Knoxville Neurology Specialists
501 20th Street, Suite 505
Knoxville,TN 37916
Phone 865-546-0157 Fax 865-374-2177

Date: _____

PATIENT INFORMATION

Name (Last, First, Middle):	SSN#	Birthdate	Age	Sex

Mailing Address	City, State, Zip

Home Phone	Cell Phone	Email Address

Marital Status	Student Status	Smoker?	Veteran (Y/N)?	Ethnicity: Hispanic or	Primary Care Physician
	☐Full-Time ☐Part-Time	Yes or No		Non-Hispanic	

Referring Physician	Referring Physician Contact #	Other Medical Providers

Race (**Circle Answer**): African American, Alaskan Native, Asian, French, German, Greek, Hawaiian, Hispanic, Indian, Multi-Racial, Native American Indian, Pacific Islander, White	Language

Emergency Contact Name	Emergency Contact Phone #s
	Hm: Cell:

Employer Name and Address	Work Phone #

How did you learn about our office? Please circle one. Billboard Ad Direct Mail Hospital Referral
Insurance Newspaper Ad Patient Referral Physician Referral Previous Patient
Internet Self-Referral Yellow Pages Other:

If patient is a minor, please fill out this portion

Parent or Guardian's Name:	Parent or Guardian's Phone #s
	Hm: Wk: Cell:

RESPONSIBLE PARTY INFORMATION (if different from above)

Name (Last, First Middle)	SSN#	Birthdate	Sex

Address	City, State, Zip

Home Phone	Cell Phone	Work Phone	Relationship to patient

PRIMARY INSURANCE

Name of Insurance Company	Name of Insured	Address of Insured (if different than address above)	
Insured's Birthdate	Insured's SSN #	Insured's Insurance ID #	Relationship to patient

SECONDARY INSURANCE (if applicable)

Name of Insurance Company	Name of Insured	Address of Insured (if different than address above)	
Insured's Birthdate	Insured's SSN#	Insured's Insurance ID #	Relationship to patient

WORKERS COMPENSATION

Are you here for workers compensation YES____NO____ Date:

ACCIDENT

Auto ☐ Work ☐ Other ☐ Date of Accident:

Do you have any Advanced Directives? (e.g., Living will or Advanced Care Plan) ☐ Yes ☐ No
Do you have a Power of Attorney? ☐ Yes ☐ No
If yes to the above questions please make sure we have a copy for your medical record.

SHARING YOUR INFORMATION

In the event our office needs to contact you regarding your appointment, etc.
I give permission to be contacted by phone/text and for messages to be left at this number.

☐ Yes (☐ Cell Home ☐ Work) ☐ No

I give permission to have letters, documents and postcards sent to my home and or patient portal account.

☐ Yes ☐ No

Covenant Medical Group

IN CONSIDERATION OF THIS PHYSICIAN PRACTICE (THE "PRACTICE") FURNISHING SERVICES TO THE PATIENT, PATIENT (OR PATIENT'S LEGALLY AUTHORIZED REPRESENTATIVE, ON PATIENT'S BEHALF) AGREES AS FOLLOWS:

I. CONSENT TO MEDICAL TREATMENT AND SERVICES: The below-signed individual hereby authorizes the Practice and its associated professionals to furnish medical treatment and services to the patient, including medical treatment and services furnished through telehealth visits, and consents to diagnostic and therapeutic medical care, items, services, and procedures furnished by the Practice, its professionals, and their assistants and designees. Such consent includes consent to photographic/video documentation of the patient's medical treatment as the patient's treating professional finds medically necessary. There are potential risks and hazards to any medical treatment or service, and there is no guarantee any particular treatment or service furnished by the Practice or its professionals will be successful. It is the Practice physician's responsibility to provide adequate information concerning a proposed treatment or service and to obtain any additional necessary consent before proceeding except as limited by emergency or other time-sensitive circumstances. The Practice's staff may obtain signature for such consent. The patient has the right to question and refuse treatment; however, if a proposed treatment is refused, the undersigned agrees CMG, the Practice, and their associated professionals and staff shall be released from any and all liability for failure to provide treatment to the patient.

TELEMEDICINE: The Practice and its associated professionals deliver certain health care services by virtual means, including without limitation, through telehealth (interactive audio, video, and other electronic communications), patient portal communications, and by telephone (collectively, "Virtual Services"). **RISKS AND BENEFITS:** Benefits of Virtual Services include enhanced access to care, patient convenience, reduced risk of exposure to communicable disease, and access to ongoing care and follow-up communication with a health care provider. Medical information is protected to the same extent as in a face-to-face visit, although confidentiality and privacy at the patient's location is not controlled by the Practice. There are risks and limitations to Virtual Services. Virtual Services and care may not be as complete as face-to-face services as a result of a practitioner's potential lack of access to all diagnostic modalities/medical equipment necessary to obtain vital signs, labs, and other pertinent health information to treat the patient, lack of access to complete medical records, and problems with information transmission, including missed information or inaccurate information being transmitted, that could affect a practitioner's medical decision-making. Further, although the Practice uses available encryption and privacy modes for Virtual Services, it is also possible security protocols could fail, causing a breach of privacy of medical information. The alternative is a face-to-face visit, which the patient may request at any time, but an equivalent in-person service may not be available at the same location or time as a Virtual Service. During a Virtual Service, a practitioner may perform a physical exam through the use of technology or a facilitator in the room with the patient. Not all medical conditions can be treated as effectively through a Virtual Service, including emergency conditions. If a practitioner determines a face-to-face evaluation is needed, the patient will be referred to an appropriate location for such evaluation. A practitioner can withdraw from a Virtual Service for any reason, including when, in the practitioner's medical judgment, treatment is not safe, private, or effective. In such event, the practitioner can instruct the patient to seek in-person care and the patient agrees to follow such instruction, including for emergency care. Virtual Services are subject to charges, copayments, and deductibles consistent with this Agreement. While a patient may expect the anticipated benefits from the use of telehealth, no results can be guaranteed. It is the patient's duty to inform his or her physician of electronic interactions that the patient may have with other health care providers. **CONSENT TO TREATMENT VIA VIRTUAL SERVICES:** By electing to proceed with a Virtual Service, the undersigned has been informed of the risk and benefits of Virtual Services, understands and agrees to the above, and consents to medical treatment or consultation by means of a Virtual Service.

II. CONSENT TO COMMUNICABLE DISEASE TESTING: The below-signed individual consents for the patient to be tested for hepatitis, human immunodeficiency virus infection, or any other blood-borne infectious disease, as well as for any other communicable disease or condition, if and when another patient, a health care practitioner, or other individual furnishing services to patient at the Practice, a Practice employee, or an emergency aid worker has a potential exposure from the patient. If such testing becomes necessary, it will be performed at no charge to the patient.

III. CALCULATION AND PAYMENT OF CHARGES: The patient is liable and individually obligated for payment of the Practice's charges on the patient's account and the undersigned individual understands and agrees to the following: (1) The Practice's charges are set out in a chargemaster, the relevant portions of which may be examined for purposes of verifying the patient's account during regular business hours in our billing office. The Practice reserves the right to change the rates in the chargemaster. Charges on the patient's account are calculated based on chargemaster rates in effect as of the date charges for items or services are accrued. (2) The patient is liable for the uninsured portion of the Practice bill, which is due in full when services are rendered. Any amount not paid in full by insurance, for any reason, is the responsibility of the patient. (3) The Practice has both an uninsured patient discount policy and an indigent care policy. If the patient is uninsured, the patient is automatically entitled to a discount on chargemaster rates in accordance with the Practice's uninsured patient discount policy. In addition, if the patient is uninsured and meets certain criteria set forth in the Practice's indigent care policy (including, without limitation, income criteria), the patient may be entitled to further discounts to chargemaster rates. Please contact the Practice's financial counselors in our office or the CMG billing office at 865-374-5200 for more information. (4) The amount of the patient's Practice charges may differ from amounts other patients are obligated to pay based upon each patient's insurance coverage, Medicare/Medicaid coverage, or lack of insurance coverage. The amount of any discount from charges varies based on the circumstances applicable to each individual under the Practice's policies. (5) After reasonable notice, delinquent accounts may be turned over to a collection agency and/or attorney for collection. The patient agrees to pay the costs of collection, including court costs, reasonable attorney fees, collections charges, and reasonable interest charges, associated with Practice's efforts to collect amounts due.

IV. MEDICARE/MEDICAID PATIENT CERTIFICATION AND ASSIGNMENT OF BENEFITS: The undersigned individual certifies that the information provided in applying for payment or reimbursement under Titles XVIII and XIX of the Social Security Act is true and correct. Further, the undersigned certifies that correct and complete information has been provided regarding the patient's insurance, HMO, health plan, workers' compensation, or other coverage for services and items furnished to the patient by the Practice, and the undersigned consents to the Practice's billing such payers for items and services furnished by the Practice to patient. The undersigned hereby irrevocably assigns to CMG (or, if

Practice professionals are not CMG employees, to Practice) all rights, title, and interest in compensation or payments otherwise payable to the patient, or received by or on behalf of the patient, for Practice items or services from any source or payer on file for the patient's account, including Medicare/Medicaid/TennCare, insurance companies, HMOs, and any other third-party payer or financially responsible person, not to exceed charges for services or items rendered. Any person, corporation, or government entity having notice of this assignment is authorized and directed to pay directly to CMG (or, if Practice professionals are not CMG employees, to Practice) all amounts due for health care items and services provided to the patient by the Practice. Except as provided in Section III or by law, the patient is financially responsible to the Practice for the charges not covered by these authorizations. The undersigned understands there are certain items and services for which payers, including Medicare and TRICARE/CHAMPUS/CHAMPVA, do not pay. Any sums not paid by a third-party payer are the patient's obligation. **The patient is responsible for all health insurance or health plan deductibles and co-insurance, as well as noncovered or excluded items or services.** If it is later determined the patient has an HMO or other health plan primary to Medicare and failed to inform the Practice prior to service of such election, the patient shall be responsible for paying the account. In the case of series services furnished to the patient by Practice, this Agreement shall remain in full force and effect for all such series services until specifically revoked in writing. The undersigned agrees to sign such further documents as may be reasonably requested to confirm and substantiate the Practice's or CMG's rights hereunder. The undersigned further agrees that a copy of this assignment may be used in place of the original copy.

V. RECEIPT OF NOTICE OF PRIVACY PRACTICES; CONSENT TO USE AND DISCLOSE HEALTH INFORMATION: The undersigned acknowledges receipt of the Practice's Notice of Privacy Practices, which is provided at https://www.covenanthealth.com/privacy-notice/ and incorporated into this Agreement by reference, and consents to use and disclosure of the patient's protected health information and other patient records (a) consistent with such Notice, including without limitation, for purposes of the treatment, payment, and health care operations functions described in such Notice, whether through electronic health information exchange or otherwise; and (b) as authorized or permitted by federal or state law. Consistent with the above, the undersigned agrees to the Practice's disclosure of all or part of the patient's medical record for treatment purposes and to any person, corporation, or agency that is or may be liable for charges incurred at the Practice or for determining the necessity, appropriateness, amount, or other matter related to such services or charges, including, without limitation, insurance companies, HMOs, PPOs, workers compensation carriers, welfare funds, governmental health plans, the Social Security Administration, the Centers for Medicare & Medicaid Services, or any contractors of the same. The undersigned also consents to release by the patient's health plan or other insurance carrier to the Practice and CMG of any eligibility, utilization, or plan data concerning the patient's coverage that may be required.

VI. PATIENT IDENTIFICATION; PERSONAL VALUABLES: The undersigned consents to photographic documentation of the patient for purposes of identification and registration. Further, the undersigned agrees that Practice is not responsible for loss of or damage to any money, jewelry, eyeglasses, clothing, hearing aids, or other personal property.

VII. HEALTH PLAN NOTIFICATION/AUTHORIZATION; APPOINTMENT: If the patient's health plan, insurer, or other coverage requires notification/authorization as a condition of payment for services, the patient must provide such notification and obtain such authorization. The patient hereby assumes full financial responsibility for charges incurred as a result of failure to comply with prior notification/authorization requirements. Notwithstanding the foregoing, the undersigned hereby appoints Practice as patient's agent for purposes of requesting prior authorization for services Practice professionals order at a Covenant Health hospital (e.g., lab services) and agrees Practice may delegate such appointment to such hospital. The undersigned acknowledges there is no guarantee or assurance authorization will be obtained.

VIII. AMENDMENTS: Revisions to this Agreement are not effective or enforceable unless accepted in writing by a CMG corporate officer.

IX. CONTACTING PATIENT. Patient may be contacted at the following number: _____. In addition, ***please check one of the following***:

☐ Practice may contact or leave messages regarding appointments and lab/test results with the following:

Name:_____Relation to patient:_____Phone:_____

Name:_____Relation to patient:_____Phone:_____

☐ Practice may not leave messages regarding appointments and lab/test results with anyone other than patient.

I HAVE READ AND UNDERSTAND THIS REGISTRATION AGREEMENT AND BY SIGNING BELOW, AGREE TO ITS TERMS. IF THE UNDERSIGNED IS NOT THE PATIENT, SUCH INDIVIDUAL HEREBY CERTIFIES THAT HE/SHE IS THE PATIENT'S AUTHORIZED REPRESENTATIVE AND HAS ALL NECESSARY LEGAL AUTHORITY TO ENTER INTO THIS AGREEMENT ON THE PATIENT'S BEHALF.

SIGNATURE: PATIENT (OR PATIENT'S LEGALLY AUTHORIZED REPRESENTATIVE)

SIGNED _____ PRINTED NAME _____

PATIENT NAME _____ RELATIONSHIP TO PATIENT _____

DATE and Time _____

A copy of this agreement will be provided on request.

Knoxville Neurology Specialists
Covenant Medical Group

501 20th Street Suite 505
Knoxville, TN 37916

Phone: (865) 546-0157
Fax: (865) 374-2177

Dr. Timothy Braden | Dr. Joel Torres | Dr. D. Greg Wheatley | Kendra Bellamy, FNP-BC

Appointment Cancelation and No-show Policy

Last minute cancelation and same day no-shows make it difficult to serve other patients who are waiting to be scheduled. We ask that you give a twenty four (24) hour notice of cancelation or reschedule prior to your appointment if you will be unable to keep that appointment. No-shows or appointments canceled with less than 24 hour notice will be subject to a fee of $25.00 which is the sole responsibility of the patient and will not be billed to insurance. Thank you for your cooperation in helping us better serve you as well as all of our patients.

Patient Printed Name:_____ Date:_____

Patient Signature:_____ Date:_____

Name: _____ Date of Birth: _____

Medicare Secondary Payer Questionnaire (MSPQ)

TO BE COMPLETED BY MEDICARE PATIENTS ONLY

1. Is the patient, friend or family member available to answer the MSPQ?

   [ ] Yes [ ] No

2. Are you receiving Black Lung benefits?

   [ ] Yes [ ] No If yes, is this visit related to Black Lung? _____

   If yes, are the services to be paid by a government research program? _____

   If yes, is this visit related to the government research program? _____

   If yes, has the Department of Veteran's Affairs (DVA) authorized and agreed to pay for your care today?

   If yes, is this visit related to the DVA? _____

3. Are the service to be paid by a government research program?

   [ ] Yes [ ] No If yes, are the services to be paid by a government research program? _____

   If yes, has the Department of Veteran's Affairs (DVA) authorized and agreed to pay for your care today?

   If yes, is this visit related to the DVA? _____

4. Has the Department of Veterans Affairs (DVA) authorized and agreed to pay for your care at this facility?

   [ ] Yes [ ] No If yes, is this visit related to the DVA? _____

5. Was the illness/injury due to a work-related accident/condition?

   [ ] Yes [ ] No If yes, what was the date of the work related accident/injury? _____

   If yes, what type of accident was this? _____

   If yes, was this employment related? _____

   If yes, please complete Workers Compensation Billing Info below

   Health Plan Name _____

   Address _____

   Policy Number _____Claim Number_____

   Claim Related Employer _____

   Plan Information _____

6. Was illness/injury due to a non-work-related accident?

   [ ] Yes [ ] No

   If yes, what was the date of the accident? _____ Type of accident? _____

Name: _____ Date of Birth: _____

Medicare Secondary Payer Questionnaire (continued)

If yes, please circle one - No Fault Insurance involved Tort Liability Crime Victim

In what state did the accident occur? _____

7. Are you entitled to Medicare based on Age?

   [ ] Yes [ ] No

8. Are you entitled to Medicare based on Disability?

   [ ] Yes [ ] No

9. Are you entitled to Medicare based on End Stage Renal Disease?

   [ ] Yes [ ] No

10. Are you currently employed?

    [ ] Yes [ ] No [ ] No, never employed

    If No, what was the date of your retirement? _____

    Do you have a spouse who is currently employed? Spouse's name? _____

    If yes, please list the Name and address of the spouse's employer _____

    _____

    _____

    If No, what was the date of the spouse's retirement? _____

11. Do you have Group Health Plan Coverage based on your own, a spouse's or other family member's current employment? _____

    Does the employer that sponsors that Group Health Plan employ 20 or more employees? _____

    If yes, what is the Health Plan Name? _____

    Address _____

    Policy Number _____ Group Number _____

    Member number _____

    Subscribers Name _____

    Relationship _____

REVIEW OF SYSTEMS

PATIENT NAME:_____ DATE OF BIRTH:_____

General:

	Yes	No
Weight Change > 10lbs		
Fever		
Fatigue		
Difficulty Sleeping		

Male:

	Yes	No
Sexual dysfunction		
Infertility		
Painful Intercourse		

Head and Neck:

	Yes	No
Visual Changes (Not Glasses)		
Dizziness		
Sinus problems		
Frequent persistent nosebleeds		
Ear pain		
Trouble hearing		
Ringin in Ears		
Hoarseness		
Persistent sore throat		
Mouth sores		
Swollen glands (Frequent)		

Women:

	Yes	No
Breast pain/lumps		
Pelvic pain		
Vaginal discharge		
Vaginal dryness		
Frequent sweats/hot flashes		
Mentstrual problems		
Menopause		
Pregnancy Problems		

Respiratory/Lungs:

	Yes	No
Stop breathing during sleep		
Shortness of Breath		
Coughing up blood		
Wheezing		
Cough		
Sore Throat		
Snoring		

Skeletal:

	Yes	No
Gout		
Back Pain (Major)		
Neck Pain (Major)		
Weakness of arm or leg		
Joints Swelling/Stiffness		
Deformities of Back/Extremeties		

Heart/Vascular:

	Yes	No
Chest pain/tightness		
Smothering feeling at night		
Ankle swelling		
Palpitations		
Passing out		

Neuro:

	Yes	No
Numbness or tingling		
Severe frequent headaches		
Abnormal coordination		
Trouble with speech		
Forgetfulness/confusion		

Stomach/Bowel:

	Yes	No
Black/Bloody stools		
Nausea/Vomiting (Frequent)		
Frequent heart burn/acid (GERD)		
Abdominal pain		
Diarrhea (Frequent)		
Constipation		
Difficulty swallowing		

Skin and Hair Problems:

	Yes	No
Changes in hair/hair loss		
Major skin problems		
Wounds that will not heal		
Persistent rash		
Changes in moles		

Kidney/Bladder:

	Yes	No
UTI		
Urinary Incontinence		
Urinary Hesitancy		
Frequent Urination		
Urinary Urgency		
Urinating at night		
Pain with urination		
Blood in urine		
Urinary Retention		

Psych/Social:

	Yes	No
Anxiety		
Depression		
Insomnia		

_____

Signature (Patient or Legal Representative)

_____

Relationship to Patient *Date*

PATIENT NAME:_____ **DOB:**____/____/____

TO BE COMPLETED BY NURSE			
Weight	lbs / kgs	Height	inches / cm

PHQ-2 Depression Screening Questionnaire

How often have you been bothered by the below symptoms the last two weeks?

Feeling Down, Depressed, Hopeless	O Not at all O Several Days	O More than half the days O Nearly every day
Little interest - Pleasure in Activities	O Not at all O Several Days	O More than half the days O Nearly every day

PHQ-9 Detailed Depression Screening Questionnaire

If you selected "Not at all" for both questions above, please ignore this section.

Trouble Falling or Staying Asleep	O Not at all O Several Days	O More than half the days O Nearly every day
Feeling Tired or Little Energy	O Not at all O Several Days	O More than half the days O Nearly every day
Poor Appetite or Overeating	O Not at all O Several Days	O More than half the days O Nearly every day
Feeling Bad About Yourself	O Not at all O Several Days	O More than half the days O Nearly every day
Trouble Concentrating	O Not at all O Several Days	O More than half the days O Nearly every day
Moving or Speaking Slowly	O Not at all O Several Days	O More than half the days O Nearly every day
Thoughts Better Off Dead or Hurting Self	O Not at all O Several Days	O More than half the days O Nearly every day

Medication Adherence

Does the patient have any barriers to medication adherence?
(ie. Any reason that the patient cannot take medication as prescribed?)

O YES O NO

If YES, the reason is?
- O Financial
- O Transportation
- O Trouble Remembering
- O Health literacy
- O Lack of Confidence
- O Time Constraints
- O Cognitive deficit
- O Functional status impairment
- O Other

Is the patient taking over-the-counter medications?

O YES O NO

Fall Risk Assessment

1. Have you fallen in the last year? O YES O NO
2. Are you worried you might fall? O YES O NO
3. Do you use a cane or walker? O YES O NO
4. Do you need someone to help you get up in the morning? O YES O NO

Tobacco Use:

- ☐ Never (less than 100 in lifetime)
- ☐ 4 or less cigarettes (less than 1/4 pack)/day in the last 30 days
- ☐ 5-9 cigarettes (between 1/4 to 1/2 pack)/day in the last 30 days
- ☐ 10 or more cigarettes (1/2 pack or more)/day in the last 30 days
- ☐ Cigars or pipes daily within the last 30 days
- ☐ Cigars or pipes, but not daily within the last 30 days
- ☐ Smokeless tobacco user within last 30 days
- ☐ Smoker, current status unknown
- ☐ Former smokeless tobacco user, quit
- ☐ Former smoker quit more than 30 days
- ☐ Refused tobacco status screen
- ☐ Unable to assess due to cognitive impairment

Types:
- ☐ Cigarettes
- ☐ Cigars
- ☐ Oral
- ☐ Pipe
- ☐ Smokeless Cigarettes
- ☐ Spit Tobacco
- ☐ SNUS Products
- ☐ Other: _____

Packs Per Day ☐

Years Smoked ☐

Alcohol:

Use:
- ☐ Never used
- ☐ Deny use
- ☐ Past User
- ☐ Not used since pregnant
- ☐ Used early in pregnancy
- ☐ Unable to assess due to cognitive impairment
- ☐ Current user

Type:
- ☐ Beer
- ☐ Wine
- ☐ Liquor
- ☐ Other:_____

Frequency:
- ☐ 1-2 times per year
- ☐ 1-2 times per month
- ☐ 1-2 times per week
- ☐ 3-5 times per week
- ☐ Daily
- ☐ Several times per day
- ☐ Binge
- ☐ Occasional use
- ☐ Regular use

Advanced Directive

- O Yes
- O No
- O No Advanced Directive, information given
- O Unable to answer at this time
- O Healthcare Proxy
- O Revocation

Patient Preferred Pharmacy

Pharmacy Name

Phone

Knoxville Neurology Specialists
501 20th Street, Suite 505
Knoxville, TN 37916
Phone: (865) 546-0157

Patient Information Form

Name: _____ Date: _____

DOB: _____ Sex: _____ Age: _____ Handness: Right / Left

Referring MD: _____ PCP: _____

Reason for visit: _____

Duration of symptoms _____

Specific concerns needing addressed: _____

Medical History *(please circle)*

A-Fib	Coronary	Heart Disease	Lupus
Abnormal Heartbeat	Dementia	Heart Attack/MI	Sjörgen's Syndrome
B12 Deficiency	Diabetes	High Cholesterol	Stroke
Bladder problems	Emphysema/Asthma	Hypertension	Thyroid Problems
Chronic Neck/Low back pain	Fibromyalgia	Irritable Bowel	

Cancer - please list: _____

Other: _____

_____

Past Surgical History *(please circle)*

Aortic Aneurysm	Carotid Surgery	Heart Surgery	Prostate Cancer	Vein Surgery
Appendectomy	Carpal Tunnel	Hysterectomy	Prostate Surgery	
Back Surgery	Cataract Surgery	Knee Surgery	Shoulder Surgery	
Brain Aneurysm	Colon Cancer	Lung Cancer	Sinus Surgery	
Brain Tumor	Gallbladder	Neck surgery	Thyroid Cancer	

Other: _____

_____

Medications (Continued on back if more space is needed – also able to give completed list to intake staff in lieu of this)

Name of medication	**Dose** (10 mg, 20 meq, etc.)	**Frequency** (Daily, Twice daily, etc)

Allergies: _____

_____

_____

Medications Continued...

Name of medication	Dose (10 mg, 20 meq, etc.)	Frequency (Daily, Twice daily, etc)