Medical Weight Loss Intake Form

Patient First Name

Patient Middle Name

Patient Last Name

Patient Preferred Name

Address

Address 2

City

State

Zip

Cell Phone

Sex

- [ ] Male
- [ ] Female
- [ ] Other

Explain

Martial Status

- [ ] Single
- [ ] Married
- [ ] Divorced
- [ ] Widowed

Age

Date of Birth

Race

- [ ] White
- [ ] Black/African American
- [ ] Asian
- [ ] American Indian/Alaska Native
- [ ] Native Hawaiian/Other Pacific Islander
- [ ] Other
- [ ] Unreported/Declined to Report

List

Ethnicity

- [ ] Hispanic or Latino
- [ ] Non Hispanic or Latino
- [ ] Unreported/Declined to Report

Email Address

Occupation

Emergency Contact First Name

Emergency Contact Last Name

Emergency Contact Phone

Emergency Contact Reletionship

How did you hear about us?

Are you under the care of a qualified healthcare professional? If so, list their name.

Please bring any blood work results if you had those done with your PCP in the last 6 months to 1 year.

As detailed in the Consent portion, it is highly recommended that you are under the care of a qualified healthcare professional, who has verified that it is safe for you to exercise and be on a weight loss program and is monitoring medications and any health concerns that you list here (besides your weight issues- that's what we're covering). If you are on medications (particularly for high blood pressure, heart issues, or diabetes), you will need these to be monitored during and after the program as your need for them may change.

I acknowledge the above statement above.

Signature

Medical History

Please list any medical conditions a medical provider has diagnosed you with in the past: (such as high blood pressure, diabetes, arthritis, etc.)

What medications, supplements and over the counter items do you take regularly or are currently prescribed:

Any past surgeries and/or hospitalizations?

Please describe your family history in terms of heart disease, diabetes, obesity, high cholesterol, high blood pressure, and cancer:

What are your main interests and hobbies?

What is your line of work or study?

Do you exercise regularly? Please detail.

What kind of other movement or activities do you enjoy?

You have problems falling or staying asleep?

☐ Yes ☐ No

How many hours do you sleep per night?

☐ Less than 4 hrs ☐ 5-6 hrs ☐ 7-8 hrs ☐ 9-10 hrs ☐ 11+ hrs

Do you wake up feeling refreshed?

☐ Yes ☐ No

How are your energy levels?

☐ Very Low ☐ Low ☐ Moderate ☐ High

Does your energy levels affect your daily activities?

☐ Yes ☐ No

Does your mood affect your life or daily activities?

☐ Yes ☐ No

How would you describe your general mood?

How would you describe your stress levels?

☐ Low ☐ Moderate ☐ High

What are your sources of stress?

How do you manage stress?

Do you have people close to you who support you?

☐ Yes ☐ No

Diet and lifestyle

Do you regularly drink alcoholic beverages?

☐ Yes ☐ No

If yes, how many drinks/week?

Do you use recreational drugs?

☐ Yes ☐ No

What do you use?

Do you use tobacco or nicotine products?

☐ Yes ☐ No

What type?

How is your appetite?

☐ Low ☐ Moderate ☐ High

Snack Habits

What?

How much?

When?

Typical Breakfast

What?

How much?

When?

Typical Lunch

What?

How much?

When?

Typical Dinner

What?

How much?

When?

How often do you eat out?

What restaurants do you frequent?

How often do you eat "fast food"?

Do you have any food allergies or intolerances?

☐ Yes ☐ No

Please list them.

Do you have any food dislikes?

☐ Yes ☐ No

What

Do you have any food cravings?

☐ Yes ☐ No

What?

Do you eat because of emotion?

☐ Yes ☐ No

Please explain.

Do you drink coffee, tea, or other caffeinated beverages?

☐ Yes ☐ No

How much daily?

Do you drink soda/soft drinks?

☐ Yes ☐ No

How much daily?

Do you use sugar subsitutes?

☐ Yes ☐ No

What do you use?

What are your worse food habits?

How much fluids do you normally drink? Please approximate in ounces.

Please list all the beverages you drink regularly.

What past struggles and difficulties have you experienced in terms of food and dieting?

What diet and exercise programs, protocols, plans or approaches have you tried in the past?

What types of diet and exercise approaches have worked for you in the past?

What types of diet and exercise approaches have not worked for you in the past?

When did you first become overweight and how did you weight gain start?

What do you think is the cause of you weight problem?

What was your highest weight? (excluding pregnancy)

What was your lowest weight?

Have you ever stayed the same weight for 10 years or more?

How MOTIVATED are you to lose weight?

Is there anything else you would like to tell us?

Please check any factors that you feel have contributed to your current weight.

- [ ] **Slow Metabolism**
- [ ] **Comfort food dependency**
- [ ] **Binge eating**
- [ ] **History of trauma**
- [ ] **Medication related weight gain**
- [ ] **Family history of obesity**
- [ ] **Lack of exercise**
- [ ] **Late night snacking**
- [ ] **History of grief or loss**
- [ ] **Significant restrictive eating behaviors such as anorexia**

Health History

Have you experienced:

Fatigue
☐ No, never ☐ Yes, currently
☐ Not currently, but within the last year
☐ No currently, but longer than 1 year ago

Unexplained weight loss or gain
☐ No, never ☐ Yes, currently
☐ Not currently, but within the last year
☐ No currently, but longer than 1 year ago

Change in appetite
☐ No, never ☐ Yes, currently
☐ Not currently, but within the last year
☐ No currently, but longer than 1 year ago

Depressive symptoms
☐ No, never ☐ Yes, currently
☐ Not currently, but within the last year
☐ No currently, but longer than 1 year ago

Anxiety
☐ No, never ☐ Yes, currently
☐ Not currently, but within the last year
☐ No currently, but longer than 1 year ago

Mood swings
☐ No, never ☐ Yes, currently
☐ Not currently, but within the last year
☐ No currently, but longer than 1 year ago

Nervousness
☐ No, never ☐ Yes, currently
☐ Not currently, but within the last year
☐ No currently, but longer than 1 year ago

Addictive dependency
☐ No, never ☐ Yes, currently
☐ Not currently, but within the last year
☐ No currently, but longer than 1 year ago

Disordered eating patterns/tendencies
☐ No, never ☐ Yes, currently
☐ Not currently, but within the last year
☐ No currently, but longer than 1 year ago

Tension
☐ No, never ☐ Yes, currently
☐ Not currently, but within the last year
☐ No currently, but longer than 1 year ago

Lack of mental focus
☐ No, never ☐ Yes, currently
☐ Not currently, but within the last year
☐ No currently, but longer than 1 year ago

Thyroid problems
☐ No, never ☐ Yes, currently
☐ Not currently, but within the last year
☐ No currently, but longer than 1 year ago

Diabetes
☐ No, never ☐ Yes, currently
☐ Not currently, but within the last year
☐ No currently, but longer than 1 year ago

Blood sugar irregularities
☐ No, never ☐ Yes, currently
☐ Not currently, but within the last year
☐ No currently, but longer than 1 year ago

Excessive thirst or hunger
☐ No, never ☐ Yes, currently
☐ Not currently, but within the last year
☐ No currently, but longer than 1 year ago

Sugar cravings
☐ No, never ☐ Yes, currently
☐ Not currently, but within the last year
☐ No currently, but longer than 1 year ago

Abnormal hair growth
☐ No, never ☐ Yes, currently
☐ Not currently, but within the last year
☐ No currently, but longer than 1 year ago

Excessive perspiration
☐ No, never ☐ Yes, currently
☐ Not currently, but within the last year
☐ No currently, but longer than 1 year ago

Feeling excessively hot or cold
☐ No, never ☐ Yes, currently
☐ Not currently, but within the last year
☐ No currently, but longer than 1 year ago

Headache
☐ No, never ☐ Yes, currently
☐ Not currently, but within the last year
☐ No currently, but longer than 1 year ago

Lightheadedness
☐ No, never ☐ Yes, currently
☐ Not currently, but within the last year
☐ No currently, but longer than 1 year ago

Joint pain or stiffness
☐ No, never ☐ Yes, currently
☐ Not currently, but within the last year
☐ No currently, but longer than 1 year ago

Muscle weakness or soreness
☐ No, never ☐ Yes, currently
☐ Not currently, but within the last year
☐ No currently, but longer than 1 year ago

High blood pressure
☐ No, never ☐ Yes, currently
☐ Not currently, but within the last year
☐ No currently, but longer than 1 year ago

Heart murmur/palpitations
☐ No, never ☐ Yes, currently
☐ Not currently, but within the last year
☐ No currently, but longer than 1 year ago

Cold or pale extremities
☐ No, never ☐ Yes, currently
☐ Not currently, but within the last year
☐ No currently, but longer than 1 year ago

Asthma
☐ No, never ☐ Yes, currently
☐ Not currently, but within the last year
☐ No currently, but longer than 1 year ago

Shortness of breath
☐ No, never ☐ Yes, currently
☐ Not currently, but within the last year
☐ No currently, but longer than 1 year ago

Heartburn
☐ No, never ☐ Yes, currently
☐ Not currently, but within the last year
☐ No currently, but longer than 1 year ago

Abdominal discomfort after eating
☐ No, never ☐ Yes, currently
☐ Not currently, but within the last year
☐ No currently, but longer than 1 year ago

Nausea
☐ No, never ☐ Yes, currently
☐ Not currently, but within the last year
☐ No currently, but longer than 1 year ago

Abdominal bloating
☐ No, never ☐ Yes, currently
☐ Not currently, but within the last year
☐ No currently, but longer than 1 year ago

Belching or excessive gas
☐ No, never ☐ Yes, currently
☐ Not currently, but within the last year
☐ No currently, but longer than 1 year ago

Constipation
☐ No, never ☐ Yes, currently
☐ Not currently, but within the last year
☐ No currently, but longer than 1 year ago

Informed Consent

Informed Consent for Medically Managed Weight Loss Therapy

I acknowledge that I am voluntarily entering into a medically managed weight loss program with Lakeside Integrative Healthcare. I fully realize that entering any program involving weight reduction, which includes moderate calorie restriction, exercise, and medications, involves potential risks and side effects. The risks include, but may not be limited to the following:

1. **Cardiovascular (heart or blood pressure):** These problems may include heart palpitations, irregular beats, or rapid heartbeat. These effects are usually mild but can result in serious problems including heart attack or stroke. Also, these medications may increase blood pressure, which if left untreated can lead to heart attack or stroke. If you discontinue the weight loss medication, the elevated blood pressure usually resolves. For this reason, if you are on blood pressure medications you are required to monitor your blood pressure daily and discontinue medications if blood pressure rises, your heart rate increases, or you feel palpitations.

2. **Sudden Death:** Patients with morbid obesity, particularly those with hypertension, heart disease, or diabetes, have a statistically higher chance of suffering sudden death when compared to normal weight people without such medical problems. Rare instances of sudden death have occurred while obese patients were undergoing medically supervised weight reduction, though no cause and effect relationship with the diet has been established. The possibility cannot be excluded that some undefined or unknown factor in the treatment program could increase this risk in an already medically vulnerable patient.

3. **Reduced Potassium Levels:** The calorie level you will be consuming is 800 or more calories per day and it is important that you consume the calories which have been prescribed in your diet to minimize side effects. Failure to consume all the food and fluids, nutritional supplements or taking a diuretic medication (water pill) may cause low blood potassium levels or deficiencies in other nutrients. Low potassium levels can cause serious heart irregularities. When someone has been on a reduced calorie diet, a rapid

increase in calorie intake, especially overeating or binge-eating, can be associated with bloating, fluid retention, disturbances in electrolytes, or gallbladder attacks and abdominal pain. For these reasons, following the diet carefully and following the gradual increase in calories after weight loss is essential.

4. **Gall Bladder Disease:** Any program resulting in rapid weight loss may precipitate the formation of gallstones, which could lead to cholecystitis (inflammation of your gallbladder), which is a medical urgency or emergency and could require surgery. This is typically because of the rapid weight loss, not the medications you are taking. Symptoms include right upper abdominal pain, abdominal pain just below your ribs, nausea, and vomiting.

5. **Pancreatitis:** Pancreatitis, or an infection in the bile ducts, may be caused by gallstones or the development of sludge or obstruction in the bile ducts. The symptoms of pancreatitis include pain in the left upper abdominal area, nausea, and fever. Pancreatitis may be precipitated by binge-eating or consuming a large meal after a period of dieting. Also associated with pancreatitis is long-term abuse of alcohol and the use of certain medications and increased age. Pancreatitis may require surgery and may be associated with more serious complications and death.

6. **Psychiatric:** There are reported cases of “hysterical or psychotic reactions” associated with the use or discontinuation of some of the drugs utilized for weight loss purposes. These reactions are extremely rare.

7. Men over 40 and post-menopausal women in general, and patients with risk factors for cardiovascular disease should have a cardiovascular evaluation before entering a medically managed weight loss program. This may include an ECG, a stress test, or other testing procedures, as per the discretion of a cardiologist. If you are over the age of 40, post-menopausal (female), smoke, have a history of high blood pressure, high cholesterol or you are diabetic, you acknowledge that you have had a cardiac evaluation and that you have been cleared medically prior to starting this weight loss program.

8. Common, but troublesome side effects may include but not be limited to dry mouth, palpitations, “speedy” feeling, headaches, sleeplessness., Rash, fever, nausea, vomiting, allergic reactions, decreased insulin sensitivity, flushing, headache, fatigue, lightheadedness, abdominal cramping, joint pain, fluid retention, and additional side effects not listed that will be discussed during your evaluation with Lakeside Integrative Healthcare. These side effects are generally rare, and most patients tolerate treatment without an issue.

9. Drug interactions may occur if other medications are taken. Therefore, I will check with my prescribing medical provider before starting the program if I am taking other medications.

10. Certain medical conditions may be worsened if on this program, including glaucoma, hypertension, and heart disease.

11. Pregnancy (Females Only). If you become pregnant, inform your physician immediately. Your diet must be changed promptly to avoid further weight loss because a restricted diet could be damaging for a developing fetus. You must take precautions to avoid becoming pregnant during the course of weight loss.

12. The use of medications for weight management is indicated for those patients who have a BMI of 30 or higher or a BMI of 27 or higher with other medical conditions such as high blood pressure, diabetes, or high cholesterol. Prescribing medications for patients not fitting these criteria, is considered “off label” and not “FDA approved.” Therefore, the potential risks vs. benefits may be great. For patients not fitting the BMI criteria for use of appetite suppression medication, you are acknowledging that:

- You have put forth a true effort to lose weight through diet and exercise over the past 6 months and have still not achieved your weight loss goals.
- That your inability to lose weight is causing significant emotional distress

- You are choosing to enter this medically managed weight loss program voluntarily and hold harmless Lakeside Integrative Healthcare for use of such medications.

13. You acknowledge that alcohol and illicit drug use is prohibited in the program. Drugs like cocaine and amphetamines when used in conjunction with appetite suppressants and other medications prescribed could cause in serious injury or death. The use of alcohol will also affect your results.

14. I understand that the physician and I will determine what my daily caloric intake will be at my initial visit.

15. I acknowledge that I understand that the amount of weight loss varies from patient to patient, and is, to a large extent dependent on each patient's personal motivation and commitment to their diet and exercise plan. No claims as to efficacy or specific amount of weight loss is either expressed or implied. I understand the importance of routinely following up with Lakeside Integrative Healthcare to monitor my progress during treatment. I understand this is vital to the safety of the treatment program and certify that I will be returning monthly as prescribed.

16. I hereby authorize Lakeside Integrative Healthcare, its medical providers, and additional staff of Lakeside Integrative Healthcare to evaluate me for admission into Lakeside Integrative Healthcare weight management program and treat me accordingly. I consent to obtaining blood work before treatment if deemed necessary. I certify that I am signing this under my free will and am competent in making my own medical decisions.

17. I have reviewed the risks mentioned and have determined the benefits outweigh the possible risks associated with medically managed weight loss therapy with Lakeside Integrative Healthcare. I release any claim in court or any type of complaint that could result from treatment with Lakeside Integrative Healthcare and any other staff associated with Lakeside Integrative Healthcare and will not hold liable any provider or staff of Lakeside Integrative Healthcare.

18. I understand that treatment modalities utilized by Lakeside Integrative Healthcare might not be supported by scientific/medical literature and could be seen as experimental or based off anecdotal claims. Many medical providers, including endocrinologists, surgeons, family practice doctors, etc., might see these types of treatments as not medically necessary. I also understand that many of the medications being utilized within Lakeside Integrative Healthcare medically managed weight loss program are considered to be used "off label" and might not be FDA approved for weight loss purposes.

By signing below, I acknowledge that I have had an opportunity to discuss concerns and the above information with Lakeside Integrative Healthcare either in person or by telephone conversation. I consent to the treatment being offered to me by Lakeside Integrative Healthcare and I am satisfied with the explanation. I acknowledge that I have read or have had read to me the above consent and understand the information presented.

Name

Patient's Signature

Risks and Benefits Acknowledgement

Risk and Benefits Acknowledgement

I recognize the potential risks of this treatment program, and I also understand the potential benefits of weight loss, which may include:

1. Decreased risk of heart attack.
2. Decreased risk of adult onset diabetes mellitus.
3. Decrease risk to developing arthritis or developing musculoskeletal conditions that are caused by excessive weight.
4. Increased emotional and psychological well-being.
5. Decreased risk of developing certain types of cancer.

I acknowledge that the medically managed weight loss program recommended to me by Lakeside Integrative Healthcare is just one of multiple strategies to reduce weight. Alternative treatment options include:

1. Diet and exercise alone without medications.
2. The use of other kinds of medications to achieve appetite suppression.
3. Non-medical weight loss programs like Weight Watchers.
4. Bariatric Surgery.

Patient Name

Signature

My obligations and Representations

My Obligations and Representations

Any questions I have regarding this treatment have been answered to my satisfaction. I understand that I will be responsible for administering the medications prescribed to me if I do not have them administered to me in clinic. I also promise to comply with the dosages and frequency of medications prescribed to me.

I certify that I am under the regular care of a primary care provider for any other conditions I might have or am found to have. I will consult with my primary care provider or specialist regarding any other condition I might have. I understand that if I do not have a primary care provider, that I will be encouraged to seek one out. I acknowledge that I am seeking care at Lakeside Integrative Healthcare for medically managed weight loss services that Lakeside Integrative Healthcare offers. I acknowledge I am not wanting to establish primary care with Lakeside Integrative Healthcare and I am here for specialized care including weight loss therapy, diet counseling, exercising counseling, etc.

Patient Name

Signature

Regaining Weight Acknowledgement

Regaining Weight Acknowledgement

There is a risk of regaining the weight you have lost. Obesity is a chronic condition, and the majority of overweight individuals who lose weight have a tendency to regain all or some of it back over time. Factors which favor maintaining weight loss include exercise, adherence to a diet that is low-calorie, nutritious, and full of lean proteins and vegetables, and planning a strategy for coping with weight regain before it occurs. Successful treatment may take months or even years. Utilizing medications to assist you in your weight loss goals in addition to diet and exercise could result in the weight coming back if you do not maintain eating a healthy diet and exercising. Additionally, if you have had fluctuations in your weight in the past, it may be more difficult to maintain the weight you lose.

Patient Name

Signature

Clinic Policies

Lakeside Integrative Healthcare Clinical Policies

If you have any questions, please feel free to ask us.

- If you are late or miss your appointment, you may be subject to a $50 fee.
- Services must be paid for at the time of service.
- Health insurance typically does not cover the services provided at Lakeside Integrative Healthcare. If you want to seek insurance reimbursement, we would be happy to provide you with itemized invoices that you can submit to your insurance company.
- Phentermine and Vyvanse are considered controlled substances. I agree that I will take my medications as prescribed. I agree to follow my medical providers instructions. I also agree that I will not sell or share my prescriptions to other individuals.

- I understand that treatments used at Lakeside Integrative Healthcare might not be considered a medical necessity. Treatments rendered are for the purpose of improving your quality of life through hormone restoration, nutritional and supplemental counseling, and weight loss treatment.

- I agree that if I have any side effects or become sick, that I will follow up with my primary care provider or go to an urgent care or emergency department.

- I acknowledge that Lakeside Integrative Healthcare are not my primary care providers unless I elect them so. I agree that I will continue with routine care through my primary care provider and notify them of treatments prescribed at Lakeside Integrative Healthcare.

- I understand that there are no refunds for services or products rendered. We cannot accept back used medications once they have been dispensed per state regulation.

- I understand that having an appointment with Lakeside Integrative Healthcare does not necessarily entitle me to being issued a prescription for hormone replacement, weight loss medication or additional medications. Every individual is different, and it is at the medical providers discretion to issue a prescription.

- I understand that I must maintain my follow-up appointments to remain on treatment. It is important that lab work is monitored regularly for safety purposes. It is important that a Lakeside Integrative Healthcare provider manages my treatment, and it is at their discretion to provide treatment.

- I acknowledge that I have been advised of the risks and benefits of treatment. I also acknowledge that I have been advised of possible complications and side effects. I understand the risks, benefits, complications, and side effects of treatment.

- I am voluntarily requesting treatment with Lakeside Integrative Healthcare and its medical providers regarding weight loss therapy as determined by a mutual decision between myself and the medical provider even if my hormone levels are considered to be in normal range for my age based off of other medical society recommendations and guidelines or if I am just considered overweight and not obese.

- I do not hold any medical practitioner of Lakeside Integrative Healthcare responsible for performing age-related preventive care. I agree that I will follow up with my primary care provider to obtain these screenings and I hold Lakeside Integrative Healthcare and its medical providers harmless if an adverse event occurs during my treatment. I will ensure that my primary care provider provides the results of such screenings to Lakeside Integrative Healthcare as this could change the treatment prescribed to me.

I have read, understand, and agree to all the above statements.

Patient Name

Signature

Consent

CONSENT FOR CARE TREATMENT

I, the undersigned do hereby agree and give consent to providers with Lakeside Integrative Health Care, to furnish treatment to the patient listed below that is considered necessary and proper in diagnosing or treating his/her physical and/or mental condition.

Name **Date of Birth**

Patient’s Signature

Privacy Practices

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Privacy & Accountability Act of 1996 (HIPAA) I have certain rights to privacy regarding my protected health insurance. I understand that this information can and will be used to :

- Conduct, plan and direct my treatment and follow-up among multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certification.
  I acknowledge that I have reviewed your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may obtain a current copy of the Notice of Privacy Practices.I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you do not agree that you are bound to abide by such restrictions.

Signature

Date

Patient Consent

PATIENT CONSENT FOR USE AND DISCLOSE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Lakeside Integrative Health Care, to use and disclose protected health information about me to carry out treatment, payment and healthcare operations. Lakeside Integrative Health Care, Notice of Privacy Practices provides a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to singing this consent. Lakeside Integrative Health Care reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to:

Lakeside Integrative Health Care

With this consent form, Lakeside Integrative Health Care, may call my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out treatment, payment and healthcare operations such as appointment reminders, insurance items and any calls pertaining to my clinical care including laboratory results, among others.

With this consent form, Lakeside Integrative Health Care, may mail, to my home or other alternative location, any items that assist in carrying out treatment, payment or healthcare operations such as appointment reminder cards and patient statements as long as they are marked personal and confidential. With this consent form, Lakeside Integrative Health Care, may email, to my home or other alternative location, any items that assist the practice in carrying out treatment, payments or healthcare operations such as appointment reminders. I have the right to request that Lakeside Integrative Health Care, restrict how it uses or discloses my protected health information (PHI) to carry out treatments, payments and healthcare operations. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Lakeside Integrative Health Care, use and disclosure of PHI to carry out treatment, payment and healthcare operations.

I may revoke my consent in writing except to the extent the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent or later revoke it, Lakeside Integrative Health Care, may decline to provide treatment for me.

Name

Signature

Date