

## **Patient and Visitor Code of Conduct**

### **Welcome to Broad Top Area Medical Center, Inc. (BTAMC)**

At BTAMC, we are dedicated to delivering high-quality, compassionate healthcare in a safe and inclusive environment across all our locations. To foster a culture of mutual respect and safety between patients, their families, and our providers, we ask that everyone adhere to the guidelines set forth in our Patient Code of Conduct.

### **Patient/Visitor Responsibilities**

#### **As a patient of BTAMC you are responsible for:**

- Attending scheduled appointments or notifying your provider as soon as possible if you need to cancel, in accordance with the BTAMC's Broken/Missed Appointments & Follow-Up Visits Policy.
- Providing accurate and complete information about your present symptoms, past illnesses, hospitalizations, medications and other matters related to your health
- Reporting unexpected changes in your condition to your provider(s)
- Following the treatment plan recommended by your provider, nurse, and other healthcare personnel or helping us understand why you are not able to do that at the time
- Promptly paying for services in accordance with BTAMC's Patient Accounting/Collections Policy, including copayments and deductibles due at the time of service or making arrangements to do so.
- Respecting the privacy of other patients and their protected health information.

### **Code of Conduct**

BTAMC aims to provide a safe and healthy environment for everyone and expects patients, staff and visitors to refrain from behaviors that are disruptive or pose a threat to the rights and safety of others. The following behaviors are prohibited:

- Possession of firearms or any weapon.
- Engaging in threatening, intimidating, or abusive conduct
- Using profanity or similarly offensive language
- Criticizing staff in front of other patients or staff members
- Making disrespectful or discriminatory comments, actions or requests about others' race, accent, religion, gender, gender identity, sexual orientation or any other identities.
- Verbal aggression, including yelling or other actions which disrupt the care and treatment of our patients
- Physical assault such as hitting or unwanted touching.
- Possession or being under the influence of drugs or alcohol.
- Photographing and/or recording of staff without written consent.

If you experience or witness any of these behaviors, please report it to a member of the health care team. Our staff is dedicated to providing the highest quality of care to our patients. Please show them the respect they deserve as they carry out their duties. Patient and Visitors who do not comply with this Code of Conduct will be asked to leave. Thank you.

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As a Federally Qualified Health Center (FQHC), we are required to collect the following information from every patient we serve. Per federal privacy rules, (HIPAA) this protected information is kept confidential and is not disclosed, unless authorized by the patient.

Thank you for your cooperation and choosing BTAMC as your health care provider.

**Today's Date:** \_\_\_\_\_

Patient Demographic Information			
Last:	First:	Middle:	
Date of Birth:	Legal Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Preferred Name:	
PO Box/Street & Apt #:	City:	State:	Zip:
Social Security #:	Home Phone:	Cell Phone:	Work Phone:
Email Address: <div style="text-align: right;"><input type="checkbox"/> I DO   <input type="checkbox"/> I DON'T   authorize BTAMC to leave a detailed message</div>			
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed		Primary Language: <div style="text-align: right;"><input type="checkbox"/> English   <input type="checkbox"/> Sign Language <input type="checkbox"/> Spanish   <input type="checkbox"/> Other: _____</div>	
Homebound: <input type="checkbox"/> Yes <input type="checkbox"/> No		Do you need a translator: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Ethnicity: <div style="display: flex; justify-content: space-between;"><div><input type="checkbox"/> Not Hispanic   <input type="checkbox"/> Hispanic <input type="checkbox"/> Latino/Latina   <input type="checkbox"/> Spanish <input type="checkbox"/> Declined/Refused   <input type="checkbox"/> Other: _____ (please describe)</div><div><input type="checkbox"/> Caucasian   <input type="checkbox"/> African American <input type="checkbox"/> Asian   <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Hawaiian/Pacific Native *More than one race – please select all that apply or describe:</div></div>			
Shelter Status: <input type="checkbox"/> Houseless-Street <input type="checkbox"/> Houseless-Shelter <input type="checkbox"/> Doubling-up <input type="checkbox"/> Public Housing <input type="checkbox"/> N/A			
Gender Identity: (How do you identify yourself today?) <div style="display: flex; justify-content: space-between;"><div><input type="checkbox"/> Male   <input type="checkbox"/> Transgender Male/Female-to-Male <input type="checkbox"/> Female   <input type="checkbox"/> Transgender Female/Male-to-Female</div><div><input type="checkbox"/> Declined/Refused <input type="checkbox"/> Non-binary</div></div>			
Sexual Orientation: <input type="checkbox"/> Straight or Heterosexual <input type="checkbox"/> Lesbian, Gay or Homosexual <input type="checkbox"/> Bisexual <div style="display: flex; justify-content: space-between;"><div><input type="checkbox"/> Other: _____</div><div><input type="checkbox"/> Declined/Refused   <input type="checkbox"/> Uncertain/Don't Know</div></div>			

Insurance Coverage <u>Please provide insurance card(s)</u>			
Primary Insurance Name:	Policy #:	Group #	Insurance Phone:
Insurance PO Box/Street Address:	City	State	Zip
Secondary Insurance Name:	Policy #	Group #	Insurance Phone:

Responsible Party <i>(if patient is not financially responsible)</i>			
Last:	First:	Middle:	
Date of Birth:	Address:	Phone:	
Social Security Number:	City	State	Zip
Relationship: <input type="checkbox"/> Self/Same as Patient <input type="checkbox"/> Spouse/Partner <input type="checkbox"/> Parent <input type="checkbox"/> Other Please Describe _____			
Email Address:			



### Employment Information

Employment Status:

☐ Full-time    ☐ Part-time    ☐ Self Employed    ☐ Military Veteran    ☐ Retired  
☐ Disabled    ☐ Student    ☐ Seasonal Worker without a Residence    ☐ Migratory Worker with a Residence

Occupation:

Employer Name:

Phone #:

Po Box/Street Address

City

State

Zip

### Patient Pharmacy Information

Pharmacy Name:

Pharmacy Telephone Number:

Address

City

State

Zip

### Emergency & Non-Emergency Contacts & Consent to share personal health information

**I authorize BTAMC to share my personal health information with the individuals listed below:**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

☐ Emergency Contact    ☐ Medical    ☐ Billing    ☐ Scheduling

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

☐ Emergency Contact    ☐ Medical    ☐ Billing    ☐ Scheduling

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

☐ Emergency Contact    ☐ Medical    ☐ Billing    ☐ Scheduling

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

☐ Emergency Contact    ☐ Medical    ☐ Billing    ☐ Scheduling

### TREATMENT & PAYMENT AUTHORIZATION

As a patient of BTAMC, I authorize treatment for myself, or the identified minor. I consent to clinical assessment, treatment, testing or tele-health services, including audio/visual or audio only encounter. I understand BTAMC uses an integrated, team-based approach to evaluation and management. Services may include primary medical care, integrated behavioral health services, preventative or additional dental services, patient outreach support and assistance, care management services, and/or some specialty services. Additionally, our integrated care specialists may provide consultation, behavioral health assessments, counseling interventions or support services, as you and your BTAMC provider decide are appropriate. I authorize BTAMC to release my medical information for the continuum of care with other medical providers and facilities, or with insurance payors to seek reimbursement for services provided.

I understand that I am financially responsible for all service charges for myself or identified minor, whether or not the service(s) are covered by insurance. BTAMC will submit claims to my insurance company to secure payment for all services provided. I understand charges not covered by insurance such as, co-pays, co-insurance, deductibles or sliding fees are my responsibility. I understand that I may apply for Sliding Fee Discounts or set up payment arrangements with the BTAMC Billing Department. I understand any checks returned by my financial institution will incur a \$25.00 charge.

**Patient/Guardian Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Data Entry- Staff Initials:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Scanned – Staff Initials:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*"The mission of Broad Top Area Medical Center, Inc. is to provide access to affordable, high-quality care without discrimination."*

**PATIENT LEGAL NAME:** \_\_\_\_\_ **DATE OF BIRTH:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

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

### Clinical Intake Information

◆ Please briefly state in the box below the reason for your visit ◆

How did you hear about our practice?

### ◆ Medical Problems – Past & Present◆

Please review the following symptoms and circle those items that are a problem for you.

Vision problems	Wheezing	Lumps in breast	Frequent Urination	Excessive hunger
Hearing problems	Asthma / COPD	Breast discharge	Incontinence	Excessive thirst
Sinus trouble	Emphysema	Trouble swallowing	Blood in Urine	Weakness
Hay fever	Bronchitis	Nausea	History of STD's	Fatigue
Nosebleeds	TB exposure	Vomiting	Anemia	Fever / Sweating
Sore throat	Chest pain	Abdominal pain	Easy bruising	Fainting
Hoarseness	Chest discomfort	Hepatitis / Jaundice	Pain in legs	Seizures / Tremor (Dup)
Lumps in neck	Shortness of breath	Gallstones	Joint pain / stiffness	Migraine/Headaches
Tooth problems	High blood pressure	Diarrhea	Blood clot	Numbness/tingling
Cough	Diabetes	Constipation	Weight loss / gain	Anxiety/Depression
Coughing blood	High cholesterol	Blood in stool	Heat/cold intolerance	Difficulty sleeping
Back Pain	Nerve Pain	Muscle aches/pain	Stroke (CVA)	Other Causes of Chronic Pain??
Learning or Attention problems	Lung problem?	Other:		

### ◆ Past Medical History ◆

Condition / Disease	Year Began	Condition / Disease	Year Began
<input type="checkbox"/> Usual Childhood Disease (Mumps, Measles, Chicken Pox)		<input type="checkbox"/> Cancer Type: _____ Location: _____	
<input type="checkbox"/> Covid-19 / SARS-CoV-2		<input type="checkbox"/> Bleeding Problems / Hemophilia / Anemia	
<input type="checkbox"/> Hypertension		<input type="checkbox"/> Brain Injury / Brain Malformation	
<input type="checkbox"/> High Cholesterol		<input type="checkbox"/> Epilepsy / Seizures	
<input type="checkbox"/> Hypothyroid (low) or Hyperthyroid (high)		<input type="checkbox"/> Depression / Anxiety / Nervousness	
<input type="checkbox"/> COPD, Emphysema or Asthma		<input type="checkbox"/> Mental Disorder / Behavioral Problem	
<input type="checkbox"/> Respiratory Disease / TB		<input type="checkbox"/> Dementia / Alzheimer's Disease	
<input type="checkbox"/> Diabetes		<input type="checkbox"/> MS / ALS / Parkinson's Disease	
<input type="checkbox"/> Reflux/GERD / Ulcers / Stomach Problems		<input type="checkbox"/> Arthritis/Joint problems / RA / Lupus	
<input type="checkbox"/> Heart Disease / Mitral Valve Prolapse		<input type="checkbox"/> Hepatitis / Liver Disease	
<input type="checkbox"/> Blood Clot / DVT / Pulmonary Embolus		<input type="checkbox"/> Kidney Disease	

### ◆ Past Surgical Procedures / Hospitalizations / Serious Injuries or Fractures ◆

Operation / Hospitalization / Injury	Month / Yr.	Operation / Hospitalization / Injury	Month / Yr.

### ◆ Other Physicians and Specialists ◆

List below your other physicians (i.e., Gyn, Dermatology, GI, Orthopedics, Urology, Psychiatry, etc. )

◆ **Medication or Food Allergies or Intolerances** ◆

List below medications or foods causing an allergic reaction (i.e., rash, swelling) or intolerance (i.e., nausea)

Medication / Food	Reaction	Medication / Food	Reaction

◆ **Medications, Vitamins and Herbal Supplements** ◆

Medication	Strength	Number of pills taken & frequency	Medication	Strength	Number of pills taken & frequency

◆ **Disease Prevention and Health Maintenance** ◆

Please list below the most recent dates of your vaccines and health screening tests

	Month / Yr.		Month / Yr.		Month / Yr.
COVID-19 Vaccine		Mammogram		Endoscopy (EGD)	
Flu Vaccine		Pap Smear		Stent Placement	
Pneumonia Vaccine		Prostate Exam		Heart Catheterization	
Tetanus Vaccine		Colonoscopy		Heart Stress Test	
Hepatitis B Vaccine		Bone Density		Echocardiogram	
Shingles Vaccine		Eye Exam		EKG	
Gardasil Vaccine		Foot Exam		Most Recent Lab Work	

◆ **Family Health History** ◆

Please list below the health history of your genetic (blood) relatives

Relative	Living or Deceased	Current age or age at death	Cause of Death	Health Problems
Paternal Grandfather:				
Paternal Grandmother:				
Maternal Grandfather:				
Maternal Grandmother:				
Father:				
Mother:				
Sibling:				
Sibling:				
Children:				

◆ **Social History** ◆

What type of exercises do you perform, duration & frequency?		
In what type of residence do you live (i.e., house, assisted living, nursing home)?		
What are your hobbies?		
Do you drink alcohol?	What type of alcohol?	No. of drinks per week?
Are you a current smoker?	If you smoke, how many packs per day?	
Are you a former smoker?	If so, what year did you quit?	No. of years you smoked?
On average, how much did you smoke per day?		Do/Did you use other nicotine products?
Are you sexually active: Yes / No	Do you have sex with: Men / Women / Both	How many partners have you had during the past 12 months?
Are you concerned that you may have been exposed to HIV? Yes / No		
What is the highest grade you finished in school?		

# Broad Top Area Medical Center, Inc.

## 2025 SLIDING FEE SCALE DISCOUNT PROGRAM – PATIENT EDUCATION & INTEREST FORM

### FEDERAL POVERTY GUIDELINES

Broad Top Area Medical Center Inc., (BTAMC) is a non-profit Federally Qualified Health Center, our Mission is to provide access to affordable, high-quality healthcare without discrimination based on one's race, color, sex, disability, age, creed, or national origin. BTAMC will provide in-scope services to all patients, regardless of their insurance status or ability to pay. Every patient may apply for our Sliding Fee Scale Discount Program (SFS) to determine qualification. Patients may choose to decline our benefit program.

Eligibility for Sliding Fee Discounts is based on the federal poverty level (FPL) income guidelines which are adjusted annually and operate in accordance with other federal program regulations. **ALL** patients are encouraged to apply. Uninsured and under-insured patients may qualify for the program based on their household size and their family's income. Sliding Fee Scale Discount Program applications are available at every BTAMC reception desk and on-line – visit our web site: [www.broadtopmedical.com](http://www.broadtopmedical.com)

#### Important discount program points are:

- The Sliding Fee Scale provides significant discounts for **Medical** and **Dental** services at every BTAMC location.
- The Sliding Fee Scale **is not** an insurance program – it is a benefit offered to ALL of our patients.
- The Sliding Fee Scale benefit period is from **March 1<sup>st</sup> to the last day of February**.
- Your eligibility is based **only** on your household size and the gross annual income for your household.
- You may qualify for the program, even if you do have third-party medical insurance and/or dental coverage.
- You will qualify for the program if your household income is below and/or up to **200 %** of the federal poverty level.
- You must apply for the program to determine your qualified Sliding Fee Scale Discount.
- You must provide proof of income along with your application such as tax forms **or** pay stubs **or** bank statements.
- You are encouraged to re-apply anytime your household income or household size changes, such as when someone loses insurance, someone becomes unemployed, or if you lose **or** add a family member – even when the change is temporary.
- **You must renew your application and submit proof of income each year to qualify for Sliding Fee Scale Discounts.**
- Applications & questions can be submitted to the office in person, by mail or via secure Email to:

[enrollment@broadtopmedical.com](mailto:enrollment@broadtopmedical.com)

#### 2025 POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES AND THE DISTRICT OF COLUMBIA

\* For families/households with more than 8 persons, add **\$5,500** for each additional person.

#### ON THE TABLE BELOW PLEASE CIRCLE FAMILY SIZE & ESTIMATED ANNUAL HOUSEHOLD INCOME FOR 2025

*We ask every patient to share their annual household income. We only collect aggregate information because BTAMC receives federal funding for assistance programs that benefit patients with lower incomes. Your information is confidential. Thank you!*

Family Size	(<=100%)	(101% - 125%)	(126% - 150%)	(151% - 175%)	(176% - 200%)	Above 200% FPL
<b>1</b>	\$0 - \$15,650	\$15,651 - \$19,563	\$19,654 - \$23,475	\$23,476 - \$27,388	\$27,389 - \$31,300	\$31,301 +
<b>2</b>	\$0 - \$21,150	\$21,151 - \$26,438	\$26,439 - \$31,725	\$31,726 - \$37,013	\$37,014 - \$42,300	\$42,301 +
<b>3</b>	\$0 - \$26,650	\$26,651 - \$33,313	\$33,314 - \$39,975	\$39,976 - \$46,638	\$46,639 - \$53,300	\$53,301 +
<b>4</b>	\$0 - \$32,150	\$32,151 - \$40,188	\$40,189 - \$48,225	\$48,226 - \$56,263	\$56,264 - \$64,300	\$64,301 +
<b>5</b>	\$0 - \$37,650	\$37,651 - \$47,063	\$47,064 - \$56,475	\$56,476 - \$65,888	\$65,889 - \$75,300	\$75,301 +
<b>6</b>	\$0 - \$43,150	\$43,151 - \$53,938	\$53,939 - \$64,725	\$64,726 - \$75,513	\$75,514 - \$86,300	\$86,301 +
<b>7</b>	\$0 - \$48,650	\$48,651 - \$60,813	\$60,814 - \$72,975	\$72,976 - \$85,138	\$85,139 - \$97,300	\$97,301 +
<b>8</b>	\$0 - \$54,150	\$54,151 - \$67,688	\$67,689 - \$81,225	\$81,226 - \$94,763	\$94,764 - \$108,300	\$108,301 +

☐ I understand that I may qualify for the Sliding Fee Discount Program but at this time, I choose to decline.

☐ Yes, I would like to apply for the sliding fee discount program, please contact me at this Phone Number: \_\_\_\_\_

Print Name of Patient/Applicant or Parent/Guardian

Signature of Patient

Date

Patient/Applicant's Date of Birth

Signature of Staff/Witness

Date



**Broad Top  
Health & Wellness**

BTAMC Inc.

**Broad Top Area Medical Center, Inc.**

**AUTHORIZATION FOR THE RELEASE OF CONFIDENTIAL INFORMATION**

PATIENT NAME: \_\_\_\_\_ DOB: \_\_\_\_\_  
 ADDRESS: \_\_\_\_\_ SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 PHONE#: \_\_\_\_\_ EMAIL ADDRESS: \_\_\_\_\_

**I, HEREBY AUTHORIZED THE FOLLOWING:**

**Name of Practitioner/Facility:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone & Fax:** \_\_\_\_\_

**To RELEASE information TO and OR Exchange records with:** Broad Top Area Medical Center, Inc.

**\*\*CIRCLE Office of choice and direct all records to this office\*\***

☐ **Broad Top Medical Center**

4133 Medical Center Drive, PO Box 127  
 Broad Top, PA 16621-9001  
 Phone: 814-635-2916  
 Fax: (814) 635-2918

☐ **Belleville Wellness Center**

375 S. Kishacoquillas Street  
 Belleville, PA 17004-8620  
 Phone: 717-935-2065  
 Fax: 717-935-5560

☐ **Mount Union Medical Center**

95 S. Park Street  
 Mount Union, PA 17066-1334  
 Phone: 814-542-8627  
 Fax: 814-542-5444

☐ **Juniata Valley BTAMC Clinic**

846 Medical Center Drive, PO Box 355  
 Alexandria, PA 16611-2936  
 Telephone: 814-667-7400  
 Fax: 814-667-7395

☐ **Southern Huntingdon County Dental Clinic**

626 Water Street, Suite 2, PO BOX 146  
 Orbisonia, PA 17243-9432  
 Phone: 814-447-3159  
 Fax: 814-447-3195

☐ **Trough Creek Medical Center**

358 Seminary Street, PO Box 158  
 Cassville, PA 16623-6203  
 Phone: 814-448-9226  
 Fax: 814-448-2068

☐ **Huntingdon Family Care Center**

835 Washington Street, PO Box 185  
 Huntingdon, PA 16652-1725  
 Phone: 814-506-8114  
 Fax: 814-506-8553 or 814-506-8623

☐ **Pediatric & Family Healthcare**

6311 Margy Drive, Suite 2  
 Huntingdon, PA 16652-6934  
 Phone: 814-506-8490  
 Fax: 814-506-8493

☐ **Southern Huntingdon County Medical Center**

626 Water Street, Suite 1, PO Box 40  
 Orbisonia, PA 17243-9432  
 Phone: 814-447-5556  
 Fax: 814-584-5741

☐ **Primary Care Center**

790 Bryan Street, Suite 2  
 Huntingdon, PA 16652-2410  
 Phone: 814-907-3400  
 Fax: 814-907-3500

☐ **Family Wellness Center**

419 14<sup>th</sup> Street  
 Huntingdon, PA 16652-1726  
 Phone: 814-643-3205  
 Fax: 814-643-6903

☐ **Walk-In Clinic**

6678 Towne Center Blvd.  
 Huntingdon, PA 16652-6934  
 Phone: 814-643-1232  
 Fax: 814-643-4267

**The extent or nature of information to be released is indicated below:**

_____ COMPLETE DENTAL RECORDS	_____ X-RAYS
_____ COMPLETE MEDICAL RECORDS	_____ LABORATORY
_____ OFFICE NOTES (DATES) _____	_____ MEDICATION LISTS
_____ OPERATIVE REPORT	_____ HISTORY & PHYSICAL
_____ DISCHARGE SUMMARY	_____ OTHER: _____
_____ INPATIENT CARE (DATES OF SERVICE) _____	
_____ EMERGENCY CARE (DATES OF SERVICE) _____	





**AUTHORIZATION FOR THE RELEASE OF CONFIDENTIAL INFORMATION**

**The purpose for release of the above information is indicated below:**

\_\_\_\_ CONTINUED CARE    \_\_\_\_ TRANSFER    \_\_\_\_ INSURANCE    \_\_\_\_ LEGAL    \_\_\_\_ OTHER

If other is checked, please specify reason needed:

\_\_\_\_\_

***I \_\_\_\_\_ GIVE CONSENT TO THE RELEASE OF THESE RECORDS, WHICH I UNDERSTAND MAY INCLUDE PSYCHIATRIC INFORMATION, DRUG AND ALCOHOL INFORMATION, AND/OR HIV/AIDS INFORMATION.***

I understand this consent is voluntary and that I may revoke this authorization at any time (except to the extent that action based on this consent has already been taken) by written, dated, and signed communication to the facility. This consent will expire in one year from the date signed, unless otherwise stated as follows: \_\_\_\_\_.

I understand that I may refuse to sign this authorization. If I refuse, the identified records will not be disclosed. Whether I sign or refuse to sign, my treatment will not be affected.

**X** \_\_\_\_\_ **DATE SIGNED:** \_\_\_\_\_  
(Signature of PATIENT)

**X** \_\_\_\_\_ **WITNESS:** \_\_\_\_\_  
(Signature of Parent, Guardian, or Legal Representative)

If signed by other than the patient, state relationship and reason for patient's inability to sign:

\_\_\_\_\_

**Verbal consent requires the signature of two witnesses:**

\_\_\_\_\_  
Signature of Witness (1)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness (2)

\_\_\_\_\_  
Date

Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer will be protected by the Health Insurance Portability and Accountability Act.

A copy of this authorization has been \_\_\_\_ **Accepted** \_\_\_\_ **Rejected** by the Patient/Representative.