Fishman Foot Care

PATIENT INFORMATION FORM

(PLEASE PRINT)

DATE: ___/____/____ SOCIAL SECURITY #: _____/_____/_____

PATIENT NAME: _____ _____ ___ DATE OF BIRTH: ___/___/___ AGE: ___ SEX: M F
LAST FIRST MI

HOME ADDRESS: _____ CITY/STATE: _____ ZIP: _____

MAY WE LEAVE A MESSAGE?

HOME PHONE #: (____) ____-_____ YES NO

WORK PHONE #: (____) ____-_____ YES NO

CELL PHONE #: (____) ____-_____ YES NO

E-MAIL: _____ YES NO

PRIMARY LANGUAGE: _____

RACE:_____ ETHNICITY:_____

MARITAL STATUS: _____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____ PHONE #: (____) ____-_____

PRIMARY CARE DOCTOR: _____ PHONE: _____

PHARMACY: _____ LOCATION: _____ PHONE #: (____) ____-_____

WHO REFERRED YOU TO US?_____

CURRENT PROBLEM

WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY? _____

WAS THIS PROBLEM CAUSED BY AN INJURY? ☐ YES (DESCRIBE) _____ ☐ NO

IF YES, WAS IT A WORK OR MOTOR VEHICLE RELATED INJURY? ☐ YES ☐ NO

I, hereby acknowledge that Dr. Michael Fishman, D.P.M. does **NOT** accept Worker's Compensation/ Personal Injury. By signing below, I acknowledge that I am agreeing my services are **NOT** Worker's Compensated/ Personal Injury related, and am agreeing to **NOT** filing a claim after services are rendered.

_____ DATE: _____

PATIENT SIGNATURE

PATIENT NAME: _____ DATE OF BIRTH: ____/____/_____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDE PRESCRIPTIONS, OVER-THE-COUNTER MEDS AND HERBAL SUPPLEMENTS):

NAME DOSE FREQUENCY OF MEDICATIONS?

_____

_____

_____

_____

_____

_____

_____

ALLERGIES: ☐ MEDICATIONS _____

☐ ANESTHESIA _____ ☐ FOODS _____

☐ TAPE ☐ LATEX ☐ SULFA ☐ IODINE ☐ PENICILLIN

☐ NONE KNOWN ALLERGIES

PLEASE LIST ALL PRIOR SURGERIES:

TYPE OF SURGERY DATE TYPE OF SURGERY DATE

_____ _____

_____ _____

_____ _____

SOCIAL HISTORY

USE OF ALCOHOL: ☐ NEVER ☐ NO LONGER USE ☐ HISTORY OF ALCOHOL ABUSE

☐ CURRENT USE - TYPE _____ ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

USE OF TOBACCO: ☐ NEVER ☐ QUIT – HOW LONG AGO? _____ ☐ SMOKE ____ PACKS/DAY FOR ____ YEARS

USE OF RECREATIONAL DRUGS: ☐ NEVER ☐ QUIT – HOW LONG AGO? _____ TYPE _____

☐ CURRENT USE - TYPE _____ ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

HOW MUCH ARE YOU ON YOUR FEET AT WORK? ☐ 10% ☐ 25% ☐ 50% ☐ 75% ☐ 100%

EXERCISE: ☐ NEVER ☐ RARE ☐ OCCASIONAL ☐ WEEKLY ☐ SEVERAL TIMES A WEEK ☐ DAILY

TYPES OF EXERCISE: _____

FAMILY HISTORY

DO YOU HAVE A FAMILY HISTORY OF: ☐ DIABETES: TYPE 1 OR TYPE 2 ☐ CANCER ☐ HEART DISEASE

☐ HIGH BLOOD PRESSURE ☐ STROKE ☐ CORONARY ARTERY DISEASE ☐ THYROID DISEASE

☐ RHEUMATOID ARTHRITIS

☐ OTHER _____

PATIENT NAME: _____ DATE OF BIRTH: ____/____/_____

PLEASE LIST ANY OTHER MEDICAL CONDITIONS:

_____

_____

_____

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

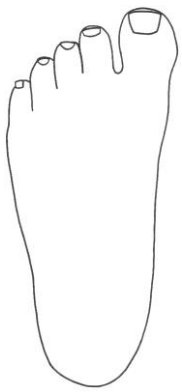
ACID REFLUX	Y	N	FIBROMYALGIA	Y	N	NEUROPATHY	Y	N
ANEMIA	Y	N	GOUT	Y	N	OPEN SORES	Y	N
ARTHRITIS	Y	N	HEART ATTACK	Y	N	ULCERS	Y	N
ASTHMA	Y	N	HEART DISEASE/FAILURE	Y	N	POLIO	Y	N
BACK TROUBLE	Y	N	HEPATITIS	Y	N	RHEUMATIC FEVER	Y	N
ABNORMAL BLEEDING	Y	N	HIV+/AIDS	Y	N	SICKLE CELL DISEASE	Y	N
BLOOD CLOTS	Y	N	HIGH BLOOD PRESSURE	Y	N	SKIN DISORDER	Y	N
BLOOD TRANSFUSION	Y	N	KIDNEY DISEASE	Y	N	SLEEP APNEA	Y	N
BRONCHITIS/EMPHYSEMA	Y	N	LIVER DISEASE	Y	N	STOMACH ULCERS	Y	N
CANCER	Y	N	HIGH CHOLESTEROL	Y	N	STROKE	Y	N
DIABETES: TYPE 1	Y	N	MIGRAINE HEADACHES	Y	N	THYROID DISEASE	Y	N
DIABETES:TYPE 2	Y	N	MITRAL VALVE PROLAPSE	Y	N	TUBERCULOSIS	Y	N

PLEASE WRITE YOUR PAIN LEVEL FROM 0 MEANING IT DOES NOT BOTHER YOU. 10 MEANING YOU ARE IN EXCRUSIATING PAIN AND NEED TO GO TO THE E.R.

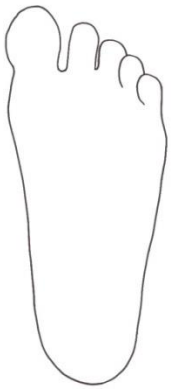
PAIN LEVEL OF: _____

WHERE IS THE PAIN/PROBLEM LOCATED? PLEASE MARK ON THE PICTURES BELOW.

LEFT FOOT



TOP OF FOOT

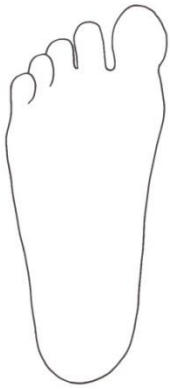


BOTTOM OF FOOT

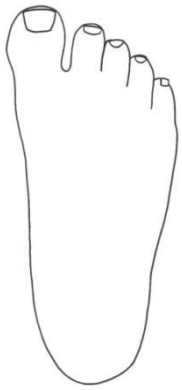
INSIDE OF FOOT

OUTSIDE OF FOOT

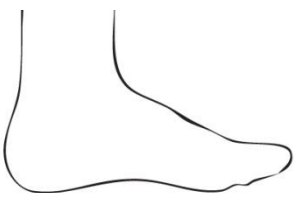
RIGHT FOOT



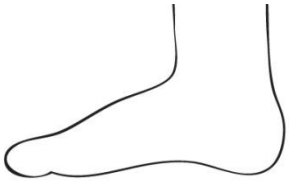
BOTTOM OF FOOT



TOP OF FOOT



OUTSIDE OF FOOT



INSIDE OF FOOT

SHOE SIZE: _____

PATIENT NAME: _____ DATE OF BIRTH: ____/____/_____

INSURANCE AUTHORIZATION AND ASSIGNMENT

I REQUEST THAT PAYMENT OF AUTHORIZED INSURANCE BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF TO DR. FISHMAN FOR ANY SERVICES THAT DR. FISHMAN PROVIDES. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS OR THE PAYABLE TO RELATED SERVICES. I UNDERSTAND THAT MY SIGNATURE REQUESTS THAT PAYMENT BE MADE AND AUTHORIZES RELEASE OF MEDICAL INFORMATION TO PAY THE CLAIM. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR THE BALANCE NOT COVERED BY MY INSURANCE. ANY ACCOUNT BALANCES WHICH REMAIN OUTSTANDING ARE SUBJECT TO A $5.00 PER MONTH BILLING CHARGE. IF I FAIL TO MAKE A PAYMENT AND THE BALANCE OF MY ACCOUNT IS PLACED FOR COLLECTION, I WILL BE RESPONSIBLE FOR REASONABLE COLLECTION COSTS, INCLUDING ATTORNEY'S FEES.

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR AND OFFICE STAFF OF ANY CHANGES IN MY MEDICAL STATUS.

_____ _____

PRINT NAME OF PATIENT, PARENT OR GUARDIAN SIGNATURE OF DOCTOR

_____ _____

IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT DATE

_____

SIGNATURE

_____

DATE

PATIENT NAME: _____ DATE OF BIRTH: ____/____/_____

FINANCIAL POLICY

Thank you for choosing our office to provide you with medical care. We are committed to serving you with skill and high quality care. The medical services provided by our office are services you have
elected to receive which may imply a financial responsibility on your part.

CO-PAYMENTS, CO-INSURANCE, DEDUCTIBLES: All co-payments, co-insurance and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance.

SELF-PAY ACCOUNTS: Payment in full is due at the time of service if you do not have health insurance.

NON-COVERED SERVICES: Please be aware that some of the services you receive may not be covered or not considered reasonable or necessary by Medicare or other insurers. You are responsible for payments of these services.

CLAIM SUBMISSION: We will submit your claims and assist you I any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company.

PATIENT BILLING: Occasionally after payment and/or explanation of benefits (EOB) are received from your insurance company/companies there is a co-insurance or deductible that we were not aware of at the time of service. You will be sent three notices of your financial responsibility. After the third and final notice, your account may be forwarded to collections. All cost incurred including, but not limited to, collection fees, attorney fees and court fees shall be your responsibility in addition to the balance due to the office. Please let the billing office know if you have any difficulties resolving your bill. Payment arrangements can be made on a case by case basis. We accept the following payments methods: Cash, Check, VISA, MasterCard, Discover, and American Express. (An additional $30.00 will be added to your statement if the check is returned for insufficient funds.)

I have read the above policy regarding my financial responsibility to Dr. Michael Fishman D.P.M. for medical services provided. I agree to pay Dr. Michael Fishman D.P.M. any balance unpaid by my insurance carrier for myself or the below named person.

ASSIGNMENT OF BENEFITS:
I, the undersigned, certify that I or my dependent) have coverage with my insurance as presented and assign directly to **Dr. Michael Fishman D.P.M.** all insurance benefits, payable to me for services rendered. I understand that I am responsible for payment of deductibles, co-payments, co-insurances, and/or non-covered services. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize RELEASE OF MEDICAL INFORMATION to my insurance carrier, or requested physician to provide continuity of care. I authorize the use of this signature on all insurance submissions.

INSURANCE AUTHORIZATION AND ASSIGNMENT
I REQUEST THAT PAYMENT OF AUTHORIZED INSURANCE BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF TO DR. FISHMAN FOR ANY SERVICES THAT DR. FISHMAN PROVIDES. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS OR THE PAYABLE TO RELATED SERVICES. I UNDERSTAND THAT MY SIGNATURE REQUESTS THAT PAYMENT BE MADE AND AUTHORIZES RELEASE OF MEDICAL INFORMATION TO PAY THE CLAIM.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR THE BALANCE NOT COVERED BY MY INSURANCE. ANY ACCOUNT BALANCES WHICH REMAIN OUTSTANDING ARE SUBJECT TO A $5.00 PER MONTH BILLING CHARGE. IF I FAIL TO MAKE A PAYMENT AND THE BALANCE OF MY ACCOUNT IS PLACED FOR COLLECTION, I WILL BE RESPONSIBLE FOR REASONABLE COLLECTION COSTS, INCLUDING ATTORNEY'S FEES.

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR AND OFFICE STAFF OF ANY CHANGES IN MY MEDICAL STATUS.

_____ _____

SIGNATURE OF PATIENT **DATE**

_____ _____

PRINT NAME OF PATIENT, PARENT GUARDIAN IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT

PATIENT NAME: _____ DATE OF BIRTH: ____/____/_____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.
We create a record of the care and services you receive at our office. We need this record to provide you with quality care and to comply with certain legal requirements.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU
The following categories describe different ways that we use and disclosed medical information without your specific written authorization.

- FOR TREATMENT. We may use medical information about you to provide you with medical treatment or services.
- FOR PAYMENT. We may use and disclose medical information about you so that the treatment and services you receive at Michael Fishman D.P.M. may be billed to and payment may be collected from you, an insurance company or health plan or other third party.
- FOR HEALTH CARE OPERATIONS. We may use and disclose medical information about you for Michael P. Fishman D.P.M. operations.
- APPOINTMENTS. We may use your information to provide appointment reminders. Special situations which do not require your written authorization include: (1) Organ and Tissue Donation, (2) Military and Veterans Health Benefits, (3) Worker's Compensation, (4) Public Health Risks, (5) Health Oversight Activities (6) Lawsuits and Disputes (7) Law Enforcement (8) Coroners, Medical examiners and Funeral Directors (9) National Security, Intelligence and federal Protective Service Activities (10) Inmates.

AUTHORIZATIONS FOR OTHER USES AND DISCLOSURES OF MEDICAL INFORMATION
Other uses and disclosures of medical information not covered by the uses of and disclosures stated above will be made only with your written authorization. If you give us an authorization, you may later revoke that permission in writing, at any time.

YOUR RIGHTS REGARDING MEDICAL INFORMATON ABOUT YOU
You have the following rights regarding medical information we maintain about you.

- RIGHT TO INSPECT AND COPY. You have the right to inspect and copy medical information that may be used to make decisions about your care.
- RIGHT TO AMEND. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information.
- RIGHT TO AN ACCOUNTING OF DISCLOSIRES. You have the right to request an "accounting of disclosure."
- RIGHT TO REQUEST RESTRICTIONS. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment.
- RIGHT TO CONFIDENTIAL COMMUNICATIONS. You have the right to request communications of your health information by alternative means or at alternative locations.

RIGHT TO PAPER COPIES OF ELECTRONIC NOTICES. You have the right, where you have agreed to receive electronic notices, to obtain a paper copy of the notice upon request.

OUR LEGAL DUTIES

- We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information.
- We are required to abide by the terms of the notice currently in effect.
- We reserve the right to change the terms of this notice and make the new notice provisions effective for all protected health information we maintain. Revised notices will be sent to all our patients within 20 days from the time such revisions are made.

COMPLAINTS
If you believe your privacy rights have been violated, you may file a complaint with (Medical Group) or with the Secretary of the Department of Health and Human Services.

CONTACT
To file a complaint with Michael P Fishman D.P.M. contact Kathryn Mabry at (562) 431-2558.

COMPREHENSIVE PRIVACY NOTICE
A more detailed, comprehensive notice regarding our privacy practices is available upon request to the person stated above.

EFFECTIVE DATE: This notice is effective on April 16, 2003.

PATIENT NAME: _____ DATE OF BIRTH: ____/____/_____

Michael Fishman D.P.M.
● Foot & Ankle Specialist ● Adult & Pediatric Surgery ●
3851 Katella Ave., Suite #255
Los Alamitos, CA 90720
P: (562)431-2558 F: (562)296-8389

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclosure your health information.

By signing below, I acknowledge that I have received a copy of the Notice of Privacy Practices of Michael P. Fishman, D.P.M.

Signature of Patient or Personal Representative.

Print Name of Patient or Personal Representative.

Date

Description of Patient or Personal Representative's Authority

PATIENT NAME: _____ DATE OF BIRTH: _____/_____/_____

Michael Fishman D.P.M.

• Foot & Ankle Specialist • Adult & Pediatric Surgery •
3851 Katella Ave., Suite #255
Los Alamitos, CA 90720
P: (562)431-2558 F: (562)296-8389

Michael Fishman DPM INC. is offering a secure and convenient method of payment for the portion of services that your insurance does not cover, but for which you are responsible. This would include co-payments, co-insurance and annual deductibles. Your credit card information will be kept confidential and secure, and payments to your card are processed only after the claim has been filed and processed by your insurance carrier(s).

I, _____, authorize Michael Fishman DPM INC. to capture my credit card information and to charge my credit card as payment for any balance put into the "patient responsibility" as a result of my insurance plan's deductible, co-insurance, or co-payment. I understand and agree that this payment will be processed after the claim is finalized and when I, the patient, received a copy of the Explanation of Benefits (EOB) from my insurance plan. Michael Fishman DPM INC. will also provide myself with a receipt as proof of payment.

I certify that I am an authorized user of this credit card, and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.

I authorize Dr. Michael Fishman DPM to charge the outstanding patient balances for me and/or my dependents to the following credit cards:

Visa MC DISCOVER AMEX

Account Number _____

Expiration Date: _____ Security Code: _____ Billing Zip Code: _____

Full Name on Credit Card (please print): _____

Signature: _____ Date: _____

<u>Credit Card on File Billing Authorization FAQ</u>

Q: *<u>What is a deductible?</u>*
A: An annual deductible is the dollar amount you must pay out of your own pocket during your plan year for medical expenses before your insurance begins to pay.
Q: *<u>Is my credit card secure?</u>*
A: Yes, we keep your credit card information securely within your HIPPA compliant Electronic Medical Record and Billing System.
Q: *<u>What if I need to discuss my bill?</u>*
A: Our office will always work with you to resolve any issues and will refund you if we have made a billing error. We only charge the amount that we are instructed by your insurance carrier to collect as part of patient responsibility on your EOB. The Billing Department can be reach at 562-546-7185. If you disagree with how your insurance carrier processed the claim, you will need to contact their customer service department directly.

PATIENT NAME: _____ DATE OF BIRTH: ____/____/_____

REVIEW OF SYSTEMS
Please check any that apply to you

General/Constitutional
☐ Chills
☐ Fatigue
☐ Fever
☐ Weakness
☐ Weight gain/loss

Eyes
☐ Blurry vision
☐ Cataracts
☐ Discharge
☐ Double vision
☐ Excessive tearing
☐ Eye pain
☐ Glasses/Contacts
☐ Infections
☐ Pain with light
☐ Redness
☐ Loss of vision

ENT
☐ Head injury
☐ Headaches
☐ Pain
☐ Sweats
☐ Discharge
☐ Frequent colds
☐ Hay fever
☐ Infections
☐ Nasal Obstruction
☐ Nosebleeds
☐ Sinus infections
☐ Bleeding gums
☐ Hoarseness
☐ Postnasal drip
☐ Tongue Burning
☐ Hearing aid
☐ Ringing in ears
☐ Frequent sore throats
☐ Lumps
☐ Tenderness
☐ Tonsils enlarged

Respiratory
☐ Asthma
☐ Cough
☐ Wheezing
☐ Coughing blood
☐ Shortness of breath

Cardiovascular
☐ Chest pains
☐ Palpitations
☐ Varicose veins
☐ Heart murmur
☐ Leg pain (walking, etc)
☐ Swelling of legs
☐ Thrombophlebitis
☐ Ulcers on legs

Gastrointestinal
☐ abdominal pain
☐ Constipation
☐ Diarrhea
☐ Heartburn
☐ Jaundice
☐ Liver disease
☐ Rectal bleeding
☐ Excessive hunger
☐ Excessive thirst
☐ Gallbladder disease
☐ Vomiting/nausea

Musculoskeletal
☐ Arthritis
☐ Joint pain
☐ Gout
☐ Back problems
☐ Joint stiffness
☐ Muscle cramps
☐ Muscle stiffness
☐ Paralysis
☐ Restricted motion
☐ Weakness

Neurological
☐ Loss of consciousness
☐ Blackouts
☐ Dizziness/fainting
☐ Headaches/ Memory loss
☐ Numbness/ Paralysis
☐ Bell's Palsy
☐ Stroke
☐ Tingling/ tremors

Female Genitalia
☐ Birth control
☐ Intermittent

Skin
☐ Eczema
☐ Itchiness/dryness
☐ Hives/ lumps
☐ Mole size increase
☐ Nail color appearance change
☐ Rashes

Hematologic/Lymph
☐ Anemia
☐ Bleeding easily
☐ Blood clots
☐ Bruise easily
☐ Lumps/ swollen glands
☐ Transfusion reaction

Allergic/ Immunologic
☐ Coughing/ with exercise
☐ Itchy/ watery eyes
☐ Runny/ stuffy nose
☐ Wheezing/ with exercise

Urinary
☐ awakening to urinate
☐ Bed- wetting
☐ Blood in urine
☐ Burning/Pain urinating
☐ Excessive urination
☐ Flank pain
☐ Incontinence
☐ Infections
☐ Stones
☐ Urine odor/discoloration
☐ Other conditions

_____

PATIENT NAME: _____ DATE OF BIRTH: ____/____/_____

NO SHOW/CANCELLATION POLICY

At Michael Fishman DPM INC., our goal is to provide quality treatment and care in a timely manner to all our patients. We schedule our appointments so that each patient receives the right amount of time to be seen by Dr. Michael Fishman. We have implemented a cancellation and "no show" policy which enables us to better utilize available appointments for our patients. The following policy is with regard to patients who fail to keep their scheduled in office appointments, procedure appointments or scheduled surgery appointments. This is effective immediately.

Please be courteous and call our office promptly if you are unable to attend an appointment. This time will be reallocated to someone who is in urgent need of treatment. Available appointments are in high demand and your early cancellation will give another person the opportunity to have access to timely care.

General Care

Patients who fail to show for their scheduled appointment and/or did not notify the office within 2 business days of their scheduled appointment time shall be subject to a "No Show/Cancellation" fee of $100.00. In the event of an actual emergency and prior notice could not be given, consideration will be given, and a one-time exception may be granted.

Office Procedures

Patients who fail to show for their scheduled office procedure appointment or did not notify the office within 2 business days of their scheduled appointment time, shall be subject to a "No Show/Cancellation" fee of $250.00.

Surgeries

Patients who fail to show for their scheduled surgery appointment, did not notify the office within 2 business days or cancel less than 14 days of their scheduled surgery appointment time, shall be subject to a "No Show/Cancellation" fee of $250.00.

If any appointment is cancelled by the physician or office as a medical necessity, then the patient is not subject to this charge. Insurance authorization denials are also an exemption of the fees.

These "No Show/Cancellation" fees are not covered by insurance and are therefore the sole responsibility of the patient.

_____ _____

SIGNATURE OF PATIENT **DATE**

_____ _____

PRINT NAME OF PATIENT, PARENT GUARDIAN IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT