

**BREAST CANCER ALLIANCE OF NORTH TEXAS**

**W. LEE BOURLAND, MD  
ARCHANA GANARAJ, MD  
KANDICE KILBRIDE, MD  
8160 WALNUT HILL LANE  
MARGOT PEROT BUILDING  
SUITE 113  
DALLAS TX 75231  
214-345-7374**

Dear Patient,

Thank you for choosing our practice for your healthcare needs. Enclosed you will find new patient information that needs to be downloaded on your computer, completed and brought to our office the day of your appointment. If you do not have this packet with you, you will need to be rescheduled as our clinical scheduling is set to expedite timely patient care.

This is also a reminder if you have had your mammograms/sonograms at an outside facility, it is your responsibility to bring those films and reports with you.

If you have had a prior breast surgery, we will also need a copy of the pathology reports and operative reports.

If your insurance is an HMO or POS meaning that on your insurance card you have a primary care physician, you will be responsible for obtaining that referral and bringing it with you. Again, if you do not have this referral with you, you will be rescheduled due to our scheduling.

Sincerely,  
W. Lee Bourland, MD  
Archana Ganaraj, MD  
Kandice Kilbride, MD

**\*PLEASE MARK ONE:**

- Dr. Ganaraj
- Dr. Bourland
- Dr. Kilbride
- Daphne McDonald, WHNP, BC

**PATIENT REGISTRATION FORM**

**PATIENT NAME:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_ **CITY, STATE, ZIP:** \_\_\_\_\_

**HOME#** \_\_\_\_ - \_\_\_\_ - \_\_\_\_      **CELL#** \_\_\_\_ - \_\_\_\_ - \_\_\_\_      **WORK#** \_\_\_\_ - \_\_\_\_ - \_\_\_\_

**AGE:** \_\_\_\_\_      **DATE OF BIRTH:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_      **SS#** \_\_\_\_ - \_\_\_\_ - \_\_\_\_

**MALE**       **FEMALE**       **DRIVER'S LICENSE #** \_\_\_\_\_

**OCCUPATION:** \_\_\_\_\_ **EMPLOYER:** \_\_\_\_\_

\*\*\*\*\*

**PRIMARY INSURANCE:** \_\_\_\_\_ **PHONE#** \_\_\_\_ - \_\_\_\_ - \_\_\_\_

**ADDRESS:** \_\_\_\_\_ **CITY, STATE, ZIP:** \_\_\_\_\_

**INSURED'S NAME:** \_\_\_\_\_ **DATE OF BIRTH:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**SS#:** \_\_\_\_ - \_\_\_\_ - \_\_\_\_ **RELATIONSHIP TO THE INSURED:** \_\_\_\_\_

**EMPLOYER:** \_\_\_\_\_ **WORK#** \_\_\_\_ - \_\_\_\_ - \_\_\_\_      **ALTERNATE#** \_\_\_\_ - \_\_\_\_ - \_\_\_\_

**POLICY NUMBER** \_\_\_\_\_ **GROUP NUMBER** \_\_\_\_\_

**SECONDARY INSURANCE:** \_\_\_\_\_ **PHONE#** \_\_\_\_ - \_\_\_\_ - \_\_\_\_

**ADDRESS:** \_\_\_\_\_ **CITY, STATE, ZIP:** \_\_\_\_\_

**INSURED'S NAME:** \_\_\_\_\_ **DATE OF BIRTH:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**SS#:** \_\_\_\_ - \_\_\_\_ - \_\_\_\_ **RELATIONSHIP TO THE INSURED:** \_\_\_\_\_

**POLICY NUMBER** \_\_\_\_\_ **GROUP NUMBER** \_\_\_\_\_

**IN CASE OF EMERGENCY-NOTIFY:** \_\_\_\_\_ **PHONE#** \_\_\_\_ - \_\_\_\_ - \_\_\_\_

\*\*\*\*\*

I HEREBY AUTHORIZE ARCHANA GANARAJ, M.D./ W. LEE BOURLAND, M.D./KANDICE KILBRIDE, M.D./DAPHNE McDONALD, WHNP, BC TO RELEASE ANY INFORMATION ACQUIREE IN THE COURSE OF MY EXAMINATION AND TREATMENT TO THE OTHER PHYSICIANS AND MY INSURANCE COMPANIES, AS NEEDED FOR MY CARE AND CLAIM PROCESSING. I HEREBY AUTHORIZE MY INSURANCE COMPANIES TO SEND BENEFITS FOR SERVICES RENDERED TO MY PHYSICIAN. I ALSO UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES INCURRED EXCLUDING ANY CONTRACTUAL ADJUSTMENTS BETWEEN MY INSURANCE COMPANY AND THE PHYSICIAN.

**\*PATIENT SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

## **BREAST CANCER ALLIANCE OF NORTH TEXAS**

**W. LEE BOURLAND, M.D., F.A.C.S.**  
**ARCHANA GANARAJ, M.D.**  
**KANDICE KILBRIDE, M.D.**

### **PATIENT'S PERSONAL HISTORY**

Name: \_\_\_\_\_ Age: \_\_\_\_\_

Date: \_\_\_\_\_

Reason for  
visit? \_\_\_\_\_

How long have you noticed this condition or symptom?  
\_\_\_\_\_

Date of your most recent mammogram: \_\_\_\_\_

Where? \_\_\_\_\_

**PERSONAL HISTORY:** Do you have a history of any of the following:

Yes No

Cancer (other than breast / ovarian) \_\_\_\_ \_\_\_\_

Diabetes \_\_\_\_ \_\_\_\_

Heart Trouble \_\_\_\_ \_\_\_\_

High Blood Pressure \_\_\_\_ \_\_\_\_

Stroke \_\_\_\_ \_\_\_\_

Epilepsy \_\_\_\_ \_\_\_\_

Bleeding Disorder \_\_\_\_ \_\_\_\_

Asthma \_\_\_\_ \_\_\_\_

Allergies \_\_\_\_ \_\_\_\_

Alcoholism \_\_\_\_ \_\_\_\_

Have you had any type of breast surgery? \_\_\_\_ \_\_\_\_

If yes, date of Surgery.  
\_\_\_\_\_

What was your diagnosis?

\_\_\_\_ Benign (non-cancer) \_\_\_\_ Cancer

\_\_\_\_ Fibrocystic \_\_\_\_ DCIS (Ductal Carcinoma In-Situ)

\_\_\_\_ Hyperplasia \_\_\_\_ Infiltrating Ductal Carcinoma

\_\_\_\_ Atypical Hyperplasia \_\_\_\_ Fibroadenoma

\_\_\_\_ LCIS (lobular Carcinoma In-Situ) \_\_\_\_ Unknown

\_\_\_\_ Cosmetic Only

Has any relative in your family had breast cancer?

Living Age at Death

Who? \_\_\_\_\_ age of Dx: \_\_\_\_\_ Yes \_\_\_ No

Who? \_\_\_\_\_ age of Dx: \_\_\_\_\_ Yes \_\_\_ No

Who? \_\_\_\_\_ age of Dx: \_\_\_\_\_ Yes \_\_\_ No

Has any relative in your family had ovarian cancer?

Living Age at Death

Who? \_\_\_\_\_ age of Dx: \_\_\_\_\_ Yes \_\_\_ No

Have you lost weight in the past year? \_\_\_ Yes \_\_\_ No How much? \_\_\_\_\_

Over what period of time? \_\_\_\_\_ Was weight loss intentional? \_\_\_ Yes \_\_\_ No

Menstrual Periods: Age Onset: \_\_\_\_\_ Regular? \_\_\_\_\_ Date of last period? \_\_\_\_\_

Difficulty with periods? \_\_\_ Yes \_\_\_ No Age at Menopause? \_\_\_\_\_

Age you first gave birth? \_\_\_\_\_ Number of pregnancies? \_\_\_\_\_ Ages of children? \_\_\_\_\_

What method of birth control are you currently on? \_\_\_\_\_

Have you ever taken birth control pills or Depo-provera shot? \_\_\_ Yes \_\_\_ No How long? \_\_\_\_\_

Are you now or have you ever been on Hormone Replacement Therapy? \_\_\_ Yes \_\_\_ No

Which one? \_\_\_\_\_ How long? \_\_\_\_\_

Are you allergic to any medicines? If so, please list all: \_\_\_\_\_

Are you allergic to any foods? If so, please list all: \_\_\_\_\_

What happens when you take these medicines or foods? \_\_\_\_\_

Please list the name and dosage of all the medications you are currently taking:

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Are you taking Aspirin, any blood thinning medication or Vitamin E now or within the last ten (10) days?  Yes  No

**HOSPITALIZATIONS:**

Description Year Hospital

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Major Illness \_\_\_\_\_

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Surgery \_\_\_\_\_

List the names and addresses of other physicians involved in your medical care:  
Primary/Internist:

OB/GYN: \_\_\_\_\_

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

\*\* I certify that all the information submitted by me on the information and history forms is true and complete to the best of my knowledge.\*

Date: \_\_\_\_\_  
PatientSignature \_\_\_\_\_

Date: \_\_\_\_\_  
Physician Signature \_\_\_\_\_

\_\_\_\_ W. Lee Bourland, M.D.,F.A.C.S. \_\_\_\_ Archana Ganaraj, M.D.  
\_\_\_\_ Kandice Kilbride, M.D.  
8160 Walnut Hill Lane Ste 113 8160 Walnut Hill Lane Ste 113  
Dallas, Texas 75231 Dallas, Texas 75231  
214-345-7374

**BREAST CANCER ALLIANCE OF NORTH TEXAS**

**CURRENT SYMPTOMS**

MARK YES OR NO

YES

NO

Have you had any recent:

Headaches

\_\_\_\_\_

\_\_\_\_\_

Night Sweats

\_\_\_\_\_

\_\_\_\_\_

Fevers

\_\_\_\_\_

\_\_\_\_\_

Chills

\_\_\_\_\_

\_\_\_\_\_

Difficulty swallowing

\_\_\_\_\_

\_\_\_\_\_

Pain when you swallow

\_\_\_\_\_

\_\_\_\_\_

Changes in vision

\_\_\_\_\_

\_\_\_\_\_

Changes in hearing

\_\_\_\_\_

\_\_\_\_\_

Chest pain

\_\_\_\_\_

\_\_\_\_\_

Difficulty breathing

\_\_\_\_\_

\_\_\_\_\_

Shortness of breath

\_\_\_\_\_

\_\_\_\_\_

Abdominal pain

\_\_\_\_\_

\_\_\_\_\_

Nausea

\_\_\_\_\_

\_\_\_\_\_

Vomiting

\_\_\_\_\_

\_\_\_\_\_

Diarrhea

\_\_\_\_\_

\_\_\_\_\_

Blood in your stools

\_\_\_\_\_

\_\_\_\_\_

Difficulty urinating

\_\_\_\_\_

\_\_\_\_\_

Pain, swelling, numbness

\_\_\_\_\_

\_\_\_\_\_

Tingling in your arms or lungs?

\_\_\_\_\_

\_\_\_\_\_

## Hereditary Cancer Risk Assessment

**Patient Name:**

**Patient Day Time Phone:**

Most of the time, cancer happens by chance. However, in some families cancer may be caused by changes in certain genes that can be passed from generation to generation. These genetic changes significantly increase a person's risk for certain cancers, including as second cancer in those who have already been *can be significantly* reduced with the right medical interventions. A careful review of your family history is an essential first step, so please check all of the boxes that apply to you:

**Have YOU been diagnosed with... YES NO UNKNOWN**

Breast cancer before age 50?

Ovarian cancer at any age?

Two breast cancers, or breast *and* ovarian cancer?

Male breast cancer at any age?

Are you of Ashkenazi Jewish Ancestry?

**Have any of your FAMILY members been diagnosed with... WHO?**

*(Please indicated **maternal** or **paternal** as they are BOTH important)*

Breast cancer before age 50?

Ovarian Cancer at any age?

Two breast cancers, or **breast and ovarian** cancer?\*

Male breast cancer at any age?

*\*Can be two cancers in one person, or two or more people in your family with these cancers.*

If any YES boxes are checked, you have a personal family history suggestive of one of the more common

hereditary cancer syndromes and are a candidate for further risk assessment and, if appropriate, genetic

testing. We have discuss this with you and provide you with additional information that will help you

understand your individual risks and how best to address them.

*Candidate for further risk assessment and/or genetic testing*

*Patient offered genetic testing and:*

*Information given to patient to review*

**Accepted**  **Declined**

*Referred patient for genetic counseling: Date:*

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Health care provider's Signature

\_\_\_\_\_  
Date

**BREAST CANCER ALLIANCE OF NORTH TEXAS**

**W. LEE BOURLAND, M.D.  
ARCHANA GANARAJ, M.D.  
KANDICE KILBRIDE, M.D.**

**TO OUR HMO, PPO, MC, AND POS PATIENTS**

As a courtesy to you, our patient, our office attempts to verify your insurance benefits prior to your office visit. Unfortunately, the information given to us by your insurance company is minimal and is not enough for us to completely process your visit with us. When we contact your insurance company, usually the office staff is told that you are on an insurance list for a specific HMO, PPO, or other Managed Care plan, whether you have met your deductible and what the office visit co-pay is. If, for example, your co-pay is 80/20, this means that you pay 20% of all covered charges (after your deductible has been met) and the insurance company will pay 80% of the remaining covered charges.

We are not informed of the specifics of your coverage, exactly what procedures your insurance covers and what they will not cover. It is your responsibility to obtain that information since only you have access to the insurance plan booklets and to your Human Resource department of the company through which you are insured. It is important to have this information because you are responsible for paying all charges associated with your care which the insurance company does not cover. Knowing what your insurance company covers and/or may not cover gives you the choice to elect certain procedures. Also, you are able to receive maximum benefits allowed by your policy.

**WHAT SHOULD I BRING TO THE PHYSICIAN'S OFFICE**

\*Your referral number from your primary care physician (PCP) if your visit requires one. Your PCP does not always follow through in providing these number to our office. Not having that number with you will cause unnecessary delays or rescheduling of your appointment.

\*Your insurance card which provides the necessary information for our office to file a claim for you.

\*Method for paying your co-pay, which is due at the time services are rendered. We accept cash, checks and all credit cards for your convenience.

Please Contact Our Office If You Have Further Questions.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Patient Name (Print)

\_\_\_\_\_  
Date

**BREAST CANCER ALLIANCE OF NORTH TEXAS**

**W. Lee Bourland, M.D., P.A.**

**Archana Ganaraj, M.D.**

**Kandice Kilbride, M.D.**

8160 Walnut Hill Lane Ste 113

Dallas, TX 75231

(214) 345-7374

**FINANCIAL POLICY**

Our office is delighted to have the opportunity to serve you. We would like to clarify our office financial policy. If you are not on an insurance plan that we have a signed contract with, we will collect payment in full at the time of service. For your convenience, we accept MasterCard, Discover, American Express and Visa in addition to cash and checks. You will be provided with the proper form to forward to your insurance company for reimbursement. The following is an outline of some of the financial and procedural steps required creating a successful relationship.

\*Any co-pay or deductible is due at the time services are rendered, unless other arrangements have been made prior to your visit.

\*The remainder of your charges will be filed with your insurance company for direct payment to our office.

\*If your insurance company remits payments to you by mistake, please forward the payment upon receipt to this office with the Explanation of Benefits attached to the original check. You may sign the back of the check and mark "Pay to the order of \_\_\_\_\_ (your doctor's name)".

Please do not send this check back to the insurance company.

\*If the insurance company denies your claim for any reason, you will be responsible for payment of the charges. If there is a question regarding why this claim was denied, you will need to contact your insurance company for clarification.

\*Your claim will be promptly filed to your insurance company. If there has been no response within 45 days, we will request your assistance in contacting your insurance company to help expedite the processing of your claim.

Our primary goal is to provide you with quality, cost effective medical care. Together, we are trying to adapt to the changing way the healthcare is financed and delivered. Again, we value you as a patient and our first priority is to provide you (and your family) with the best possible care. Our staff will be glad to answer any questions you may have.

**I have read and understand my financial obligations under the above policy and will be fully responsible for the payment of any and all services.**

\_\_\_\_\_  
PATIENT'S SIGNATURE

\_\_\_\_\_  
PATIENT'S NAME (PRINTED)

\_\_\_\_\_  
DATE

## **BREAST CANCER ALLIANCE OF NORTH TEXAS**

### **SURGICAL FINANCIAL POLICY / INSTRUCTIONS**

These instructions are provided to you to assist in making the business part of your surgical Procedure as smooth as possible.

We will file a claim to your insurance company for your surgery with the information that you have provided to the office. We will need a copy of your insurance card to utilize all the required information. Please verify with your insurance company as whether they will require a separate, completed claim form from you to file this procedure. If this is necessary, You will need to provide us with this form prior to any procedure being preformed. Surgery Deposits are required prior to any procedure being performed. This consists of whatever portion of your deductible not yet met as well as your percentage (or coinsurance) that the insurance company will not cover. Arrangements for payment need to be made prior to your procedure being performed. Our office will contact you by telephone to discuss this after your benefits have been verified. If your insurance company has not made payment on your claim within 45 days from the date it was filed, we may request your assistance in contacting your insurance company to expedite payment.

### **PRE-CERTIFICATION/SECOND OPINION/ASSISTANT SURGEONS**

Some insurance companies require pre-certification prior to a procedure being performed. We will contact them for you; however, it is your responsibility to contact our office or your insurance company to make sure that this has been done. If pre-certification is not done prior to your procedure, your insurance company can reduce the benefits or deny your claim altogether. Please be advised that pre-certification does not guarantee payment of benefits.

A second surgical opinion may be required prior to your surgery. Another surgeon of the same specialty usually does this. Please confirm with your insurance company if this is required and if you need assistance, our office will be most cooperative in assisting you with scheduling this appointment.

Some surgical procedures require an assistant surgeon. This will be another surgeon that your physician has asked to help during your procedure. You may check with our scheduling secretary for the name of the physician that will perform this service, as in some cases, you may not even be aware of their presence. You will receive a separate billing from any provider involved in your care.

**I have read and understand my financial obligations under the above policy and will be fully responsible for payment of any and all services as outlines above.**

\_\_\_\_\_  
PATIENT'S SIGNATURE

\_\_\_\_\_  
PATIENT'S NAME (PRINT)

\_\_\_\_\_  
DATE

**BREAST CANCER ALLIANCE OF NORTH TEXAS**

**CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS**

I consent to the use or disclosure of my protected health information by Drs. Bourland, Ganaraj & Kilbride for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Drs. Bourland, Ganaraj, & Kilbride. I understand that diagnosis or treatment of me by Drs. Bourland, Ganaraj, & Kilbride may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Drs. Bourland, Ganaraj, & Kilbride is not required to agree to the restrictions that I may request. However, if Drs. Bourland, Ganaraj, & Kilbride agrees to a restriction that I request, the restriction is binding on Drs. Bourland, Ganaraj, & Kilbride I have the right to revoke this consent, in writing, at any time, except to the extent that Drs. Bourland, Ganaraj, & Kilbride has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Drs. Bourland, Ganaraj, & Kilbride's Notice of Privacy Practices prior to signing this document. The Drs. Bourland, Ganaraj, & Kilbride's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the Drs. Bourland, Ganaraj, & Kilbride. The Notice of Privacy Practices for Drs. Bourland, Ganaraj, & Kilbride is also provided in the reception area. This Notice of Privacy Practices also describes my rights and the Drs. Bourland, Ganaraj, & Kilbride's duties with respect to my protected health information.

Drs. Bourland, Ganaraj, & Kilbride reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of Drs. Bourland, Ganaraj, & Kilbrides and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

I am giving my permission for my health information, demographic information and my billing account to be discussed with the individuals listed below:

_____	_____
_____	_____
_____	_____

\_\_\_\_\_  
Signature of Patient or Guardian

\_\_\_\_\_  
If Guardian, relationship

\_\_\_\_\_  
Patient name (Print)

\_\_\_\_\_  
Date

## **BREAST CANCER ALLIANCE OF NORTH TEXAS**

### **Notice of Privacy Practices**

*To our patients.* This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

#### **Our commitment to your privacy**

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with the following important information:

#### **Use and disclosure of your health information in certain special circumstances**

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including  
2 veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

#### **Your rights regarding your health information**

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit a signed and dated request to Drs. Bourland, Ganaraj, & Kilbride at 8160 Walnut Hill Lane, Suite 113, Dallas, Texas 75231.
4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Drs. Bourland, Ganaraj, & Kilbride at 8160 Walnut Hill Lane, Suite 113, Dallas, Texas 75231. You must provide us with a reason that supports your request for amendment.
5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact our front desk receptionist.
6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Cindy Fendley at 214-345-7374. All complaints must also be submitted in writing to the practice address. You will not be penalized for filing a complaint.
7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact Cindy Fendley at 214-345-7374.

I hereby acknowledge that I have been presented with a copy of Drs. Bourland, Ganaraj, & Kilbride's Notice of Privacy Practices.

Signature \_\_\_\_\_

Date \_\_\_\_\_

Name of Patient (Print)\_\_\_\_\_