Ascent Neurobehavioral Institute
540 West Plumb Lane, Suite 1A
Reno, Nevada 89509
775-322-4666
Fax 775-322-4747

PATIENT INFORMATION

Thank you for choosing Ascent Neurobehavioral Institute. Please fill out this form completely in order to ensure the fastest and best healthcare service. Please use only blue or black ink.

Name:_____
First Middle Last

SS#:_____ **DOB:**_____ **Gender:** Male Female

Address:_____
Street Apt.# City State Zip Code

Home Phone#:_____ **Work Phone#:**_____ **Cell Phone#:**_____

Marital Status: S M W D **Employment:** Employed/ Disabled/ Unemployed/ Student/ Retired

Email Address:_____ **Spouse's Name:**_____

Primary Care Physician:_____ **Phone #:**_____

Other Therapist:_____ **Phone #:**_____

Pharmacy Name:_____ **Location:**_____ **Phone#:**_____

EMERGENCY CONTACT INFORMATION:

Emergency Contact Person:_____ **Relationship to Patient:**_____

Home Phone#:_____ **Work Phone#:**_____ **Cell Phone#:**_____

IF PATIENT IS A MINOR:

Mother's Name:_____
First Middle Last

Address:_____
Street Apt# City State Zip Code

Home Phone#:_____ **Work Phone#:**_____ **Cell Phone#:**_____

Father's Name:_____
First Middle Last

Address:_____
Street Apt# City State Zip Code

Home Phone#:_____ **Work Phone#:**_____ **Cell Phone#:**_____

RESPONSIBLE PARTY: (Complete this section only if someone other than the patient is financially responsible)

Name:_____
First Middle Last

Relationship to Patient:_____ **SS#:**_____ **DOB:**_____

Address:_____
Street Apt.# City State Zip Code

Home Phone#:_____ **Work Phone#:**_____ **Cell Phone#:**_____

INSURANCE INFORMATION:

Primary Insurance Plan:_____

Insurance ID#:_____ **Group#:**_____

Subscriber Name:_____
First Middle Last

Subscriber SS#:_____ **Subscriber DOB:**_____

Subscriber Employer:_____ **Employer's Phone#:**_____

Secondary Insurance Plan:_____

Insurance ID#:_____ **Group#:**_____

Subscriber Name:_____
First Middle Last

Subscriber SS#:_____ **Subscriber DOB:**_____

Subscriber Employer:_____ **Employer's Phone#:**_____

I certify that this information is true and correct to the best of my knowledge. I will notify the front office staff of any changes in any of the information listed, including insurance changes. I authorize Ascent Neurobehavioral Institute to release any medical information necessary to process my claims and payment of medical benefits to my insurance carrier(s).

_____ _____
Signature of Patient/Guardian/Responsible Party **Date**

ELECTRONIC PRESCRIPTION AUTHORIZATION

Our office sends prescriptions electronically. Please complete the following information to ensure that your prescriptions are successfully sent to your pharmacy.

Patient's Name:_____
(First) (Middle) (Last)

Address:_____
(Street) (Apt.#) (City) (State) (Zip)

Home Ph#:_____ Work Ph#:_____ Cell Ph#:_____

LOCAL:

Pharmacy Name:_____ Location:_____

Pharmacy Phone:_____ Pharmacy Fax:_____

MAIL ORDER:

Pharmacy Name:_____ Location:_____

Pharmacy Phone:_____ Pharmacy Fax:_____

Please give a copy of your prescription drug card to the receptionist

By signing below, I authorize Ascent Neurobehavioral Institute to submit my prescriptions electronically to my pharmacy. I understand that I will need to allow at least 48 hours for any refill request(s).

_____ _____
Signature of Patient/Guardian **Date**

Ascent NBI & TMS Center
540 West Plumb Lane, Suite 1A, Reno, NV 89509
Ph 775-322-4666, Fax 775-322-4747

FINANCIAL AND OFFICE POLICY

PLEASE READ CAREFULLY AND SIGN WHERE INDICATED. THE PATIENT OR RESPONSIBLE PARTY IS RESPONSIBLE FOR THE INFORMATION CONTAINED IN THIS POLICY.

OFFICE COPY – *IF YOU WOULD LIKE A COPY OF THESE POLICIES FOR YOUR RECORDS, PLEASE FEEL FREE TO EITHER MAKE A COPY OR ASK THE PATIENT COORDINATOR TO MAKE A COPY FOR YOU WHEN YOU CHECK IN FOR YOUR APPOINTMENT.*

Initial **Financial Policies:**

— All patients should provide accurate and complete personal and insurance information prior to being seen by the doctor or therapist. Please notify our office at least 24 hours prior to your appointment of any changes, addition or cancellation to your insurance. If we do not receive this information at least 24 hours prior to your appointment, the patient is responsible for the full amount of the office visit payable upon arrival. After benefits are verified, if there is a credit balance on the patient account, credit will be given towards future appointments.

— Deductibles, copays, or charges for non-covered services are due at the time of the appointment and will be collected upon arrival.

— Cash pay patients are expected to pay in full at the time of service upon arrival for the scheduled appointment.

— Payment for services is due upon arrival at the scheduled appointment unless prior arrangements have been made at least 24 hours in advance of the appointment. Patients who arrive at their appointment and are unable to pay their co-payment (without having made prior arrangements) will be rescheduled and charged a missed appointment fee equal to the amount of the visit. This fee is not covered by insurance.

— Our office accepts cash, personal checks, Mastercard, Visa, and Discover cards.

Insurance

___(please initial) Ascent NBI & TMS Center participates in several insurance plans. Participation is dependent upon which provider is seen. It is the patient's responsibility to contact his or her insurance carrier, prior to scheduling the first appointment, to verify provider participation in a particular insurance plan. For out-of-network benefits, Ascent NBI will accept payment from the out-of-network plan, however, the patient is responsible for the full amount not paid by their insurance plan. It is the patient's responsibility to verify and comply with any precertification and referral requirements of their insurance plan.

Usual and Customary Rates

___(please initial) Ascent NBI & TMS Center is committed to providing the best treatment for our patients. We charge what we believe to be reasonable and customary fees for our region and specialty.

If your insurance company uses a different fee schedule, the patient is responsible for any remaining balance.

Missed Appointments

___(please initial) **Patients are responsible for their appointments. If you must cancel or change your appointment, you must do so no later than 24 business hours in advance of the appointment.** Failure to receive or respond to a courtesy reminder call from our staff does not remove patient responsibility for the appointment. **Cancellations or appointment changes made less than 24 business hours prior to the scheduled appointment will result in a fee for the full amount of the office visit.** Missed appointment fees must be paid in full before the appointment can be rescheduled (unless other arrangements are made) and are not billable to insurance.

Account Balances

___(Please initial) Patient statements are mailed out monthly and payment in full is due upon receipt. Balances 30 days past due, without payment arrangements, will be charged a $25 late fee and are subject to collection action. All past due balances without a current payment agreement on file must be paid no later than 7 days prior to the next scheduled appointment date or the appointment may be cancelled. Overdue accounts may be referred to a third-party collection agency. All fees incurred to secure past due balances will be charged to the patient account. Currently, this is an additional 35% added to the patient balance.

Returned Checks

___(Please initial) Checks returned by your bank unpaid are subject to a $25.00 NSF fee. The check amount and $25 fee must be paid in full within 10 days of return date or prior to the next scheduled appointment, whichever is earlier. If not received, the appointment will be cancelled and the account referred to collections. The check amount plus fee and all future payments must be by cash, money order, or credit/debit card.

Regardless of insurance status, the patient is ultimately responsible for payment of services. By signing below, you acknowledge that you have read, understand, and agree to the financial policy of Ascent NBI & TMS Center.

Patient (or Legal Guardian) Printed Name	Signature of Responsible Party	Date

Office Policy:

Initial

— Please arrive at least 10-15 minutes prior to your appointment (20 minutes for first time patients) to allow sufficient time to complete any necessary paperwork. If you arrive for your appointment more than 15 minutes late, please be aware that there is a possibility that your appointment may be rescheduled, as to not inconvenience other patients, and a missed appointment fee may apply.

— If you cannot keep your appointment, please call (775) 322-4666 to cancel or reschedule your appointment. Appointment changes and cancellations MUST BE MADE 24 BUSINESS HOURS PRIOR TO YOUR APPOINTMENT. We do understand that emergencies and illnesses occur, and we are willing to work with patients on an individual, case-by-case basis. Documentation is required.

— Please note that in the event of a missed, rescheduled, or cancelled appointment without proper notice, **medication refills may be denied.**

— Effective June 1, 2011, a credit/debit card authorization form must be completed and kept on file to pay for missed/cancelled appointments that incur a missed/cancelled appointment fee and to cover any returned checks and applicable fee.

Miscellaneous Fees:

• Returned check fee	$25.00
• Medical records	60¢ per page plus postage
• Lost or expired prescriptions	$10.00
• Phone calls to the provider that exceed 5 minutes (not billable to the insurance)	$25.00 per additional 5 minute block

My signature below indicates that I am financially responsible for payment of service and any unpaid balances and agree to the policies as stated above and set forth by Ascent NBI & TMS Center.

_____ _____ _____

Patient (or Legal Guardian) Printed Name Signature of Responsible Party Date

CREDIT CARD AUTHORIZATION

By signing below, I authorize Ascent NBI & TMS Center to charge my credit card for cancellation and missed appointment charges to my patient account.

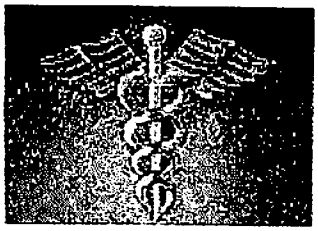
Credit Card: VISA MASTERCARD DISCOVER

Name on Credit Card: _____

Credit Card Number: _____ Expiration Date:__/__CSV Code:____

_____ _____

Authorized Signature **Date**



Ascent Neurobehavioral Institute
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May 11, 2011

Our office policy in regard to the treatment of minors (under the age of 18 years) is as follows:

All patients who have not reached their 18th birthday on the day of treatment must be accompanied by a parent or legal guardian at the time of their treatment. Exceptions are patients who are over the age of 16 and have been emancipated from their parents or legal guardian for four months, or are married, or a mother (having a child of their own). Minor patients who do not meet the exception will not be treated without their parent or legal guardian accompanying them to the visit.

This policy has been added to all new patient paperwork.

_____ _____

Parent/Guardian Signature Date

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW IT CAREFULLY
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your protected health information (PHI). We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your PHI. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect September 1, 2010, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by the applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all PHI that we maintain, including health information we created or received before we make the changes. Before we make significant changes in our privacy practices, we will change this Notice and make the new Notice available upon request. We will post a copy of our current notice in our office.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of the Notice, please contact us using the information listed at the end of this Notice.

UNDERSTANDING YOUR PROTECTED HEALTH INFORMATION (PHI)

Each time you visit our office a record is made of your visit and includes PHI that includes your symptoms, examination notes, test results, diagnoses, treatment and plan of care for you. This PHI, often referred to as your health or medical information, serves as a:

- Tool for planning your care, treatment and any follow-up care you may need
- Means of communication among other health care professionals who contribute to your care
- Legal document describing the care you received
- Means by which you and/or a third party payer (for example: insurance carriers, Medicare) can verify that services billed were actually provided
- Source of information for federal and state public health officials charged with protecting the health of the nation
- Tool that can be used to assess and continually improve the care rendered and the medical treatment that you receive.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION (PHI)

We use and disclose health information about you for treatment, payment and healthcare operations.

Treatment: We may use your PHI to treat you or disclose your PHI to a physician or other healthcare provider for which you are referred for treatment.

Payment: We may use and disclose your PHI to obtain payment for services we provide to you. This includes submitting billing and charge information to your insurance company or third party payer for reimbursement of the treatment services that we provided you.

Healthcare Operations: We may use and disclose your PHI in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities reviewing the competence or qualifications of healthcare professionals, evaluating practitioners or provider performance, conducting training programs, accreditation and certification, licensing or credentialing activities.

To Business Associates for Treatment, Payment or Healthcare Operations: We may use and disclose your PHI to our business associates in order to carry out treatment, payment or healthcare operations that the business associate performs on our behalf. For example, we may disclose your PHI to a company we hire to bill insurance companies on our behalf to help us obtain payment for the treatment we provided you.

Your Authorization: In addition to our use of your PHI for treatment, payment or healthcare operations, you may give us written authorization to use your PHI to disclose it to anyone for any purpose. If you give us authorization you may revoke it in writing at any time. Your revocation will not affect any use or disclosure performed by your authorization while it was in effect. Unless you give us written authorization, we cannot use or discuss your PHI for any reason except those described in the Notice.

To Your Family and Friends: With your verbal authorization we can disclose your PHI to a family member, friend or other person to the extent necessary to help with your healthcare or with payment of your healthcare.

Person Involved in Care: We may use or disclose PHI to notify, or assist in the notification of (including, identifying, and locating) a family member, your personal representative or another person responsible for your care, of your locations, your general conditions or death. If you are present, then prior to use or disclosure of your PHI, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose PHI based on determination using our professional judgment disclosing only PHI that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and experience with common practice to make reasonable inferences of your best interest allowing a person to pick up filled prescriptions, samples, medical supplies or other similar forms of health information.

Required by Law: We may use or disclose your PHI when we are required to do so by federal, state or local law. We disclose your PHI in response to a court or administrative order including court ordered subpoenas or discovery requests.

Health Oversight Activities: We may disclose your PHI to a health oversight agency for activities authorized by law such as audits, investigations, inspections and licensure.

Public Health Reporting including Abuse or Neglect: We may disclose your PHI to appropriate authorities if we reasonable believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. We may disclose your PHI to the extent necessary to avert a serious threat to your health or the health or safety of others.

National Security: We may disclose to military authorities the PHI of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having custody of PHI of an inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your PHI to provide you with appointment reminders such as voicemail messages, postcards or letters.

Laboratory/Pathology/Culture Results: All patients are attempted to be notified of their results by telephone if there appears to be a concern. It is your responsibility to call our office for your results if we are unable to reach you.

PATIENT RIGHTS

Access: You have the right to inspect and obtain a copy of your PHI, with limited exceptions. You must make a request in writing to obtain access to your PHI. You may obtain a form to request access by using the contact information listed at the end of this Notice. There is a charge of $0.60 per page for medical records. If your records are transferred to directly to another physician there is no fee charged.

Disclosure Accounting: You have the right to receive a list of instances in which we disclosed your PHI for purposes, other than treatment, payment, healthcare operations and certain other activities, for the past 6 years. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

Restriction: You have the right to request that we place additional restrictions on our use and disclosure of your PHI. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement, except in emergency situations. You may obtain a form to request restricted disclosures by using the contact information listed at the end of this Notice.

Alternative/Confidential Communication: You have the right to request that we communicate with you about your PHI by alternative means or to an alternative location. For example, you may request that we contact you at a work phone number instead of your home phone number. You must make your request in writing. Your request must specify the alternative means or action and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendments: You have the right to request that we may amend your health information. Your request must be in writing and it must explain why the information should be amended. We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our web site or by electronic mail (e-mail), you are entitled to receive this Notice in written format.

Email: Email is to be used for initial contact, generalized information on procedures, or scheduling appointments. Email cannot substitute for a physician visit. Do not send urgent emails or requests for immediate medical attention. Please call our office if in need of immediate assistance (775) 322-4666.

QUESTIONS OR COMPLAINTS

If you want more information about our privacy practices or have questions or concerns please contact us.

If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice please contact our privacy officer at (775) 322-4666. You may be asked to submit your complaint in writing so that our Privacy Officer can complete a thorough investigation.

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You have the right to refuse to sign this Acknowledgement****

Ascent Neurobehavioral Institute has provided you a copy of its Notice of Privacy Practices. The Notice of Privacy Practices explains your privacy rights as a patient and includes a complete description of the uses/or disclosures of my protected health information (PHI). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment
- Obtain payment for that treatment
- Conduct normal healthcare operations

The Practice has explained to me that the Notice will be available to me in the future at my request and that I have a right to obtain a copy of the Notice prior to signing this consent. I have been encouraged to read the Notice carefully prior to my signing this consent.

My signature below indicates that I have been provided a copy of the Notice of Privacy Practices by Ascent Neurobehavioral Institute. The Practice has given me the opportunity to ask any questions about this notice and all of my questions have been answered.

_____
Patient/Guardian Name (printed)

_____ _____
Patient/Guardian Signature Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained due to the following:

_____Individual refused to sign

_____Communication barriers prohibited obtaining the acknowledgement

_____An emergency situation prevented us from obtaining acknowledgement

_____Other:_____

_____ _____
Practice Representative Date

Patient Record of Disclosures

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that communication of PHI be made by alternative means, such as sending correspondence to home or office, leaving messages on answering machines, and leaving correspondence with spouse or family member.

I wish to be contacted in the following manner (circle all that apply):

Home telephone number:_____

- Leave a message with detailed information
- Leave a message with call back number only

Cell phone number:_____

- Leave a message with detailed information
- Leave a message with call back number only

Work telephone number:_____

- Leave a message with detailed information
- Leave a message with call back number only

Written communication:

- Mail to my home address
- Mail to my work address
- Fax to this number:_____

The following person(s) are able to speak with the doctor or office staff regarding my treatment or billing questions:

Name (First and Last)	Relationship to Patient	Phone Number(s)

This consent will remain in effect unless otherwise revoked in writing.

_____ _____

Patient/Guardian Signature Date

DEVELOPMENTAL QUESTIONNAIRE

This questionnaire asks you to respond to a series of questions about you and your family. This type of information is very helpful in making an accurate diagnosis. Please complete these forms as best you can. We will have the opportunity to discuss them in detail at your appointment.

TODAY'S DATE:_____

NAME:_____ DOB:_____ AGE:_____

Referred by:_____ Phone:_____

Address:_____

Primary Care Physician:_____ Phone:_____

Address:_____

Therapist:_____ Phone:_____

Address:_____

Have you notified your physician of this appointment:_____

Have you been seen by any of the professionals listed below for emotional/behavioral problems such as depression, anxiety, etc? Please check all that apply:

☐ Psychiatrist
☐ Primary Care Physician
☐ Therapist
☐ Psychologist

Please specify the type of treatment received:_____

Why are you seeking professional help at this time:_____
_____
_____
_____

Outpatient Treatment:

Physician/therapist	Address	Duration of Treatment
		From: To:
		From: To:

Inpatient Treatment:

Facility Name	Address	Treating MD	Duration of stay

Medications used that helped:_____
_____
_____
_____
_____
_____

EDUCATIONAL PLACEMENT:

Did you experience any problems in school? ☐No ☐Yes If yes, please describe:_____

_____

_____

Have you repeated any grades? ☐No ☐Yes If yes, please describe:_____

_____

Ever in any type of special education class? ☐No ☐Yes If yes, please describe:_____

_____

Any behavior problems? ☐No ☐Yes If yes, please describe:_____

_____

_____

SOCIAL HISTORY:

Married: ☐No ☐Yes Divorced: ☐No ☐Yes # of marriages:_____

Children: ☐No ☐Yes Ages:_____ # living w/you:_____

Do you smoke cigarettes? ☐No ☐Yes

Do you currently us any type of illegal drugs? ☐No ☐Yes If yes, what types of drugs and how much per day?_____

Do you drink alcohol? ☐No ☐Yes If yes, what type of alcohol and how much per day?_____

Any history of legal problems? ☐No ☐Yes If yes, please specify:_____

_____

_____

_____

List any stressful or traumatic events in your life which may have affected your development and ability to function (i.e., birth of sibling, death in the family, divorce, illnesses, frequent school changes, witnessing a trauma, etc.):

Incident	Age	Comments

MEDICAL HISTORY:
Check all those that apply. In the extra space provided, please describe the condition and specify the type of treatment received.

☐Asthma: _____
☐Anemia: _____
☐Seizures: _____
☐Heart Problems: _____
☐Thyroid Problems: _____
☐Glaucoma: _____
☐High Blood Pressure: _____
☐Strokes/Heart Attacks: _____

List any other existing or recent medical conditions treated: _____
_____
_____

List Surgeries: Age Complications
_____
_____

List other Hospitalizations: Age Reason Length of Stay
_____
_____

List any Head Injuries: Age Loss of consciousness
_____
_____

List any allergies to medications: _____
_____

PRESENT MEDICAL STATUS:

Current health: ☐poor ☐fair ☐good ☐excellent

Are you in any way physically ill at this time: ☐No ☐Yes If yes, please explain: _____
_____

List current medications. Include dosage and reason. Include vitamin, herbs & over the counter:
_____
_____
_____
_____

Please use this space and any additional sheets for any additional information/comments you wish to share with us about you: _____
_____
_____
_____
_____
_____
_____

FAMILY PSYCHIATRIC AND MEDICAL HISTORY

Specify which family members suffer from mental health problems or any of the listed medical problems.

	Relationship to patient	Medications (specify)	Hospitalizations
Depression			
Bipolar Disorder			
Anxiety Disorder			
Schizophrenia			
Eating Disorder Anorexia/Bulimia			
Learning Disorder			
Substance Abuse Alcohol/Drugs			
ADHD/ADD			
Suicide attempt or contemplation			
OCD/Obsessive Compulsive Disorder			
Legal Problems			
Violent Behavior			
Speech Problems			
Tourettes/tic Disorder			
Obesity			
Heart Problems			
High Cholesterol			
Epilepsy/Seizures			
Thyroid Problems			
Other: please specify			

PSYCHIATRIC MEDICATION HISTORY

Date:_____Patient Name:_____ DOB:_____

Please list any psychiatric medications that you have tried and failed previously. It is important to be as accurate as possible, please contact your pharmacy for assistance if you don't have a record of previous psychiatric medications.

Name of Medication	Dose	Frequency	Start Date	Stop Date	Reason Discontinued	Prescribing Physician

Ascent NBI & TMS Center
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Dear New Establishing Patient,

Enclosed is your new patient paperwork for your scheduled appointment. Please fill the paperwork out completely and return it to our office ***at least (3) business days prior*** to your scheduled appointment. If you mail the packet back to us, please be sure that correct postage is paid or you will be charged the difference upon your first visit.

Thank you,

Office Staff

_____ INITIAL **Because this is a new patient appointment, we will call to confirm this appointment (2) business days prior to the scheduled appointment. If we do not receive confirmation from you *at least 24 hrs.* prior to the scheduled appointment, it is our policy to cancel the appointment*.**

**If we have to cancel your appointment due to lack of confirmation from you, we will be unable to reschedule you for any future appointments. Thank you for your consideration.*

Please initial and return with paperwork. Thank you.