your insurer and you. It is your responsibility to know and understand the terms, guidelines and limitations of your plan. It is also your responsibility to advise us of any changes in your insurance, your address or your employer.

Medicare & Contracted Insurance Plans
If you are on traditional Medicare or are a member of a health plan that we participate with, we will submit your claim to your insurance company. Our staff will verify your benefits and collect any co- payment, co-insurance and/or deductible at the time services are rendered as required by your insurance carrier. You will be billed in full for any services that your health plan deems as "not a benefit" or a "non-covered service".

Secondary/Supplemental Insurance Plans
We are happy to file secondary and supplemental claims as a courtesy. In the case of non-contracted secondary carriers, the balance will become patient responsibility 30 days after that claim is filed.

Non-Contracted Commercial Insurance Plans
If we do not participate with your insurance carrier, payment in full will be required by you at the time services are rendered. Our billing department will file a claim to your insurance company as a courtesy to you.

Medicare Replacement Plans
We will accept and file all PFFS (Private Fee for Service) plans. Patients are responsible for all deductibles, coinsurances and co pays. For all other plans see contracted and non-contracted insurance plans above.

Medicaid
We are not contracted with any Medicaid plan. Medicaid patients seeking services are responsible for payment in full at the time of service.

Minors
A parent or legal guardian must accompany all patients under the age of 18 to authorize treatment and financial arrangements. If this is a custodial parent, we can submit the charges to another parent's insurance, however, the parent presenting the child for care will be billed for the balance not covered by the insurance. Any patient over the age of 18 will be held financially responsible for all charges incurred.

Missed Appointments
Missed appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. Cancellations must be made 24 hours in advance of the scheduled appointment or we reserve the right to assess a fee.

Medical Records
Copies of pathology reports are provided to you or another physician at no charge. Any additional medical records requests and/or completion of forms (e.g. disability, life insurance, cancer policies, etc.) are subject to processing fees determined by state law and contractual agreements. Please be advised that medical records requests require time to be processed and cannot be provided the same day requested.

Collection Fees
Statements are sent out monthly for patients with personal balances. Payment is due upon receipt of the statement. If you are unable to pay the balance in full, please contact our billing department at (239) 313-2517. Personal balances over 90 days from the date of service will be sent to our collection agency. In the event an account is turned over to an outside collection agency, patients will be responsible for any collection fees including court costs, attorney fees and collection agency charges.

Returned Check Fee
A $25 fee will be added to your account balance in addition to the amount of the check returned for insufficient funds. This total must be paid by cash or credit card within 14 days.

Pathology Fees
Riverchase Dermatology has an on-site lab and pathologist who perform the slide preparation and interpretation of our patients' biopsy specimens. Fees associated with this service are separate from the procedure performed by your treating provider.

Depending upon specific factors, your provider may send the specimen to an outside lab for slide processing and interpretation. In those instances, patients or their insurance will receive a bill from the outside lab.

Riverchase Dermatology providers reserve the right to send their patients' specimens to the most qualified dermatopathologist of his or her choosing. Therefore, **if your insurance requires the use of a specific lab, it is your responsibility to provide us with that information prior to being seen. Failure to do so may result in additional out-of-pocket costs to you. Name of required lab (if applicable)** _____

Cosmetic Services
Patients are financially responsible for all cosmetic procedures at the time of service. This office does not bill insurance companies for cosmetic procedures. For more detailed information, please see one of our cosmetic coordinators.

My signature below indicates that I have read, understand and will comply with the information contained within this financial policy. A copy of this policy is available upon request.

_____ _____

(Signature of Patient or Guardian) **Date**

For Office Use Only:
SIGNED COPY TO CHART **Staff Initials** _____ **Date** _____

Riverchase Dermatology and Cosmetic Surgery
Cosmetic Financial Policy

We consider it a privilege that you have chosen us for your aesthetic rejuvenation goals. We strongly believe that an informed patient is a good patient and that your clear understanding of our financial policy is important to our professional relationship. Therefore, we strive to inform you of all the medical aspects of your needs as well as advise you on our payment policies for all cosmetic in-office and surgical procedures.

Consultation Fees

The fee for a cosmetic surgery consultation is $100.00 and is payable at the time of service. If, after your consultation, you have the surgery performed within one year, the fee for the consultation will be deducted from the total surgical fee. The $100.00 consultation fee will be waived for established cosmetic patients of the practice. Consultations for non-surgical facial rejuvenation (Botox®, Restylane®, Juvederm®), laser procedures or aesthetic services including skin care and makeup are complimentary unless with a plastic surgeon where a $100 consultation fee may be charged and deducted from cost of treatment.

Surgery Fees

Payment for cosmetic surgery is to be paid in full before the surgery is performed. Scheduling a surgery will require a 20% deposit. Payment for the balance of the surgery fee is due at the pre-operative exam or two weeks prior to the procedure, whichever comes first. If fees are not provided 5 business days before the scheduled procedure the surgery may be cancelled. Surgical deposits and payments are non-refundable.

Office Treatment Fees

Fees for in-office treatments such as Botox®, Restylane®, Juvederm®, chemical peels, laser hair removal, vascular lasers, laser resurfacing and other similar procedures are priced either on a per treatment basis or as a treatment package, and are payable in full at the time of your appointment. Treatments are nonrefundable. Certain cosmetic services require a deposit at time of service. Deposits are non-refundable. An appointment can be moved and deposit applied to a different date of service if patient notifies practice at a minimum of 48 hours before their scheduled treatment.

Skin Care and Retail Products

We accept returns on retail items within 7 days of product purchase for account credit only if there is dissatisfaction with the product after minimal use or a product reaction. **Returns are applicable for account credit only**. Unfortunately, due to the nature of the product being pharmaceutical, we cannot accept returns on items requiring a prescription including Tretinoin (Retin A), Tri-Luma, and Latisse.

Payment Options

We accept Visa, Mastercard, American Express, Discover, Cash and Personal Checks as forms of payment. We also recommend CareCredit Patient Financing or Prosper financing, a special program for cosmetic and plastic surgery patients. With CareCredit you can finance your cosmetic procedures and surgery without upfront costs, annual fees, or pre-payment penalties.

Gift cards are available for purchase and are applicable towards aesthetic services and non-prescription retail product.

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The practice of medicine and surgery is not an exact science, and therefore, reputable practitioners cannot guarantee results. The results of certain procedures may not last as long as expected or meet the degree of your expected improvement. It is important that you understand that all services are non-refundable. Additionally, if complications should develop or surgical revisions are necessary, you may incur additional costs.

Patient Signature: _____ Date: _____

RIVERCHASE DERMATOLOGY
Spa Blue MD AT RIVERCHASE
15051 S Tamiami Trail, Suite 203, Fort Myers, FL 33908

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION - Your protected health information may be used by your treating providers, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, we may need to give your health plan information about your treatment for reimbursement purposes. We may also tell your health plan about a treatment you are going to receive to obtain approval or to determine whether your plan will cover the treatment.

Healthcare Operations: We may use and disclose protected health information about you for operations of our health care practice. These uses and disclosures are necessary to run our practice and make sure that all of our patients receive quality care. For example, we may use health information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine health information about many patients to decide what additional services we should offer, what services are not needed or whether certain new treatments are effective. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your provider is ready to see you. We may use or disclose your information, as necessary, to contact you to remind you of your appointment or inform you of the need for an appointment, and inform you about health related benefits and services that may interest you.

We may use or disclose your protected health information in the following situations without your authorization. These situations may include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law. A separate authorization is required for uses and disclosures of your protected health information for psychotherapy notes, marketing purposes, and sale of protected health information. You may be contacted for fundraising purposes, but you have the right to opt out of such communications. **You may revoke the authorization**, at any time, in writing, to the extent that your physician or the physician's practice has taken action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

You have the right to inspect and copy your protected health information (fees may apply) - Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protective health information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

You have the right to request a restriction of your protected health information - this means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to your request for restriction, however if we do agree to restrict the use or disclosure of your protected health information, we must abide by that restriction, except in emergency circumstances when the information is required for your treatment. You may request a restriction on certain disclosures to your health plan if the disclosure is purely for carrying out payment or health care operations and the requested restriction is for services paid out-of-pocket. You may terminate your request for restriction at any time. We may also terminate a request that we have granted, after we have informed you in writing. All requests for restriction and termination of restriction must be submitted in writing to our Compliance Officer.

You have the right to receive confidential communications - you have the right to request confidential communications from us, upon request, even if you have agreed to accept this notice alternatively (i.e. electronically).

You have the right to request an amendment to your protected health information - if we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to be notified if your health information is breached - if a breach of your unsecured protected health information occurs, you will be notified in writing by our office.

Complaints - You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer at 800-591-3376. We will not retaliate against you for filing a complaint.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak to our Compliance Officer at 800-591-3376. We keep a current copy of the notice on display in our office and on our website, www.RiverchaseDermatology.com.

RIVERCHASE DERMATOLOGY
AND COSMETIC SURGERY

Riverchase Dermatology offers comprehensive services and plans of treatment that may include care from multiple providers (Physicians, Physician Assistants or Nurse Practitioners). Some insurance policies may dictate that an additional copay be collected or higher out of pocket costs than anticipated.

Ultimately it is the policy holder's responsibility to know and understand the terms, guidelines, and limitations of the individual plan they have selected with their chosen Health Insurance Carrier.

Should any questions arise regarding the specific terms of the selected policy you purchased, or any additional fees determined to be "member responsibility," please contact the Member Service line, set in place by your Health Insurance Carrier.

Riverchase Dermatology Pathology Notice

Please note: Additional pathology charges may be incurred in the event specialized testing is required to make a definitive diagnosis. Often this decision is determined by the dermapathologist at the time of processing the lab specimen. These additional tests or staining procedures are done to ensure the most complete and accurate diagnosis is achieved.

A final bill from our office will not be determined until all pathology results and reports are completed.

RIVERCHASE DERMATOLOGY
AND COSMETIC SURGERY

RIVERCHASE DERMATOLOGY

15051 S. TAMIAMI TRAIL, SUITE 203
FORT MYERS, FL 33908

SPA BLUE MD
AT RIVERCHASE

HIPAA Notice of Privacy Practices Acknowledgement & Authorization

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

MAY WE CALL YOUR HOME AND LEAVE A MESSAGE TO CALL OUR OFFICE BACK? ☐ YES ☐ NO

MAY WE PHONE YOU AT WORK AND LEAVE A MESSAGE TO CALL OUR OFFICE BACK? ☐ YES ☐ NO

DO WE HAVE YOUR PERMISSION TO TALK TO FAMILY MEMBERS OR OTHER INDIVIDUALS? ☐ YES ☐ NO

IF YES, PLEASE PROVIDE THE NAMES, PHONE NUMBER & RELATION TO YOU:

Name:_____ Phone:_____ Relation:_____

Name:_____ Phone:_____ Relation:_____

Name:_____ Phone:_____ Relation:_____

OUR OFFICE WILL MAIL BENIGN RESULTS TO THE PATIENT. THESE RESULTS ARE IN THE FORM OF A POSTCARD, ADDRESSED TO THE PATIENT. UNLESS TOLD OTHERWISE, THESE RESULTS WILL BE MAILED TO YOUR HOME ADDRESS. PLEASE NOTIFY OUR OFFICE IF YOU WANT THESE RESULTS MAILED TO AN ALTERNATE ADDRESS.

By signing this form, I acknowledge that I have received or have been given the opportunity to receive a copy of the Riverchase Dermatology Notice of Privacy Practices and have also been given an opportunity to ask questions. A copy of this consent will be included in my chart for future reference.

SIGNATURE:_____ **DATE:**_____

RIVERCHASE DERMATOLOGY
AND COSMETIC SURGERY

Patient Communication Consent Form

Text Message Account Alerts

As part of the implementation of a new Practice Management system, Riverchase Dermatology and Cosmetic Surgery now have the advantage of communicating appointment reminders via text message with our patients.

I authorize Riverchase Dermatology and Cosmetic Surgery to send text messages appointment reminders to me on my provided cell phone number. I understand that I may reply with various commands to receive account information. By accepting these terms, I agree to receive text messages from the practice. Text charges from your cell phone provider may apply.

My signature below indicates that I represent and warrant that I am the person legally responsible for use of the account, and that I agree to the terms and conditions for the use of the text messaging services. I understand that I may opt out of text message communication at any time.

Signature _____ Date _____