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New Patient Registration Packet

Date:	**Date of Birth:**	**Social Security Number:**
Patient Full Name:		
Address:		
City:	**State:**	**Zip Code:**

Home Phone:		**Cell Phone:**	**Relative Phone:**
Best time to reach you:		Day: Night:	**Email Address:**
Gender:	☐ Male	☐ Female	**Age:**
Emergency Contact Name:			**Emergency Contact Number:**
Are you a smoker?		☐Yes ☐ No	

Marital Status:	☐ Married	☐ Widowed	☐ Single	☐ Separated	☐ Divorced ☐ Life Partner
Student Status:	☐ Fulltime	☐ Part-time	☐ Not a Student		**Veteran Status:** ☐ Yes ☐ No

Homeless Status:	☐ Not Homeless ☐ Doubling Up ☐ Shelter ☐ Street ☐ Transitional	
Migrant Worker Status:	☐ Migrant ☐ Not a Farm Worker ☐ Seasonal	
Language Barrier:	☐ Yes ☐ No	**Your primary spoken language:**

Race:	☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Guamanian or Chamorro ☐ Samoan ☐ Black/African American ☐ American Indian/Alaska Native ☐ White ☐ More than one race ☐ Unreported/Chose not to disclose race
Ethnicity:	☐ Chicano ☐ Cuban ☐ Mexican ☐ Mexican American ☐ Not Hispanic or Latino ☐ Puerto Rican ☐ Another (Hispanic or Latino) ☐ Declined to specify

Number of family members in household:	
How did you hear about CHDC?	

********State your household income in one of the following categories listed below********				
Household Income:	Weekly:	Biweekly:	Monthly:	Yearly:

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with Community Health and Dental Care. Although we will compile the necessary forms to file to your insurance company it is the responsibility of the patient to dispute any services not covered by the insurance company.

I further understand that fees are due and payable on the date services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement

Type full name here to sign electronically

_____ **Patient/Guardian Signature**

_____ **Date**

Patient Name:	**Date of Birth:**

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Patient Insurance Information

Leave sections blank if they do not apply

MEDICAL INSURANCE

Primary Medical Care Provider:	
Primary Medical Insurance Coverage:	
Subscribers Name:	**Relationship to Patient:**
Group Number:	**ID Number:**

Secondary Medical Insurance Coverage:	
Subscribers Name:	**Relationship to Patient:**
Group Number:	**ID Number:**

DENTAL INSURANCE

Primary Dental Provider:	
Primary Dental Insurance Coverage:	
Subscribers Name:	**Relationship to Patient:**
Group Number:	**ID Number:**

Secondary Dental Insurance Coverage:	
Subscribers Name:	**Relationship to Patient:**
Group Number:	**ID Number:**

VISION INSURANCE

Primary Vision Provider:	
Primary Vision Insurance Coverage:	
Subscribers Name:	**Relationship to Patient**
Group Number:	**ID Number:**

Secondary Vision Insurance Coverage:	
Subscribers Name:	**Relationship to Patient:**
Group Number:	**ID Number:**

Patient Name:	**Date of Birth:**

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CONSENT FOR TREATMENT

PATIENT: DOB: DATE:

Please note that this consent applies to services rendered, both in-person and virtually, anywhere Community Health and Dental Care is providing services.

1. CONSENT FOR TREATMENT: By this document, I do hereby request and authorize CHDC (Community Health and Dental Care, Inc.), its health practices and providers, whether employed directly by CHDC or brought in on a consulting basis, including physicians, nurse practitioners and medical providers, dentists, public health dental hygienists, behavioral health providers, medication assisted treatment team, technicians, nurses, phlebotomists, scribes, and other qualified providers, resources, and personnel to perform evaluation and treatment services and procedures in accordance with the judgment of the attending medical provider(s). I understand that CHDC utilizes telehealth/telemedicine technologies including digital photography, interactive audio and/or video, cloud-based storage, and other types of secure HIPAA compliant technologies. Photographs, interactive video, and/or audio may be taken and/or utilized during my stay for treatment reasons or for monitoring my safety. Photographs may become part of my medical record, as appropriate. I acknowledge that no guarantees have been made as to the results of treatments or examinations in CHDC, or otherwise. I realize that I have the right to refuse any drugs, treatment, procedures, or photographs to the extent permitted by law.

2. PRIVACY NOTICE: I acknowledge receipt of the Health Information Privacy Notice for Community Health and Dental Care, Inc., and as amended from time to time.

3. INSURANCE AUTHORIZATION AND ASSIGNMENT: I request that payment of authorized health benefits is made on my behalf directly to the CHDC provider of service(s) furnished to me. I authorize CHDC to release any health information to my health insurance carrier and/or its legitimate agents that is necessary to process related health insurance claims and/or to verify plan benefits in accordance with HIPAA health information standards. I authorize payment of service(s), otherwise payable to me under the terms of my private, group employer's or group health insurance plan, directly to CHDC. I hereby authorize photocopies of this form to be valid as the original. I acknowledge that CHDC will perform a search for active insurance coverage on all self-pay patients unless specifically requested otherwise with CHDC staff. This search will take place post-discharge if the named patient's bill remains unpaid for a defined period of time.

4. ASSIGNMENT OF BENEFITS: In the event the undersigned is entitled to insurance benefits of any type out of any program health benefit plan or policy of insurance covering the patient or any other party liable to the patient, then such benefits are hereby assigned to CHDC and may be paid directly to CHDC. In the event benefits are paid, CHDC shall credit all payments to the patient's account; however, the patient and the undersigned, if not the patient, shall remain responsible for any portion of the CHDC bill not covered by this assignment. In the event that it is necessary to appeal an insurance payment decision, I authorize CHDC to appeal on my behalf.

5. COORDINATION OF BENEFITS (COB): Coordination of benefits is the process insurance companies use to determine how to cover your medical expenses when you're covered by more than one health insurance plan. It clarifies who pays what by determining which plan is the primary payer and which is secondary. It also ensures proper claim processing and helps avoid overpayment or duplicate payments. When a person has multiple insurance plans, COB rules determine the order in which the insurance plans will pay for covered services. The primary plan is responsible for processing the claim first and paying its share of the coverage amount. The secondary plan would then review the claim and pay the remaining balance within its coverage limits. For example, suppose you visit your doctor and get billed $250 for the appointment. Your primary health plan may cover the majority of the bill. Let's say, for example, that's $200. Then your secondary plan would pay the remaining $50. To prevent overpayment or duplication, plans will not pay more than 100% of the cost of the medical service(s), meaning that the combined benefits shouldn't surpass the total cost of the treatment. You may also be responsible for deductibles, copayments, and coinsurance. I understand it is my responsibility, as the patient, guarantor, or legal representative, to provide CHDC with all of my insurance coverage at time of service, and it is my, my guarantor, or my legal representative, responsibility to have my benefit coverage updated as needed at each service and with each of my insurance coverage plans. For example, if I am covered by two plans but then lose what was my primary coverage (plan A), what was my secondary coverage (plan B) becomes my primary coverage. I would need to contact my old secondary (plan B) to update that file to reflect it is no longer covered by plan A. By not doing so, plan B will not pay any claims as that record of being secondary expects payment from another source prior to any payment being issued. Failure to update insurance coverages may result in patient being responsible for charges and further collection activity.

6. PATIENT PAYMENT GUARANTEE AND FINANICAL RESPONSIBILITY: All services rendered are charged to the patient and are due at the time of service unless other arrangements have been made in advance with Community Health and Dental Care. Although we will compile the necessary forms to file with your insurance company, it is the responsibility of the patient to dispute any services not covered by the insurance company. I do hereby guarantee payment of all fees and charges related to all services and durable goods provided to me through CHDC health practices and providers from my first date of examination or treatment, including services provided virtually. I further understand that fees are due and payable on the date services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. I agree to make full payment immediately upon receipt of a CHDC billing statement whether it is an interim or final bill. In the event that I fail to make full payment or fail to comply with other payment arrangements made with CHDC's approval, I understand that appropriate collection measures may be initiated.

I understand, as the patient, guarantor, or legal representative, I am ultimately responsible for all payment obligations arising out of treatment or care and guarantee payment for these services. I, my guarantor, or my legal representative, am responsible for deductibles, co-payments, co-insurance amounts or any other patient responsibility indicated by my insurance carrier which are not otherwise covered by supplemental insurance.

I understand, as the patient, guarantor, or legal representative, I am responsible for knowing my insurance policy. For example, I, my guarantor, or my legal representative, will be responsible for any charges if any of the following apply: (i) my health plan requires prior authorization or referral by a Primary Care Physician (PCP) before receiving services at CHDC, and I have not obtained such an authorization or referral; (ii) I receive services in excess of such authorization or referral; (iii) my health plan determines that the services I received at CHDC are not medically necessary and/or not covered by my insurance plan; (iv) my health plan coverage has lapsed or expired at the time I receive services at CHDC; or (v) I have chosen not to use my health plan coverage. If I am not familiar with my plan coverage, I will contact my carrier or plan provider directly.

7. MEDICAL ASSISTANCE VERIFICATION: I certify that I received a service or item on the date listed below. I understand that payment for this service or item will be from Federal and State funds, and that any false claims, statements or documents, or concealment of material may be prosecuted under applicable Federal and State laws.

8. TELEPHONE CONSENT: I agree to allow CHDC, its agents, and vendors to use pre-recorded or artificial voice messages, automatic telephone dialing system to contact me at the phone numbers that I provided and are on file (including wireless or cell phone numbers), and to leave voice mail messages at these phone numbers and include in any such messages information (including information required by law) about experience outreach and amounts I owe.

9. CONSENT TO ELECTRONIC COMMUNICAITON: I consent and authorize Community Health and Dental Care and its related entities, agents, contractors, including but not limited to schedulers, billing, and other staff to use automated telephone dialing systems, SMS text messaging, and electronic mail to (1) provide messages (including pre-recorded messages or text messages) to me about my account, payment due dates, missed payments, information for or related to medical goods and/or services provided, exchange information, changes to health care law, health care coverage, care follow-up, and other healthcare information or (2) provide messages (including pre-recorded messages) during a call or via text message that delivers a ‘health care’ message made by, or on behalf of, a ‘covered entity’ or its ‘business associate’ as those terms are defined in the HIPAA Privacy Rule, 45 CFR 160.103. I understand that I may opt out by calling Community Health and Dental Care at 610-326-9460.

10. ELECTRONIC HEALTH RECORD: Healthcare providers require access to patient health information whenever or wherever a patient presents for care to assure safety, quality and to coordinate patient care across the provider network, avoiding duplication of services. CHDC has a system-wide electronic health record that is available to caregivers on a "need to know" basis, to share information about patient care provided in the hospital, outpatient or physician office settings. Confidentiality of records including those reflecting treatment for behavioral health issues, social determinants of health, HIV/AIDS, and substance use issues is maintained per relevant governmental and regulatory standards. Patient care summaries are automatically sent to designated CHDC and other community primary care/family/referring physicians, as well as to physicians who are consulted by the attending physician for coordination of care. CHDC and/or the attending physician can furnish and release to federal and state healthcare oversight agencies, or upon written request, to all insurance companies or their representatives any information with respect to treatment of the patient herein named, including copies of the medical record. This information can include clinical screenings, results, along with relevant diagnoses.

11. HEALTH INFORMATION EXCHANGES: CHDC may make your health information available electronically through a state, regional, or national Health Information Exchange (HIE) service or through NextGen Share ® Network to facilitate the secure exchange of your health information between and among several health care providers or other health care entities for your treatment, payment, or other healthcare operations purposes. This means we may share information we obtain or create about you with a HIE, which will be made available to outside entities (such as hospitals, doctors offices, pharmacies, or insurance companies) or we may receive information they create or obtain about you (such as medication history, medical history, or insurance information) so each entity can provide better treatment and coordination of your healthcare services. In cases where your specific consent or authorization is required to disclose certain health information to others, we will not disclose that health information without first obtaining your consent. Information that requires additional consent in order to be shared includes psychotherapy notes, treatment for substance or alcohol abuse, and records of tests or treatment for sexually transmitted diseases.

We also participate with the Health Share Exchange (HSX), which is a non-profit organization responsible for facilitating data sharing between healthcare providers. For example, if you were to visit an unfamiliar Emergency Department, the ED doctor will be able to access your health record to see your medical history, including allergy information. Access to your health information during an emergency situation can be life-saving, especially if you are unconscious, and unable to relay your important health information to the doctor. If for any reason you are uncomfortable with this type of data sharing, you have the option to opt out. This is your responsibility. Note: if you choose to opt out of HSX, then it is important for you to know that your information will not be available to view, even in emergency situations.

12. PATIENT PORTAL: Access to the secure patient portal is an optional service which I may suspend or terminate at any time for any reason. I understand that my access to the patient portal will not affect the level of care that I receive. I understand that it is my responsibility to notify CHDC if there is a change in my email account or if I feel that my secure password has been breached.

13. ELECTRONIC PRESCRIBING: I understand that CHDC health practices and offices may use an electronic prescription system which allows prescriptions and related information to be electronically sent between my CHDC providers and my pharmacy. I have been informed and understand that CHDC providers using the electronic prescribing system will be able to see information about medications I am already taking, including those prescribed by other providers. I give my consent to my CHDC providers to see this health information.

14. IMMUNIZATION REGISTRY: I understand that CHDC participates in the Pennsylvania Department of Health's statewide immunization registry that collects vaccination history and information to serve the public health goal of preventing the spread of vaccine preventable diseases. The registry complies with federal health information privacy laws.

15. Scribe Service: I am aware that the provider may use a virtual and/or in-person scribe service during my visit. This scribe will document my electronic medical records in real- and non-real time. The virtual connection is used in accordance with HIPAA guidelines and used for better medical care delivery, improved medical documentation, and quality assurance. I have also been informed that it is my choice if I want to use scribing in my visit with my provider. I also realize that by signing this form, I give my consent to allow the provider to use scribing in all my future visits. If at any time I decide to not allow scribing, I am to let the provider know, and the provider will not use scribing. I understand and agree that: giving my permission for scribing during my visit is voluntary; my examination, treatment, payment, health plan enrollment, or eligibility for benefits will not be affected if I say “no” to scribing; I can ask my provider to stop or pause scribing at any time; my written permission to allow scribing expires 12 months from today’s date; I will be asked to give my verbal permission of scribing at each visit and can say “no” each time and scribing will not occur; my questions about scribing and scribing consent have been answered.

In addition to the Terms and Conditions set forth in items 1 through 15 above, the following also applies to services rendered at, or rendered virtually by, CHDC:

RELEASE OF RESPONSIBILITY FOR PERSONAL VALUABLES: I have been made aware and understand that all CHDC health practices and offices provide no facilities for safekeeping of valuables. I do hereby release CHDC from any responsibility due to loss or damage of any valuables that I, or anyone accompanying me, may bring to a CHDC health practice, office or facility.

FORMS/PAPERWORK NEEDING PROVIDER/PRACTITIONER COMPLETION: I have been made aware and understand that any form/document/paperwork may be completed at the discretion of my provider, care team, or CHDC. I have also been made aware and understand that any form/document/paperwork that needs completing and/or signed by CHDC staff, including any provider or practitioner, may take up to 72 hours to complete. Examples of forms include but are not limited to Social Security and Social Security disability, physician certification form, PAIEB form, physical exam and sports physical exam forms, driver’s license permit, FMLA, annual dental forms, school medication form, day care and/or school well child form, pre-op and post-op medical assessment, medical certificate form to avoid public utility shut off. Please note this excludes medical records request forms, which may take up to 30 days to process.

PERMISSION TO FAX CHILDHOOD IMMUNIZATION RECORD TO SCHOOLS: I do hereby grant permission for CHDC to send or fax childhood immunization records to schools, upon request.

CELL PHONE AND VIDEO RECORDING: I have been made aware that at no time, while on CHDC premises and/or receiving CHDC services, both in-person and virtually, am I allowed to use my cell phone or mobile device. This includes all CHDC locations, hallways, consult rooms, exam rooms, and all other CHDC space in all locations. I have also been made aware that there is also no video recording or photograph capturing of any kind, whether through use of cell phone, mobile device, or any other equipment used to capture video and/or photographs. Cell phone/mobile device use and video recording is strictly prohibited.

ARTIFICIAL INTELLIGENCE (AI): Most people already use artificial intelligence (AI) in their daily lives, sometimes without even thinking about it as being AI-driven. Global positioning systems (GPS) are AI-based navigation applications, for instance, that help us find the quickest route between Points A and B and suggest alternate routes when an accident has jammed up traffic. AI speeds up online shopping by remembering our shopping preferences and recommending similar and complementary products. AI in healthcare describes the application of machine learning (ML) algorithms and other cognitive technologies in medical settings. In the simplest sense, AI is when computers and other machines mimic human cognition, and are capable of learning, thinking, and making decisions or taking actions. At CHDC, we may use AI to assist us with scheduling appointments, redirecting phone calls, integrating data from third-party vendors into electronic health records, and/or send text messages related to treatment and awareness campaigns.

I, my guarantor, or my legal representative, certify that I have read this document, that it has been fully explained to me and that I understand its contents, and hereby agree to all terms and conditions set forth above and acknowledge the receipt of a copy if requested .

Signature of Patient/Guarantor/Legal Representative

Patient Name: _____

Patient Signature: _____ Date: _____

Parent/Guarantor/Legal Rep: _____ Date: _____

CHDC Representative: _____ Date: _____

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CHDC Health Information Communication Preferences

PATIENT: _____ DOB: _____ DATE:_____

As our patient, we may need to reach you when you are not in the practice. For your privacy, please indicate your preferred method for us to communicate confidential health information, such as test or lab results, to you and/or others involved in your care. Please note that "appointment reminder telephone calls" may be left at the contact number(s) you list below. Please list your email address to receive online health care educational programs ordered by your care provider.

PLEASE INDICATE YOUR COMMUNICATION PREFERENCES BELOW:

☐ Give permission to leave health information pertaining to me, my dependent or child, at the numbers listed below:

Method	Yes	No	Area Code, Phone #, Ext., Email
Home Telephone	◯	◯	
Answering Machine	◯	◯	
Work Phone	◯	◯	
Cell Phone	◯	◯	
Email for our Patient Portal Secure Email Registration	◯	◯	
Email to Receive Provider-Ordered Online Patient Education Programs	◯	◯	

Without specific permission, we will **not** release any health information to anyone other than you. In some cases you may wish for another person to have access to your health information. Please identify those individuals and their relationship to you (i.e. spouse, parent, son, daughter, partner etc.):

◯ Do not release health information to anyone other than myself.

◯ I give permission to release health information pertaining to me to the individuals listed below.

Name	Relationship (i.e. spouse, parent, son, daughter, etc.)	Area Code, Phone # - Extension

Comments

I assume responsibility to inform the practice of changes in my phone number(s) or my preferences or to revoke this specific health information authorization at any time.

_____ _____

Signature of Patient or Patient's Legal Representative Date

Type full name here to sign electronically

_____ (Please Print Name) **CHDC Representative**_____

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Outreach Consultation Form

As a patient of Community Health & Dental Care, you are eligible to receive **FREE** assistance from our team of highly experienced Patient Case Manager. Please review the following list of services and provide your signature to acknowledge receipt. If you would like to consult with one of our Case Coordinators, please indicate below:

Families

- ☐ Medicaid
- ☐ CHDC Dispensary Services
- ☐ Chip
- ☐ CHDC Health Care Discount Application (Sliding Fee)
- ☐ Enrollment Services (Choosing an HMO and CHDC as PCP)
- ☐ CCIS (Child Care Information Service, subsidized child care)
- ☐ SNAP (Supplemental Nutritional Assistance Program)
- ☐ Cash Assistance
- ☐ School Meals (Assistance)
- ☐ ERAP (Emergency Rental Assistance Program)
- ☐ LIHEAP (Low Income Heating Assistance Program)
- ☐ LIHWAP (Low Income Household Water Assistance Program)
- ☐ Healthy Women (Free mammograms, clinical breast and pelvic exams, and PAP tests)
- ☐ Pennsylvania's Health Insurance Marketplace (PENNIE)
- ☐ Referrals to Mental Health and Substance Abuse Treatment Options
- ☐ Literacy Council of Montgomery County, Chester County, and Berks County
- ☐ Legal Aid
- ☐ WIC (Women Infant Children)
- ☐ Laurel House (Domestic Violence)
- ☐ Safe Haven (Adoptive Service)
- ☐ CADCOM (Assistance with Utility Services)
- ☐ Housing Referrals
- ☐ CHDC Patient Transportation Assistance Program (Free transportation for our patients)
- ☐ TransNet, Barta, Rover (Medical assistance Transportation Program
- ☐ PAP (Patient pharmaceutical assistance program)
- ☐ "New Eyes" (free eyewear: frames and lenses)

Adults

- ☐ Aging and Adult referrals
- ☐ Medicare Advantage Plans
- ☐ Medicare Part D (Prescription Drug Coverage)
- ☐ Support Services Waiver Referrals
- ☐ AIDS Waiver Program
- ☐ Pace
- ☐ Pace-Net

Would you like to schedule an appointment with a Patient Case Manager? **Y / N**

Patient Signature:

Patient Name:	**Date of Birth:**

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Community Health and Dental Care, Inc.

Healthcare Discount Application

Please fill out the application completely and attach all income information.

PERSONAL INFORMATION

Last Name:	First Name:
Date of Birth:	Social Security Number:
Home Address:	Home Phone Number:
	Cell Phone Number:
City/State/Zip:	Email:

HOUSEHOLD INFORMATION - List household members claimed on tax form (1040, 1040A and/or 1040EZ) and/or other forms

NAME	SOCIAL SECURITY NO.	DATE OF BIRTH	RELATIONSHIP

Please check the statement that best describe your housing situation:

- ☐ I live in my home which I rent, lease or own
- ☐ I live with family members and do not have any housing costs
- ☐ I am staying with a series of friends and/or extended family members on a temporary basis
- ☐ I am staying is supportive or transitional housing (such as a sober living facility or recovery home)
- ☐ I live in a public or private facility that provides temporary shelters (such as a shelter, mission, single room occupancy facility or motel)
- ☐ I have been released from an institution (such as jail or hospital) without stable housing to return to
- ☐ I live on the streets, in a car, park, sidewalk, in an abandoned building or any unstable or non-permanent situation
- ☐ I live in a foster care environment

Circle the amount that is closest to your household income

$12,000	$13,500	$15,000	$16,500	$18,000	$19,500	$21,000	$22,500	$24,000	$25,500
$27,000	$28,500	$30,000	$31,500	$33,000	$34,500	$36,000	$37,500	$39,000	$40,500
$42,000	$43,500	$45,000	$46,500	$48,000	$49,500	$51,000	$52,500	$54,000	$55,500
$57,000	$58,500	$60,000	$61,500	$63,000	$64,500	$66,000	$67,500	$69,000	$70,500
$72,000	$73,500	$75,000	$76,500	$78,000	$79,500	$81,000	$82,500	$84,000	$85,500

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I have completed this application for healthcare discount eligibility and confirm that all my information is correct to the best of my knowledge. I understand a minimum payment of $20.00 for Medical/Vision/BH, $35.00 for Dental Services and $5.00 for Dispensary will be collected at the time of each visit. I understand that discounts are available regardless of my insurance status and if I do not qualify for a discount, I will be responsible to pay 100% of billed charges. For example, if I am eligible for an 80% discount I will be responsible for 20% of the applicable charges. I am aware that this discount does not apply to Dental and Medical lab fees. I understand for self-declared individuals that my slide discount may change subject to administrative approval.

☐ Community Health and Dental Care has offered and explained to me the benefits of applying for the healthcare discount. At this time I choose not to apply for the healthcare discount. I understand that I may apply at any time should I change my mind or my personal situation changes such as household size, insurance status and/or gross income.

Type full name here
to sign electronically

APPLICANTS SIGNATURE:_____ Date: _____

DO NOT FILL OUT BELOW THIS LINE -ELIGIBILITY INFORMATION – FOR OFFICE USE ONLY

PROOF OF INCOME

☐ Most recent Income Tax Returns (1040, 1040A, 1040EZ; applicable adjusted gross income line)
☐ Two recent pay stubs (check one) ___Weekly___Biweekly___Monthly
☐ Social Security/Disability letters
☐ Proof of Residency

☐ Other: _____

Annual Gross Income $ _____ Family Size: _____

Patient discount applied to applicable charges:

Medical/Vision Discount: ☐ 100% ☐ 80% ☐ 60% ☐ 40% ☐ 20% ☐0%
Dental Discount: ☐ 100% ☐ 70% ☐ 55% ☐ 40% ☐ 25% ☐0%
Dispensary Discount: ☐ 100% ☐ 80% ☐ 60% ☐ 40% ☐ 20% ☐0%

Processed by:_____ Date: _____