



# Southwest Medical Group Plastic Surgery

Southwest Washington Health System

Allen Gabriel, MD • Brinda Thimmappa, MD  
505 NE 87<sup>th</sup> Avenue, Building A, Suite 250 • Vancouver, WA 98664  
360.514.1010 office | 360.514.1011 fax  
www.swplasticsurg.com

Name: \_\_\_\_\_  
Last First

Address: \_\_\_\_\_  
City, State Zip

Phone: \_\_\_\_\_  
Home Cell/Alternate

Marital Status:  Single  Married  Divorced  Widowed Sex:  Male  Female

DOB: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

**Patient Insurance Information:** Please present insurance cards to receptionist.

PRIMARY Insurance Name: \_\_\_\_\_

Address: \_\_\_\_\_  
City, State, Zip

Name of Insured: \_\_\_\_\_ DOB: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Co-pay Amount: \_\_\_\_\_

SECONDARY Insurance Name: \_\_\_\_\_

Address: \_\_\_\_\_  
City, State, Zip

Name of Insured: \_\_\_\_\_ DOB: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Co-pay Amount: \_\_\_\_\_

**Emergency Contact:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_  
City, State, Zip

Home Phone: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_

**Assignment of Benefits – Financial Agreement**

I hereby give lifetime authorization for payment of insurance benefits to be made directly to Southwest Medical Group Plastic Surgery, and any assisting physicians for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default I agree to pay all costs of collections and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Your Signature: \_\_\_\_\_ Date: \_\_\_\_\_



### Pediatric Female Questionnaire:

#### **Constitutional**

- Failure to Thrive  Yes  No
- Fatigue  Yes  No
- Obesity  Yes  No
- Unexplained Fevers  Yes  No

#### **Ophthalmology**

- Apparent Vision Problems  Yes  No
- Drainage From Eyes  Yes  No
- Glasses/Contacts  Yes  No
- Lazy Eye  Yes  No

#### **ENT/Respiratory**

- Apparent Hearing Problem  Yes  No
- Ear Pain  Yes  No
- Ear Drainage  Yes  No
- Nasal Congestion  Yes  No
- Nosebleeds  Yes  No
- Frequent Runny Nose  Yes  No
- Snoring  Yes  No
- Dental Problems  Yes  No
- Fluoridated H2O Source  Yes  No
- Hoarseness  Yes  No
- Persistent Sore Throat  Yes  No
- Thrush  Yes  No
- Thumb Sucking  Yes  No
- Speech Problems  Yes  No
- Breathing Problems  Yes  No
- Chronic Cough  Yes  No
- Trouble Breathing  Yes  No
- Exposure Tobacco Smoke  Yes  No
- Exposure to TB  Yes  No
- Nosebleeds  Yes  No
- Wheezing  Yes  No

#### **Cardiology**

- Chest Pain  Yes  No
- Cyanotic Spells  Yes  No
- Edema  Yes  No
- Poor Exercise Tolerance  Yes  No

#### **Gastroenterology**

- Abdominal Pain  Yes  No
- Anorexia  Yes  No
- Constipation  Yes  No
- Daily Multivitamin  Yes  No
- Diarrhea  Yes  No
- Eating Dirt/Paint/Plaster  Yes  No
- Feeding Intolerance  Yes  No
- Vomiting  Yes  No
- Nausea  Yes  No

#### **Genitourinary**

- Diaper Rash  Yes  No
- Dysuria  Yes  No
- Enuresis  Yes  No
- Hematuria  Yes  No
- Irritated External Genitalia  Yes  No
- Toilet Training Problems  Yes  No
- Vaginal Discharge  Yes  No
- Sexual Abuse  Yes  No

#### **Musculoskeletal**

- Limb Pain  Yes  No
- Joint Pain  Yes  No
- Joint Swelling  Yes  No
- Gait Abnormality  Yes  No
- Weakness  Yes  No

#### **Dermatology**

- Acne  Yes  No
- Atypical Moles  Yes  No
- Atopic Dermatitis  Yes  No
- Eczema  Yes  No
- Gynecomastia  Yes  No
- Itching Skin  Yes  No
- Jaundice  Yes  No
- Rash  Yes  No
- Seborrhea  Yes  No
- Skin Lesions  Yes  No

#### **Neurology**

- Abnormal Tone  Yes  No
- Breath Holding Spells  Yes  No
- Developmental Delay  Yes  No
- Dizziness  Yes  No
- Fainting  Yes  No
- Headache  Yes  No
- Incoordination  Yes  No
- Involuntary Movements  Yes  No
- Involuntary Vocalization  Yes  No
- Poor Sucking/Feeding  Yes  No
- Starring/Unresponsive  Yes  No
- Spells  Yes  No
- ADD/ADHD  Yes  No
- Seizures  Yes  No

#### **Hematology**

- Excessive Bruising  Yes  No
- Excessive Bleeding  Yes  No
- Lymphadenopathy  Yes  No

#### **Endocrinology**

- Delayed Puberty  Yes  No
- Hair Loss  Yes  No
- Polydipsia  Yes  No
- Polyuria  Yes  No
- Precocious Puberty  Yes  No

#### **Psychology**

- Alcohol Use  Yes  No
- Drug Use  Yes  No
- Tobacco Use  Yes  No
- HIV Exposure  Yes  No
- Sleep Disturbances  Yes  No
- Discipline Problems  Yes  No
- Emotional Problems  Yes  No
- Personality Change  Yes  No
- School Problems  Yes  No
- Temper Tantrums  Yes  No



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Name: \_\_\_\_\_  
Last First

### Primary Care Provider:

### Referring Provider:

DOB: \_\_\_\_\_  
Occupation: \_\_\_\_\_  
Place Of Birth: \_\_\_\_\_

Marital Status: \_\_\_\_\_  
Do you smoke? Yes No Packs per day: \_\_\_\_\_  
Alcohol Use: Yes No Frequency: \_\_\_\_\_

### Medications Taken Regularly (including herbal supplements, teas, vitamins, birth control, etc.):

Medication:	Reason:	Last Dose:	Medication:	Reason:	Last Dose:

### Medical History:

Do you have a history of:

Hypertension Yes No  
High Cholesterol Yes No  
Diabetes Yes No  
Stroke Yes No  
Heart Disease Yes No  
Kidney Disease Yes No

Other: \_\_\_\_\_  
\_\_\_\_\_

### Allergies:

Are you allergic to:

Tetanus Antitoxin Yes No  
Penicillin Yes No  
Sulfa Yes No  
Other Drugs Yes No

List: \_\_\_\_\_  
\_\_\_\_\_

### OB/GYN:

Started menstruating at age: \_\_\_\_\_  
Date of last pap: \_\_\_\_\_  
Date of last mammogram: \_\_\_\_\_  
Number of pregnancies: \_\_\_\_\_  
Number of births: \_\_\_\_\_  
Breast Feeding: Yes No

### Operations:

**Year**  
Tonsils Yes No \_\_\_\_\_  
Appendix Yes No \_\_\_\_\_  
Gall Bladder Yes No \_\_\_\_\_  
Stomach Yes No \_\_\_\_\_  
Breast Yes No \_\_\_\_\_  
Uterus/ovaries Yes No \_\_\_\_\_  
Prostate Yes No \_\_\_\_\_  
Hernia Yes No \_\_\_\_\_  
Thyroid Yes No \_\_\_\_\_  
Other \_\_\_\_\_

### Family History: Has any blood relative had any of the following (circle yes or no and indicate relationship):

Bleeding Tendencies Yes No \_\_\_\_\_  
Heart Disease Yes No \_\_\_\_\_  
Tuberculosis Yes No \_\_\_\_\_  
High Blood Pressure Yes No \_\_\_\_\_  
Kidney Disease Yes No \_\_\_\_\_  
Migraine Headache Yes No \_\_\_\_\_  
Diabetes Yes No \_\_\_\_\_  
Thyroid Trouble Yes No \_\_\_\_\_  
Cancer Yes No \_\_\_\_\_

### Present age or age at death

If living, indicate health (good, fair, poor); If deceased, indicate cause

Father: \_\_\_\_\_

Mother: \_\_\_\_\_

### Brothers or Sisters:

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

### Children:

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_



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Patient Vitals (to be filled out by clinic staff):			
BP		HR	
Temp		Weight & Height	

Please tell us why you are here today (check all that apply):

**Cosmetic Surgery of the Face:**

- Brow lift
- Eyelid Surgery
- Botox
- Facial Resurfacing
- Face Lift
- Lip Enlargement
- Neck Lift
- Otoplasty

**Cosmetic Surgery of the Breast:**

- Breast Enlargement
- Revisionary Breast Surgery (patients with prior breast surgery)
- Breast Lift
- Breast Reduction

**Body Contouring:**

- Liposuction
- Tummy Tuck
- Thigh Lift
- Buttock Lift
- Lower Body Lift
- Gynecomastia (male chest reduction)
- Arm Lift
- Labiaplasty

**Reconstructive Consult/Follow-Up:**

- Skin Cancer
- Wound Healing
- Keloid Scar
- Burn Reconstruction
- Scar Evaluation
- Port Wine Stain

**Skin Care and Anti-Aging:**

- Preventative Skin Care
- Chemical Peels
- Laser Treatment
- Fine lines and Wrinkles

**Other:**

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

**Please list your daily skin care regimen:**

**How did you hear about our services:**

- Website
- Newspaper Article/Ad
- Magazine Article/Ad
- Emergency Room
- Other: \_\_\_\_\_

**Who may we thank for referring you to our practice:**

Friend or Family Member: \_\_\_\_\_

May we have your e-mail address to keep you updated on specials: \_\_\_\_\_



# Southwest Medical Group

Plastic Surgery

Southwest Washington Health System

## PHOTOGRAPHIC RELEASE AND CONSENT

I, \_\_\_\_\_ agree that **Dr. Gabriel and/or Dr. Thimmappa** or designated representatives or the practice may take and use preoperative and postoperative photographs of my person for confidential clinical record purposes, and that such photographs shall remain the property of **Allen Gabriel, M.D. and Brinda Thimmappa, M.D.**

"I hereby fully grant permission for the use of any of my medical records including illustrations photographs or other imaging records created in my case for use in examination testing credentialing and/or certifying purposes by The American Board of Plastic Surgery, Inc."

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Patient or Personal Representative

\_\_\_\_\_  
Relationship of Personal Representative to the Patient

\_\_\_\_\_  
Signature of Practice Representative and Witness

I fully and specifically grant my permission for the use of photographs, videotapes or case information for the following additional purposes as indicated by my initials below. As a result of this use I understand that these photographs, videotapes or case information may appear in other related, updated or reprinted formats at any concurrent or future occasion. I understand that such consent is strictly on a voluntary basis. I understand a copy of this consent may be supplied with the images to any third party wherein they may be published or presented. I understand that some photographs may, by their representation make me identifiable in appearance to others. I authorize **Dr. Gabriel and/or Dr. Thimmappa** to use my photographs, videotapes, and case information in the following educational and scientific settings that **I have initialed:**

\_\_\_\_\_ My surgeon's office patient education materials

\_\_\_\_\_ My surgeon's file of pre- and postoperative patient photographs available to prospective patients for viewing in the office

\_\_\_\_\_ Newspaper and magazine articles in which my surgeon participates

\_\_\_\_\_ Television programs in which my surgeon participates

\_\_\_\_\_ My surgeon's personal web site or web page

\_\_\_\_\_ Lectures and multimedia presentations given by my surgeon for the general public

I also authorize my plastic surgeon's professional association, the not-for-profit **American Society for Aesthetic Plastic Surgery**, to use my photographs and case information in fulfilling its mission of public education, in the settings that **I have initialed:**

\_\_\_\_\_ Patient education brochures available for purchase \_\_\_\_\_ Television Programs about plastic Surgery

\_\_\_\_\_ Educational video tapes available for purchase \_\_\_\_\_ Lectures and slide presentations available for purchase

\_\_\_\_\_ Case studies presented on the Society's web site at [www.surgery.org](http://www.surgery.org)



# Southwest Medical Group Plastic Surgery

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## OUR OFFICE POLICY REGARDING PATIENT FINANCIAL RESPONSIBILITY

We ask that you read and sign the following to acknowledge that you have been advised of your financial responsibility for medical services provided.

**Coverage: I understand that I am responsible for knowing if a procedure is a covered benefit or an exclusion on my insurance policy.**

**Medicare Patients:** We bill Medicare directly for you. However, you are responsible for charges applied to your deductible, any co-insurance, or charges not covered by Medicare. Medicare Part B automatically forwards your claim to your secondary insurance carrier if they have a contract with the carrier. This is known as a "crossover" or "medigap". We will bill secondary insurances as a courtesy; however unpaid portions are the patients responsibility.

**Participating Insurance:** Our office accepts several commercial insurance carriers such as Blue Cross/Blue Shield and we bill them directly as a courtesy to you. Prior to your visit, check with your insurance company to see if our office and physician is a provider under your contract plan, and if you need a referral authorization prior to your visit or procedure. We accept payment for covered services from the contracted insurance plans in accordance with our contracts. You are responsible for applicable co-insurance, co-pays, and deductible amounts as well as payment for services that are not covered by insurance such as cosmetic procedures at the time of your visit.

**Non-participating Insurance:** If we are not a provider for your insurance carrier and you wish to see our physicians, you are responsible for payment of all charges at the time of service. You are then responsible for submitting the claim to your insurance company for reimbursement.

**Uninsured:** All charges are to be paid in full at the time of service. Providing quality medical care for our patients is our primary concern. We are more than willing to provide that care within the guidelines of your insurance plan. It is however, your responsibility to know and understand those guidelines. It is also your responsibility to seek medical care with physicians participating in your plan when possible. Remember that insurance may not cover all fees. To be fully aware of your benefit limitations, please read your insurance policy thoroughly or talk with your insurance representative. You may be billed separately for laboratory analysis if we are required by your insurance to send specimens to an external laboratory.

**We accept payment in the form of check, cash, Visa, or MasterCard.**

I understand that I have financial responsibility for payment of medical services provided and hereby assume and guarantee payment of all expenses incurred during my office visit, diagnostics, and procedures. Should legal action be required to secure payment of this account, I agree to pay the legal expenses incurred by this office or an agency acting on behalf of this office.

I have read and understand this financial policy and agree to accept responsibility as described.

\_\_\_\_\_  
Signature of Patient/Responsible Party

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
Patient's Date of Birth

## NOTICE OF PRIVACY PRACTICES

Effective Date: March 20, 2003

### 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

#### Who Will Follow This Notice

Southwest Medical Group (SMG) respects your privacy. Southwest Medical Group staff understands that your personal health information is very sensitive. Your protected health information (PHI) includes your symptoms, test results, diagnoses, and treatment, health information from other providers, and billing and payment information relating to these services.

We will not disclose your health information to others without your authorization, except as described in this Notice, or as required by law (Federal law 45 CFR 164.500-528).

#### Your Health Information Rights

The health and billing records we create and store are the property of SMG. The PHI in it; however, generally belongs to you. You have a right to:

- Receive, read and ask questions about this Notice.
- Ask us to restrict certain uses and disclosures. You must deliver this request in writing to us. We are not required to grant the request unless the request is to restrict disclosure of your PHI to a health plan for payment or health care operations and the PHI is about a service or treatment for which you paid directly.
- Request/receive from us a paper copy of the most current **Notice of Privacy Practices** ("Notice").
- Request that you be allowed to see and get a copy of your PHI. You may make this request in writing. We have a form available for this type of request.
- Have us review a denial of access to your health information-except in certain circumstances.
- Ask us to change your health information. You may give us this request in writing. You may write a statement of disagreement if your request is denied. It will be stored in your medical record, and included with any release of your records.
- When you request, we will give you a list of certain disclosures of health information. The list will not include disclosures for treatment, payment or health care operations. You may receive this information without charge every 12 months. We will notify you of the cost involved if you request this information more than once in 12 months.
- Ask that your health information be given to you by another means or at another location. Please sign, date, and give us your request in writing.
- Cancel prior authorizations to use or disclose health information by giving us written revocation. Your revocation does not affect information that has already been released. It does not affect any action taken before we have it. Sometimes, you cannot cancel an authorization if its purpose was to obtain insurance.

#### Examples of Uses and Disclosures of PHI for Treatment, Payment and Health Care Operations:

##### For Treatment:

- Information obtained by a nurse, physician, or other member of our health care team will be recorded in your medical record and used to help decide what care may be right for you.
- SMG may also provide information to others providing you care. This will help them stay informed about your care.

##### For Payment:

- We request payment from your health insurance plan. Health plans need information from us about your medical care. Information provided to health plans may include your diagnoses, procedures performed, or recommended care.
- We bill you or the person you tell us is responsible for paying for your care if it is not covered by your health insurance plan.

##### For Health Care Operations:

- We may use your medical records to assess quality and improve services.
- We may use and disclose medical records to review the qualifications and performance of our health care providers and to train our staff.
- We may contact you to remind you about appointments and give you information about treatment alternatives or other health-related benefits and services.
- We may use and disclose your information to conduct or arrange for services, including:
  - medical quality review by your health plan
  - accounting, legal, risk management, and insurance services
  - audit functions, including fraud and abuse detection and compliance programs.

#### Statements about Certain Uses and Disclosures

- ✓ We may contact you to remind you about appointments
- ✓ We may use and disclose your health information to give you information about treatment alternatives or other health-related benefits and services.
- ✓ We may contact you to raise funds. If we contact you for fund raising, we will also provide you with a way to opt out of receiving fund-raising requests in the future.

#### Other Ways We May Use or Disclose Your PHI Without Your Authorization

**Required by Law** - We must make any disclosure required by state, federal, or local law.

**Business Associates** - We contract with individuals and entities to perform jobs for us to provide certain types of services that may require them to create, maintain, use and/or disclose your health information. We may disclose your health information to a business associate, but only after they agree in writing to safeguard your health information. Examples include billing services, accountants, and others who perform health care operations for use.

**Notification of Family and Others** - Unless you object, we may release health information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. We may tell your family your condition and that you are in a hospital.

**Public Health and Safety Purposes** - As permitting or required by law, we may disclose PHI:

- To prevent or reduce a serious, immediate threat to the health or safety of a person or the public.
- To protect public health or legal authorities.
- To protect public health and safety.
- To prevent or control disease, injury or disability.
- To report vital statistics such as births or deaths.
- To report suspected abuse or neglect to public authorities.

**Research** - We may disclose PHI to researchers if the research has been approved by an institutional review board or a privacy board and there are policies to protect the privacy of your health information. We may also share information with medical researchers preparing to conduct a research project.

**Coroners, Medical Examiners and Funeral Directors** - We may disclose PHI to funeral directors and coroners consistent with applicable law to allow them to carry out their duties.

**Organ Procurement Organizations** - Consistent with applicable law, we may disclose PHI to organ procurement organizations (tissue donation and transplant) or persons who obtain, store, or transplant organs.

**Food and Drug Administration (FDA)** - For problems with food, supplements and products, we may disclose PHI to the FDA or entities subject to the jurisdiction of the FDA.

**Workplace Injury or Illness** - Washington State law requires the disclosure of PHI to the Department of Labor and Industries, the employer, the payer (including self-insured payer) for workers' compensation and for crime victim claims. We may also disclose PHI for work-related conditions that could affect employee health. For example, an employer may ask us to assess health risks on a job site.

**Correctional Institutions** - If you are in jail or in prison, we may disclose your PHI as necessary for your health and the health and safety of others.

**Law Enforcement** - We may disclose PHI to law enforcement officials as required by law, such as reports of certain types of injuries to victims of a crime, when we receive a subpoena, court order, or other legal process.

**Government Health and Safety Oversight Activities** - We may disclose PHI to an oversight agency that may be conducting an investigation. For example; we may share health information with the Department of Health.

**Disaster Relief** - We may share PHI with disaster relief agencies to assist in notification of your condition to family or others.

**Military, Veteran, and Department of State** - We may disclose PHI to the military authorities of U.S. and foreign military personnel. For example, the law may require us to provide information necessary to a military mission.

**Lawsuits and Disputes** - We are permitted to disclose PHI in the course of judicial/administrative proceedings at your request, or as directed by the subpoena or court order.

**National Security** - We are permitted to release PHI to federal officials for national security purposes authorized by law.

**De-Identifying Information** - We may use your PHI by removing any information that could be used to identify you.

#### Southwest Medical Group Responsibilities We are Required To:

- ✓ Keep your PHI private
- ✓ Give you this Notice
- ✓ Follow the terms of this Notice

We reserve the right to change our practices regarding the protected health information we maintain. If we make changes, we will update this Notice. You may receive the most recent copy of this Notice by visiting one of our offices, by accessing our website at [www.sw-health.org](http://www.sw-health.org), or by calling (360)750-8040.

#### For more information or to Report a Problem

If you have questions, would like more information, or want to report a problem about the handling of your protected health information, you may contact: SMG Privacy Officer at 360-750-8040

If you believe your privacy rights have been violated, you may contact or submit your complaint in writing to the Privacy Officer of Southwest Medical Group at 312 SE Stonemill Drive Suite 160, Vancouver WA 98684. If we cannot resolve your concern, you also have the right to file a written complaint with the Secretary of Department of Health and Human Services: Office of Civil Rights, 200 Independence Ave., S.W., Room 531H, Washington, D.C. 20201. Your treatment will not be affected by any complaint.



## Acknowledgement of Receipt of Notice of Privacy Practices

We keep a record of health care services we provide you. You may ask to see a copy of that record. You may also ask to correct that record. We will not disclose your records to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting Southwest Medical Group's Privacy Officer.

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information.

**By my signature below, I acknowledge receipt of the Notice of Privacy Practices.**

I acknowledge that I have received the Notice of Privacy Practices.

\_\_\_\_\_  
 Signature of Patient or Patient's Representative

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Print Name

\_\_\_\_\_  
 Relationship to Patient

## Southwest Medical Group Patient Confidential Communication

The Health Insurance Portability and Accountability Act (HIPAA) gives you the right to request that we communicate financial and/or medical information to you in confidence by a particular method. In order to protect the privacy and confidentiality of your information, please complete the following. This will tell us how you wish to be contacted and to whom we may discuss your health care with.

You may contact me at the following phone numbers: (Provide all that apply)

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

\_\_\_\_\_ Yes, you may leave a confidential message at: Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_ (Check all that apply)

\_\_\_\_\_ Yes, you may leave the minimum necessary information on my answering machine or voice mail listed above.

\_\_\_\_\_ Yes, you may provide the minimum necessary medical information to the individual(s) listed below:

\_\_\_\_\_ (Name)

\_\_\_\_\_ (Relationship)

\_\_\_\_\_ (Name)

\_\_\_\_\_ (Relationship)

Our office will continue to communicate with you according to your above response(s) until you change your preferences. You may do so by completing a new form. By signing below, you grant permission to the communication above.

\_\_\_\_\_  
 Signature of Patient/Personal Representative

\_\_\_\_\_  
 Date