TIME 11:38 AM DATE 3/17/2010

PATIENT REGISTRATION

ID: _____ Chart ID: _____

First Name: _____ Last Name: _____ Middle Initial: ____

Patient Is: ☐ Policy Holder Preferred Name: _____

☐ Responsible Party

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: ____

Address: _____ Address 2: _____

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Soc Sec: _____ Drivers Lic: _____

○ Responsible Party is also a Policy Holder for Patient ○ Primary Insurance Policy Holder ○ Secondary Insurance Policy Holder

Patient Information

Address: _____ Address 2: _____

City: _____ State / Zip: _____ _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Sex: ○ Male ○ Female Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Birth Date: _____ Age: _____ Soc. Sec: _____ Drivers Lic: _____

E-mail: _____ ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ○ Full Time ○ Part Time ○ Retired

Student Status: ○ Full Time ○ Part Time

Medicaid ID: _____ Pref. Dentist: _____

Employer ID: _____ Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hyg.: _____

Section 3

Cell Phone: _____

Pager Number: _____

Driver's License: _____

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

Rem. Benefits: _____.00 Rem. Deduct: _____.00

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

Rem. Benefits: .00 Rem. Deduct: .00

Timeless Smiles Dental P.C.

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____

Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____

Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____

Are you on a special diet? ◯ Yes ◯ No _____

Do you use tobacco? ◯ Yes ◯ No

Do you use controlled substances? ◯ Yes ◯ No

Women: Are you

Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics

☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pace Maker ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No	Yellow Jaundice ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No	

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes, please explain: _____

Comments: _____

_____

_____

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

Periodontal Risk Assessment Questionnaire

Name _____ Date _____

Tobacco Use

Tobacco use is the most significant risk factor for gum disease.

Do you now or have you ever used the following:

	Amounts per day	*Used for how many years*	*If you quit, list what year*
❑ Cigarette			
❑ Cigar			
❑ Pipe			
❑ Chewing			

Blood Sugar

Diabetes

Gum disease is a common complication of diabetes. Untreated gum disease makes it harder for patients with diabetes to control their blood sugar.

IF YOU ARE A PATIENT WHO HAS DIABETES:

Is your diabetes under control? ❑ Yes ❑ No

Are you prone to diabetic complications? ❑ Yes ❑ No

How do you monitor your blood sugar? _____

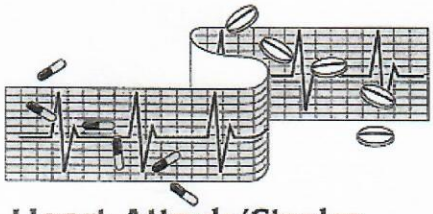
Who is your physician for diabetes? _____

IF YOU ARE NOT A PATIENT WHO HAS DIABETES:

Any family history of diabetes? ❑ Yes ❑ No

Have you had any of these warning signs of diabetes?

- ❑ frequent urination
- ❑ excessive thirst
- ❑ excessive hunger
- ❑ weakness and fatigue
- ❑ slow healing of cuts
- ❑ unexplained weight loss



Heart Attack/Stroke

Untreated gum disease may increase your risk for heart attack or stroke.

Do you have any risk factors for heart disease or stroke?

- ❑ Family history of heart disease
- ❑ Tobacco use
- ❑ Obesity
- ❑ High cholesterol
- ❑ High blood pressure

If you have any of these other risk factors it is especially important for you to always keep your gums as healthy as possible.

Medications

A side effect of some medications can cause changes in your gums.

Are you taking or have you ever taken any of the following medication:

❑ Antiseizure medications. (such as Dilantin®, Tegretol®, Phenobarbital, etc.)

❑ Yes ❑ No

If you answered yes, are you still taking the anti-seizure medication?

❑ Yes ❑ No

Other Medication: _____

❑ Calcium Channel Blocker blood pressure medication. (such as Procardia®, Cardizem®, Norvasc®, Verapamil®, etc.)

Other: _____

❑ Immunosuppressant therapy (such as Prednisone, Azathioprine, Cyclosporins, Corticosteriods (Asthma-Inhalers), etc.)

Other: _____

Family History/ Genetics

The tendency for gum disease to develop can be inherited.

Is there an immediate family member(s) who currently has or had gum problems in the past? (e.g. your mother, father, or siblings):

❑ Yes ❑ No

COLLAGENEX pharmaceuticals

Heart Murmur, Artificial joint prosthesis

If you have even the slightest amount of gum inflammation, bacteria from the mouth can enter the bloodstream and may cause a serious infection of the heart or joints.

Do you have a heart murmur or artificial joint?

❑ Yes ❑ No

If so, does your physician recommend antibiotics prior to dental visits?

❑ Yes ❑ No

Name of physician? _____

If you answered yes, it is especially important to always keep your gums as healthy and inflammation-free as possible to reduce the chance of bacterial infection originating from the mouth.

Females

Females can be at increased risk for gum disease at different points in their lives.

The following can adversely affect your gums. Please check all that apply:

❑ Pregnant ❑ Nursing ❑ Menopause

❑ Taking birth control pills

❑ Infrequent care during previous pregnancies

Women

Women with osteoporosis have a greater risk for periodontal bone loss.

Females:

Do you take any of the following:

❑ Estrogen Replacement Therapy/Hormone Replacement Therapy (such as Prempro®, Premarin®, Premphase®, Fosamax®, Actonel®, Evista®, Fortéo®, etc.)

Other: _____

Stress

High levels of stress can reduce your body's immune defense.

Are you under a lot of stress?

❑ Yes ❑ No

Nutrition

Your diet has the potential to affect your periodontal health.

Do you find it difficult to maintain a well-balanced diet?

❑ Yes ❑ No

All patients please complete the following:

Have you noticed any of the following signs of gum disease?

❑ Bleeding gums during toothbrushing

❑ Red, swollen or tender gums

❑ Gums that have pulled away from the teeth

❑ Persistent bad breath

❑ Pus between the teeth and gums

❑ Loose or separating teeth

❑ Change in the way your teeth fit together

❑ Food catching between teeth

Is it important to keep your teeth for as long as possible? ❑ Yes ❑ Not really

If you have missing teeth, why have you not had them replaced? _____

Do you like the appearance of your smile? ❑ Yes ❑ No

Do you like the color of your teeth? ❑ Yes ❑ No

Do your teeth keep you from eating any specific food? ❑ Yes ❑ No

TIMELESS SMILES DENTAL
10412 S. Kedzie Ave.
Chicago, IL 60655
Kellie Rhodes-Gayles, D.D.S.

Consent for Treatment

I hereby authorize Dr. Kellie Rhodes-Gayles or designated staff to take x-rays, models, photographs, and other diagnostic aids deemed appropriate by Dr. Rhodes to make a thorough diagnosis of (name of patient)_____'s dental needs.

Upon such diagnosis, I authorize Dr. Rhodes to perform all recommended treatment mutually agreed by me and to employ such assistance as required to provide proper care.

I agree to the use of any anesthetics, sedatives, and other medications necessary. I fully understand that the use of anesthetic agent embodies certain risks. I understand that I can ask for complete recital of any possible complications.

I_____, give consent for Dr. Rhodes or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment, and health care operations; I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.

Notice of Privacy Practices: I acknowledge that I have received 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 contact this organization at any time at the address above to obtain a current copy of the **Notice of Privacy Practices.**

We would appreciate a 48 hour notice of cancellation of scheduled appointments. If the cancellation is less than 48 hours or a no show, a **$50.00** charge will be assessed.

I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by the agreed date or dates, I understand that a 1.5% late charge (18% APR) may be added to my account.

Patient's Signature_____**Date**_____

Parent/Responsible Party's Signature_____

Relationship to Patient_____

TIMELESS SMILES DENTAL, P.C.

WELCOME TO OUR PRACTICE

This form is designed to acquaint you with our Office Policies. You have the opportunity to question, at this time and prior to service, the Office Policies and Procedures in the following areas of concern. PLEASE READ AND INITIAL EACH ITEM.

_____ This office employs a licensed, board certified Dentist and Hygienist who will be involved in your dental care.

_____ Please note, our relationship is with you and NOT your insurance company or pharmacy.

_____ If you are unable to keep your scheduled appointment, please notify us 48 hours in advance as a courtesy to other patients that are waiting for treatment.

_____ Failure to give 48 hours advance notice of cancellation will result in a minimum $50.00 charge. This is not a penalty, rather an effort to recover some cost for materials that cannot be reshelved due to sterilization management and infection control.

_____ Dental procedures **require** a **deposit** to **reserve** your appointment time. This amount will be applied to any co-payment due for the services performed on the following visit.

_____ Co-payments and Fees are due at the time of service and prior to treatment for patient comfort.

_____ If pre-treatment instructions have not been followed, your procedure may be cancelled.

_____ Diagnostic and treatment codes for billing will not be altered for insurances purposes.

_____ Statements are billed twice a month. Payment is expected within 10 days.

_____ There is a $30.00 fee for any check returned for insufficient funds.

_____ Notification of change of insurance, employer, name, phone and address is the patient's responsibility.

_____ **Patients that are 18 years and under must be accompanied by a parent or legal guardian.**

My initials and my signature below indicates I have read and understand the above office policies.

Patient Name _____

Patient / Guardian Signature _____ **Date** _____

Protecting Your Confidential Health Information is Important to Us

Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Our Promise

Dear Patient:

This notice is not meant to alarm you. Quite the opposite! It is our desire to communicate to you that we are taking seriously Federal law (HIPAA—Health Insurance Portability And Accountability Act) enacted to protect the confidentiality of your health information. We do not ever want you to delay treatment because you are afraid your personal health history might be unnecessarily made available to others outside our office.

Why do you have a privacy policy? Very good question!

The Federal government legally enforces the importance of the privacy of health information largely in response to the rapid evolution of computer technology and its use in healthcare. The government has appropriately sought to standardize and protect the privacy of the electronic exchange of your health information. This has challenged us to review not only how your health information is used within our computers but also with the Internet, phone, faxes, copy machines, and charts. We believe this has been an important exercise for us because it has disciplined us to put in writing the policies and procedures we follow to protect your health information when we use it.

We want you to know about these policies and procedures which we developed to make sure your health information will not be shared with anyone who does not require it. Our office is subject to State and Federal law regarding the confidentiality of your health information and in keeping with these laws, we want you to understand our procedures and your rights as our valuable patient.

We will use and communicate your HEALTH INFORMATION only for the purposes of providing your treatment, obtaining payment, conducting health care operations, and as otherwise described in this notice.

How your HEALTH INFORMATION may be used To Provide Treatment

We will use your HEALTH INFORMATION within our office to provide you with dental care. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care between hygienist, dental assistant, dentist, and business office staff. In addition, we may share your health information with physicians, referring dentists, clinical and dental laboratories, pharmacies or other health care personnel providing you treatment.

To Obtain Payment

We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically. We will be sure to only work with companies with a similar commitment to the security of your health information.

To Conduct Health Care Operations

Your health information may be used during performance evaluations of our staff. Some of our best teaching opportunities use clinical situations experienced by patients receiving care at our office. As a result, health information may be included in training programs for students, interns, associates, and business and clinical employees. It is also possible that health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine processes of certification, licensing or credentialing activities.

In Patient Reminders

Because we believe regular care is very important to your oral and general health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you or your family. These communications are an important part of our philosophy of partnering with our patients to be sure they receive the best preventive and restorative care modern dentistry can provide. They may include postcards, folding postcards, letters, telephone reminders or electronic reminders such as email (unless you tell us that you do not want to receive these reminders).

To Business Associates

We have contracted with one or more third parties (referred to as a business associate) to use and disclose your health information to perform services for us, such as billing services. We will obtain each business associate's written agreement to safeguard your health information.

NOTICE OF PRIVACY PRACTICES

Federal law generally permits us to make certain uses or disclosures of health information without your permission. Federal law also requires us to list in the Notice each of these categories of uses or disclosures. The listing is below.

As Required By Law

We may use or disclose your health information as required by any statute, regulation, court order or other mandate enforceable in a court of law.

Abuse or Neglect

We may disclose your health information to the responsible government agency if (a) the Privacy Official reasonably believes that you are a victim of abuse, neglect, or domestic violence, and (b) we are required or permitted by law to make the disclosure. We will promptly inform you that such a disclosure has been made unless the Privacy Official determines that informing you would not be in your best interests.

Public Health and National Security

We may be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public health or national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects of a drug treatment or medical device.

For Law Enforcement

As permitted or required by State or Federal law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstances, if you are a victim of a crime or in order to report a crime.

Family, Friends and Caregivers

We may share your health information with those you tell us will be helping you with your home hygiene, treatment, medications, or payment. We will be sure to ask your permission first. In the case of an emergency, where you are unable to tell us what you want, we will use our best judgment when sharing your health information only when it will be important to those participating in providing your care.

Workers' Compensation Purposes

We may disclose your health information as required or permitted by State or Federal workers' compensation laws.

Kellie Rhodes-Gayles, D.D.S., P.C.

(773) 233-1900

Judicial and Administrative Proceedings
We may disclose your health information in an administrative or judicial proceeding in response to a subpoena or a request to produce documents. We will disclose your health information in these circumstances only if the requesting party first provides written documentation that the privacy of your health information will be protected.

Incidental Uses and Disclosures
We may use or disclose your health information in a manner which is incidental to the uses and disclosures described in this Notice.

Health Oversight Activities
We may disclose your health information to a government agency responsible for overseeing the health care system or health-related government benefit program.

To Avert A Serious Threat To Health or Safety
We may use or disclose your health information to reduce a risk of serious and imminent harm to another person or to the public.

To The U.S. Department of Health and Human Services (HHS)
We may disclose your health information to HHS, the government agency responsible for overseeing compliance with federal privacy law and regulations regulating the privacy and security of health information.

For Research
We may use or disclose your health information for research, subject to conditions. "Research" means systemic investigation designed to contribute to generalized knowledge.

In Connection With Your Death Or Organ Donation
We may disclose your health information to a coroner for identification purposes, to a funeral director for funeral purposes, or to an organ procurement organization to facilitate transplantation of one of your organs.

If applicable State law does not permit the disclosure described above, we will comply with the stricter State law.

Authorization to Use or Disclose Health Information
Other than is stated above or where Federal, State or Local law requires us, we will not disclose your health information other than with your written authorization. You may revoke that authorization in writing at any time.

PATIENT RIGHTS
You have the following rights related to your health information.

Restrictions
You have the right to request restrictions on the use or disclosure of your health information for treatment, payment, or health care operations in addition to the restrictions imposed by federal law. Our office is not required to agree to your request, but we will endeavor to honor reasonable requests. We generally are not required to agree to a requested restriction. Our office will honor your request that we not disclose your health information to a health plan for payment or healthcare operation purposes if the health information relates solely to a health care item or service for which you have paid us out-of-pocket in full.

Confidential Communications
You have the right to request that we communicate with you by alternative means or at an alternative location. You may, for example, request that we communicate your health information only privately with no other family members present or through mailed communications that are sealed. We will honor your reasonable requests for confidential communications.

Inspect and Copy Your Health Information
You have the right to read, review, and copy your health information, including your complete chart, x-rays and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable, cost-based fee to duplicate and assemble your copy. If there will be a charge, we will first contact you to determine whether you wish to modify or withdraw your request.

Amend Your Health Information
You have the right to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe the information to be changed and your reason for the change.

Your request may be denied if the health information record in question was not created by our office, is not part of our records or if the records containing your health information are determined to be accurate and complete. If we deny your request, we will provide you with a written explanation of the denial.

Accounting of Disclosures of Your Health Information
You have the right to ask us for a description of how and where your health information was disclosed. Our documentation procedures will enable us to provide information on health information disclosures that we are required to disclose to you. Please let us know in writing the time period for which you are interested. Thank you for limiting your request to no more than six years at a time. We will provide the first accounting during any 12-month period without charge. We may charge a reasonable, cost-based fee for each additional accounting during the same 12-month period. If there will be a charge, the Privacy Official will first contact you to determine whether you wish to modify or withdraw your request.

Request a Paper Copy of this Notice
You have the right to obtain a copy of this Notice of Privacy Practices directly from our office at any time. Stop by or give us a call and we will mail or email a copy to you.

We are required by law to maintain the privacy of your health information and to provide to you or your personal representative with this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our Notice. If we change our privacy practices we will be sure all of our patients receive a copy of the revised Notice. *You have the right* to express complaints to us or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. We will not retaliate against you for submitting a complaint. Please let us know of your concerns or complaints in writing by submitting your complaint to our Privacy Officer.

Patient Acknowledgment

Patient Name(s):_____

_____

_____

Thank you very much for taking time to review how we are carefully using your health information. If you have any questions we want to hear from you. If not, we would appreciate very much your acknowledging your receipt of our policy by signing and returning this card. We look forward to seeing you again soon!

_____

Patient Signature

Date _____ / _____ / _____

For additional information about the matters discussed in this notice, please contact our Privacy Officer.

Effective Date:_____

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