

## PATIENT REGISTRATION

Patient number	ABC		
<b>Patient's Name</b>	Sex: M F	Birthdate	Age
Home Address	City		State
Please Circle One: Single, Married, Separated, Widow		Occupation	Home Phone Number
Your Employer	How Long Employed	Your Soc Sec. #	Work Phone
Are you a full time student? <input type="checkbox"/> Yes <input type="checkbox"/> No	If patient is minor we need: Mother's Birthdate:		Father's Birth Date
<b>Person responsible for account</b>	Driver's license number		
Name of spouse (Parent if minor)	E-mail address	Cell Phone	
Spouse's (parent's) employer	Spouse's Soc. Sec. #	Work phone	
<b>How did you hear about our office?</b>	<b>EMERGENCY INFORMATION</b>		
Reason for this visit	Name, Address, & telephone of _____		
	A Relative Not living with you.		
<b>DENTAL INSURANCE INFORMATION (Primary Carrier)</b>		<b>If you have a double digit insurance coverage, complete this for the second coverage</b>	
Insured's name	DOB	SS#	
Insured's employer			
Insurance Co			
Insurance Co Address			
Phone #			
Group #	Local #	Group #	Local #

## FINANCIAL POLICY

Thank you for choosing our office as your dental health care provider. We are committed to providing you with the highest quality lifetime dental care, so that you may fully attain optimum oral health. Please understand that payment of your bill is considered part of your treatment.

Payment is due at the time service is provided. Our office accepts cash, personal checks, MasterCard, Visa, and Discover. Outside financing is available upon request and approval.

**Please check if you would like more information about financing options.**

Please Note: Returned checks will be subject to additional fees. In the case it becomes necessary for our office to enlist a collection service and/or legal assistance, you will be responsible for any collection and/or legal charges incurred up to 35%.

### Do You Have Insurance?

- As a courtesy to you we will help you process all your insurance claims. Please understand that we will provide an insurance estimate to you, however it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits ultimately determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible.
- All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company. Our office is not a party to that contract.
- Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
- We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office.
- We ask that you pay the deductible and co-payment, which is the estimated amount not covered by your insurance company, by cash, check, MasterCard, Visa or Discover at the time we provide the service to you.
- Insurance payments are ordinarily received within 30-60 days from the time of filing. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.
- We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.

We thank you for the opportunity to serve your dental health care needs and welcome any questions you may have concerning your care or our financial policy.

**I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO MY DENTAL OFFICE.**

### CONSENT:

The undersigned hereby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance, rebilling, collection charge or attorney fee will be added to any overdue balance.

PATIENT Signature (Parent of Child) \_\_\_\_\_ Date: \_\_\_\_\_

## DENTAL HISTORY

**Please check any of the following problems that apply to you.**

- Sensitivity (hot, cold, sweet)   
Where? UR LR UL LL
- Headaches, earaches, neck pain
- Jaw joint pain
- Teeth or fillings breaking
- Grinding or clenching teeth
- Bleeding, swollen or irritated gums
- Loose, tipped or shifting teeth
- Bad breath

**Do you have or have you had any of the following?**

- Dentures
- Partial dentures
- Braces

**Please share the following dates:**

- Your last cleaning \_\_\_\_\_ / \_\_\_\_\_
- Your last oral cancer screening \_\_\_\_\_ / \_\_\_\_\_
- Your last complete X-Rays \_\_\_\_\_ / \_\_\_\_\_

**Name of Previous Dentist** \_\_\_\_\_

**City** \_\_\_\_\_ **State** \_\_\_\_\_

**Phone Number** \_\_\_\_\_

**What is the most important thing to you about your future smile and dental health?** \_\_\_\_\_

**If you could whiten your teeth for a cost anyone could afford, would you do it?**

**Do you smoke or use chewing tobacco?**   
How much? For how long? \_\_\_\_\_

**If I could change my smile, I would:**

- Make them whiter
- Make them straighter
- Close spaces
- Replace black metal fillings with tooth colored restorations
- Repair chipped teeth
- Replace missing teeth
- Replace old crowns that don't match
- Have a smile makeover

**On a scale of 1 – 10, with 10 being the highest rating:**

- How important is your dental health to you?  
1 2 3 4 5 6 7 8 9 10

- Where would you rate your current dental health?  
1 2 3 4 5 6 7 8 9 10

- Where do you want your dental health to be?  
1 2 3 4 5 6 7 8 9 10

**Why did you leave your previous dentist?** \_\_\_\_\_

**What is the most important thing to you about your dental visit today?** \_\_\_\_\_

## MEDICAL HISTORY

**Please check any of the following that apply to you:**

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> AIDS                   | <input type="checkbox"/> Drug Addiction             | <input type="checkbox"/> HIV Positive           | <input type="checkbox"/> Rheumatic Fever   |
| <input type="checkbox"/> Allergies (Seasonal)   | <input type="checkbox"/> Emphysema                  | <input type="checkbox"/> Jaundice               | <input type="checkbox"/> Rheumatism        |
| <input type="checkbox"/> Anemia                 | <input type="checkbox"/> Excessive Bleeding         | <input type="checkbox"/> Jaw Joint Pain         | <input type="checkbox"/> Scarlet Fever     |
| <input type="checkbox"/> Arthritis              | <input type="checkbox"/> Fainting                   | <input type="checkbox"/> Kidney Disease         | <input type="checkbox"/> Seizures          |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Glaucoma                   | <input type="checkbox"/> Liver Disease          | <input type="checkbox"/> Stomach Problems  |
| <input type="checkbox"/> Artificial Joints      | <input type="checkbox"/> Heart Conditions           | <input type="checkbox"/> Low Blood Pressure     | <input type="checkbox"/> Stroke            |
| <input type="checkbox"/> Asthma                 | <input type="checkbox"/> Heart Lesions (Congenital) | <input type="checkbox"/> Mitral Valve Prolapse  | <input type="checkbox"/> Thyroid Disease   |
| <input type="checkbox"/> Blood Disease          | <input type="checkbox"/> Heart Murmur               | <input type="checkbox"/> Nervousness/Depression | <input type="checkbox"/> Tuberculosis      |
| <input type="checkbox"/> Bruise Easily          | <input type="checkbox"/> Heart Surgery              | <input type="checkbox"/> Pacemaker              | <input type="checkbox"/> Ulcers            |
| <input type="checkbox"/> Cancer                 | <input type="checkbox"/> Hepatitis A                | <input type="checkbox"/> Phen Fen (1 month +)   | <input type="checkbox"/> Venereal Diseases |
| <input type="checkbox"/> Chemotherapy           | <input type="checkbox"/> Hepatitis B                | <input type="checkbox"/> Pregnant Currently     | <input type="checkbox"/> Other             |
| <input type="checkbox"/> Diabetes               | <input type="checkbox"/> Hepatitis C                | <input type="checkbox"/> Radiation (head/neck)  |  |
| <input type="checkbox"/> Dizziness              | <input type="checkbox"/> High Blood Pressure        | <input type="checkbox"/> Respiratory Problems   |  |

**Do you have any of the following drug allergies?**

- |   |                                       |
|---|---------------------------------------|
| <input type="checkbox"/> Aspirin          | <input type="checkbox"/> Codeine      |
| <input type="checkbox"/> Darvon           | <input type="checkbox"/> Erythromycin |
| <input type="checkbox"/> Nitrous Oxide    | <input type="checkbox"/> Valium       |
| <input type="checkbox"/> Percodan         | <input type="checkbox"/> Penicillin   |
| <input type="checkbox"/> Local Anesthetic | <input type="checkbox"/> Sulfa        |
| <input type="checkbox"/> Tetracycline     | <input type="checkbox"/> Other        |

**Are you under a physician's care? What for?**  
\_\_\_\_\_

**Are you taking any medications? What?**  
\_\_\_\_\_

**Family Physician Phone Number**  
\_\_\_\_\_

Patient Signature (Parent of Child) \_\_\_\_\_

Date \_\_\_\_\_ Dentist Signature \_\_\_\_\_

# Haygood Dental Care

C. Ryan Haygood D.D.S.

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## FINANCIAL POLICY

This statement is to inform you of our financial policy. We are committed to providing you with the highest quality of care using the best material and technology available in the market today. We are also committed to providing you with the up-to-date information and educational tools so that you may fully participate in maintaining optimum oral health. Our financial policy is intended to facilitate excellent service to you while minimizing our administrative costs.

All charges you incur are your responsibility, regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and the insurance company. Our office is not a party to that contract.

As a courtesy to you we will help you process all your insurance claims. In order for our office to file your insurance claim, you must bring a completed dental insurance form or proof of insurance at each appointment.

Returned checks and balances older than 60 days may be subject to collection fees and finance charges at the rate of 1.5% per month (18% annually) plus any court costs and reasonable attorneys' fees, with or without suit, incurred in collecting any past due balance, and a collection fee equal to 50% of the outstanding balance. Additionally, our office will charge you for broken appointments and appointments cancelled without 24-hour advance notice.

If you have any questions regarding our financial policy, please ask. We are committed to providing you with the most positive experience in dental care.

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

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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2015 East 70<sup>th</sup> Street ♦ Shreveport, LA ♦ 71105  
Phone: (318) 797-3505 ♦ Fax: (318) 797-3505

# Haygood Dental Care

C. Ryan Haygood D.D.S.

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## ASSIGNMENT OF BENEFITS AGREEMENT

Our office will accept an assignment of benefits from your insurance company with the following provisions. It is important to understand, though, that the contract regarding your dental benefits is between you, your employer, and your insurance company. The obligation you have with our practice is to pay for treatment, regardless of the amount that may or may not be reimbursed by your insurance company. The following provisions identify our policies governing insurance claims.

- Although we are willing to complete insurance information forms and submit a claim on your behalf, we do not accept responsibility for the outcome of the transaction. Completing insurance forms is a courtesy we extend to you in an effort to maximize your insurance reimbursement. By having our office process your insurance forms, it is important that you understand that this does not eliminate your financial obligation for your treatment.
- We require you to sign this form and/or any other necessary assignment documents that may be required by your insurance company. This instructs your insurance company to make payment directly to our office.
- We require you to pay the co-payment, which is the amount not covered by your insurance company, at the time we provide service to you.
- Insurance payments ordinarily are received within 30-60 days from the time of billing. If your insurance company has not made payments to our office within 60 days, we will ask you to pay the balance due at that time. You will be responsible for seeking reimbursement from your insurance company at that time.
- Our office does not guarantee that your insurance company will pay for treatment you receive from our practice. We perform routine insurance billing procedures upon verification of coverage. However, if your claim is denied, you will be responsible for paying the full amount at that time.
- Our office will not enter into a dispute with your insurance company over any claim, although we will provide necessary documentation your insurance company requests to sort out any confusion or questions that may arise. We will cooperate fully with the regulations and requests of your insurance company. It is ultimately your responsibility to resolve any type of dispute over payment made or not made by your insurance company.

**I HAVE READ AND UNDERSTAND THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO THE DOCTOR.**

**I AUTHORIZE YOU TO DEBIT MY CREDIT CARD IF YOU HAVE NOT RECEIVED PAYMENT FROM MY INSURANCE COMPANY WITHIN 60 DAYS OF RECEIVING TREATMENT.**

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PRINT NAME

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CREDIT CARD NUMBER

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EXP. DATE

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SIGNATURE OF PATIENT/RESPONSIBLE PARTY

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DATE

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# Haygood Dental Care

C. Ryan Haygood D.D.S.

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## NOTICE OF PRIVACY PRACTICES

**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**

**PLEASE REVIEW IT CAREFULLY.  
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.**

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### OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 04/14/03, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of the Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices; we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

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### USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

**Treatment:** We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

**Payment:** We may use and disclose your health information to obtain payment for services we provide to you.

**Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

**Your Authorization:** In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

**To your Family and Friends:** We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

**Persons Involved In Care:** We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity, or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

**Marketing health Related Services:** We will not use your health information for marketing communications without your written authorization.

**Required by Law:** We may use or disclose your health information when we are required to do so by law.

**Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

**National Security:** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorize federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

**Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

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## **PATIENT RIGHTS**

**Access:** You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice.

**Disclosure Accounting:** You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

**Alternative Communication:** You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing). Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

**Amendment:** You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

**Electronic Notice:** If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this notice in written form.

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**Contact Information:**      **C. Ryan Haygood, D.D.S.**  
   **1519-1 Doctors Drive**  
   **Bossier City, LA 71111**

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2015 East 70<sup>th</sup> Street ♦ Shreveport, LA ♦ 71105  
Phone: (318) 797-3505 ♦ Fax: (318) 797-3505

# Haygood Dental Care

C. Ryan Haygood D.D.S.

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## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**\*\*You May Refuse to Sign This Acknowledgement\*\***

I, \_\_\_\_\_, have received a copy of this office's Notice of Privacy Practices.

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

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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### FOR OFFICE USE ONLY

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We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# Haygood Dental Care

C. Ryan Haygood D.D.S.

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## MUTUAL AGREEMENT

Dr. C. Ryan Haygood, D.D.S. and Haygood Dental Care (collectively labeled “*Dentist*”) agree to provide treatment to \_\_\_\_\_ (“*Patient*”). The Dentist takes pride in being able to extend a greater degree of privacy than is required by law.

Nothing in the form prevents Patient from speaking privately about his or her care to another dentist, a family member, or a friend. Indeed, the patient can speak to any third party; however, should the information be intended to be released into the public domain, written pre-authorization is required from our office. That’s it. The language, then balances the legitimate rights of Patient with Dentist.

Federal and State privacy laws are complex. Unfortunately, some dental offices try to find loopholes around these laws. For example, dentists are forbidden by law from receiving money for selling lists of patients or medical information to companies to market their products or services directly to patients without authorization. Some dental practices, though, can lawfully circumvent this limitation by having a third party perform the marketing. While personal data is never technically in the possession of the company selling its products or services, the patient can still be targeted with unwanted marketing information. Dentist believes this is improper and may not be in the patients’ best interest. Accordingly, Dentist agrees not to provide medical information for the purpose of marketing directly to Patient. Regardless of legal privacy loopholes, Dentist will never attempt to leverage its relationship with Patient by seeking Patients’ consent for marketing products for others.

In consideration for treatment and the above noted patient protection, Patient agrees to refrain from directly or indirectly publishing or airing commentary upon Dentist and his practice, expertise and/or treatment—the sole exceptions being communication to a confidential dental-peer review body; to another healthcare provider; to a licensed attorney; to a governmental agency; in the context of a legal proceeding; or unless mandated by law. Publishing is intended to include attribution by name, by pseudonym, or anonymously. If Patient does prepare commentary for publication about Dentist, the Patient exclusively assigns all Intellectual Property rights, including copyrights, to Dentist for any written, pictorial, and/or electronic commentary. This assignment shall be operative and effective at the time of creation (prior to publication) of the commentary. Dentist has invested significant financial and marketing resources in developing the practice. Published comments on web pages, blogs, and/or mass correspondence, however well intended, could severely damage Dentist’s practice.

Dentist feels strongly about the practice’s right to control its public image. Both Dentist and Patient will work to prevent the publishing or airing of commentary about the other party from being accessed via Internet, blogs, or other electronic, print, or broadcast media without prior written consent. Patient will use all reasonable efforts to prevent any member of their immediate family or acquaintance from engaging in any such activity. Finally, this Agreement shall be in force and enforceable for a period of five years from the Dentist’s last date of service to Patient. As a matter of office policy, Dentist is requiring all patients in its practice sign the Mutual Agreement so as to establish that any anonymous or pseudonymous publishing or airing of commentary will be covered by this agreement for all Dentist’s patients. Further, this Agreement will survive for a minimum of three years beyond any termination of the Physician-Patient relationship.

Patient and Dentist acknowledge that breach of this Agreement may result in serious, irreparable harm. In addition to compensation for consequential damages, Patient and Dentist agree to the right of equitable relief (including but not limited to injunctive relief). Should a breach of this Agreement result in litigation, the prevailing party in the litigation shall be entitled to reasonable costs, expenses, and attorney fees associated with the litigation.

Patient has been given the opportunity to ask questions and receive satisfactory and adequate explanations.

SO AGREED THIS \_\_\_\_\_ DAY OF \_\_\_\_\_, 2010.

\_\_\_\_\_  
(PATIENT SIGNATURE)

C. RYAN HAYGOOD, D.D.S., AND HAYGOOD DENTAL CARE

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# Haygood Dental Care

C. Ryan Haygood D.D.S.

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## AGREEMENT AS TO RESOLUTION OF CONCERNS

“I”, “Patient/Guardian” shall be understood to mean \_\_\_\_\_.

“Doctor” shall be understood to mean Dr. C. Ryan Haygood, D.D.S., and/or Haygood Dental Care.

Further, I understand that I am entering into a contractual relationship with Doctor for professional care. I further understand that meritless and frivolous claims for medical/dental malpractice have an adverse affect upon the cost and availability of healthcare, and may result in irreparable harm to a healthcare provider. As additional consideration for professional care provided to me by Doctor, I, the patient/guardian and/or my representative agree not to advance, directly or indirectly, any false, meritless, and/or frivolous claim(s) of medical/dental malpractice against Doctor.

Furthermore, should a meritorious medical/dental malpractice case or cause of action be initiated or pursued, I (the patient) and/or my representative agree to use expert witness (es) who practice primarily in the same specialty as Doctor. Furthermore, I agree that these expert witnesses will be members in good standing of and adhere to the guidelines and/or code of conduct defined for expert witnesses by the Louisiana State Board of Dentistry.

In further consideration for this, Doctor agrees to the same stipulations.

\_\_\_\_\_  
Doctor

\_\_\_\_\_  
Patient/Guardian

\_\_\_\_\_  
Effective from Date of Treatment:

\_\_\_\_\_  
Date of Signature