UNITED ABILITY
Formerly UCP of Greater Birmingham

ABILITY CLINIC ENROLLMENT PAPERWORK

Dear Family,

Thank you for your interest in the Ability Clinic We look forward to working with you and your child. Please complete the enclosed information and return via email to: **cstevenson@unitedability.org**

It is important that the enclosed information be completed and returned so your child can receive an evaluation appointment.

United Ability accepts third party payment and private pay for services rendered. **A co-pay will be required at each scheduled appointment.** In addition to your co-pay, you will be responsible for any charges not paid by your insurance and will receive an invoice at the end of each month. Please note treatment rooms and common areas are videotaped on an ongoing basis for security and quality assurance purposes using only United Ability owned equipment/devices.

Please bring your insurance or Medicaid card with you for your initial appointment so that a copy can be made. Also remember to notify us of any insurance changes as soon as they occur.

If you have any questions regarding scheduling services you may call 205-944-3944.

Directions to United Ability, Ability Clinic 120 Oslo Circle Birmingham, AL 35211

Driving Directions to United Ability (formerly United Cerebral Palsy of Greater Birmingham)

1. Take the Lakeshore Drive Exit #255
2. **From I-65 South**, turn *right* onto Lakeshore Drive and go about 3.7 miles
   From I-65 North, turn *left* onto Lakeshore Drive and go about 3.7 miles
3. After you pass Cook's Pest Control on the left, take the next *left* onto Sydney Drive (at the light).

4. Turn *right* onto Oslo Circle.

When you turn onto Sydney Drive, you will see a large Colonial Building at the corner of Sydney Drive and Oslo Circle which is our Administration Building. United Ability has *THREE* buildings on Oslo Circle. For the **Ability Clinic and Outpatient Therapy, CONTINUE** on Oslo Circle and at the end of the street, turn to the left into the Ability Clinic Parking loft. Park on the left side near the garden and enter in the clinic front entrance.

UNITED ABILITY

Formerly UCP of Greater Birmingham

Thank you for choosing the Ability Clinic for your physical medicine and rehabilitation needs. We realize that navigating health care is a complex task and welcome the opportunity to provide quality care in a family environment. To make your time here the most productive, we are providing the following information to help guide your visit.

- **Cancellations-** Please notify our office at (205) 944-3944 at least 48 hours in advance if you need to cancel or reschedule an appointment. Please also contact us if you are delayed in your arrival for your appointment.
- **Arrival-** Please arrive for your scheduled appointment at least 15 minutes prior to your appointment time to allow for registration. You will be asked to present insurance cards and driver's license (or picture ID). Additionally, any applicable co-payment for insurance is due at the time of registration.
- **Legal Guardian-** If someone other than the parent or legal guardian accompanies the patient to their visit, we must have a signed statement from the legal guardian stating that I have permission to evaluate and provide medical recommendations for treatment and/or therapy. If the statement is not available, treatment will not be provided.
- **What to bring-**
    - **Medical Information-** Please bring any medical information (therapy notes, consults, evaluations, primary physician notes, etc.) that may better help understand all health concerns.
    - **Medication List-** Please bring a list of all current medications including name, dose, and when taken.
    - **Medical Equipment-** Please bring any orthotics/splints, wheelchairs, walkers or other medical equipment used.
    - **Insurance Information-** Insurance cards and appropriate co-payment is required upon registration. Please verify with your plan that the physician services are a covered benefit. Also, you may receive services from a therapist as part of this visit, which could result in a separate charge. Many insurance plans limit the number of therapy visits, so please verify to make sure therapy services are covered under your plan.

- **What to Expect-** You will receive a comprehensive exam and have the opportunity to ask questions and obtain educational information. Additionally, you may be given prescriptions for medications, therapy or equipment as part of your care. Please note treatment rooms and common areas are videotaped on an ongoing basis for security and quality assurance purposes using only United Ability owned equipment/devices.
- **To Obtain Directions and Additional Information-** Please feel free to visit our website at www.unitedability.org to access directions or to obtain additional information about services provided by United Ability.

UNITED ABILITY
Formerly UCP of Greater Birmingham

PAYMENT AGREEMENT and ACKNOWLEDGMENT OF RESPONSIBILITY OF INSURANCE VERIFICATION

United Ability accepts third party payment (insurance and Medicaid) as well as private pay for outpatient services rendered. A co-pay will be required at each scheduled appointment. In addition to your co-pay, you will be responsible for any charges not paid by your insurance and will receive an invoice at the end of each month.

To prevent any confusion that may result in denials by your third party provider, it is important for you to remember to notify us of any insurance changes or primary care physician changes as soon as they occur.

United ability is NOT responsible for checking with your insurance company to ascertain any costs that you may incur as a result of receiving outpatient therapy through the organization. You are responsible for calling your insurance company to discuss any and all coverage regarding your plan. Please ask specific information and give them the name of the therapist/s your child will be seeing as well as information on United Ability.

Additionally, if your child has Medicaid, then you are responsible for assisting us in obtaining the appropriate physician referral necessary for payment. If we are unable to get the appropriate referral for any reason, your child will be discharged from therapy until the proper paperwork is in place.

I understand that I am responsible for obtaining information from any third party providers as to therapy coverage. I also understand that if I have not met my deductible or my insurance does not pay for any reason, then I am responsible for the full balance incurred.

United Ability utilizes an off-site billing company from whom you will receive a monthly statement of payments and balance owed. Payment instructions will be included in your statement. Additionally, United Ability utilizes a collection agency for any unpaid balances.

Any questions about billing may be addressed to the following:

Dr. Evans patients (205) 944-1122

Drs. Davis, Powell and Head (205) 638-5600

My signature acknowledges understanding of the above information and I agree to pay in full for any outstanding balances.

_____ _____

Signature (Patient or Guardian) Date

_____

Printed Signature

Revised 9/21

UNITED ABILITY

Formerly UCP of Greater Birmingham

UNITED ABILITY PATIENT INFORMATION AND AUTHORIZATION FOR MEDICAL/THERAPY SERVICES

Date: _____

How did you hear about our Ability Clinic? _____

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

**Patient's Social Security Number: _____/_____/_____ [ ] Male [ ] Female

Race:_____ Ethnicity:_____ Preferred Language :_____ Diagnosis: _____

Parents/Guardian's Name:_____ **Parents/Guardian's Name DOB:** _____

Home Address: _____

Home Phone: _____Work Phone: _____ Cell Phone: _____

Alternate Phone:_____

Policy Holder Employer: _____

Policy Holder Work Address: _____

**Email address where you can be reached during the day: _____

Please list all of patient's health care providers:

Type	Name	Phone
Pediatrician/EPSDT		
Dentist		
Eye		
Neurologist		
Therapist		
Other _____		

Preferred Hospital:_____ Phone: _____

Preferred Pharmacy: _____ Location: _____ Phone: _____

List all medications (name and reason). Please use additional sheets if needed:

_____

_____

List allergies: _____

_____

Primary Insurance Company: _____

Address: _____

Policy Holder: _____ Birth date of Policy Holder: _____ Relationship to Patient: _____

Contract #:_____ Group #:_____

Secondary Insurance Company: _____

Address: _____ City: _____ State: _____ Zip: _____

Policy Holder: _____ Birth date of Policy Holder: _____ Relation to Client: _____

Contract #: _____ Group #: _____

Medicaid Coverage: [ ]Yes [ ] No **Medicaid Patient 1st Program** [ ] Yes [ ] No **Medicaid Waiver/Type:** _____

Patient First Primary Care Physician: _____

Address: _____

Phone: _____ Patient First Provider: _____

Medicaid Number: _____

Name as listed on card: _____

I hereby consent that treatment be provided by **United Ability.** I authorize **United Ability** or its agents to file claims with the companies named above for services provided and I authorize the release of any medical information necessary to process these claims. I hereby agree that I will be responsible for payment of any charges not reimbursed through third party payment or associated with collection on outstanding accounts.

Responsible Party's Signature: _____ Date: _____

Relationship to Patient: _____

UNITED ABILITY

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

UNITED ABILITY and its affiliated entities, including **HAND IN HAND and LINCPoint**, (collectively, "UNITED ABILITY") is required to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to your protected health information. We will not use, release or disclose your health information except as described in this Notice of Privacy Practices ("Privacy Notice" or "Notice"), unless specifically authorized by you in writing. We are also required by law to notify you following a breach of unsecured protected health information. In providing professional medical services to you, we will create, maintain, and store your protected health information.

WHAT HEALTH INFORMATION IS PROTECTED

We are committed to protecting the privacy of health information we gather about you while providing health-related services. Some examples of protected health information are information about your health condition; information about health care services you have received or may receive in the future; information about your health care benefits under an insurance plan; geographic information; demographic information; unique numbers that may identify you; and other types of information that may identify who you are.

EXAMPLES OF DISCLOSURES FOR TREATMENT, PAYMENT AND HEALTH OPERATIONS: The following categories describe the ways that we may use, release, and disclose your health information for treatment, payment, and health care operations **without the need** for a signed authorization from you.

Treatment: We will use your protected health information in the provision and coordination of your health care. For example, we may disclose all or any portion of your medical record information as part of your care and continued treatment to your attending physician and other health care providers who have a legitimate need for such information.

Family/Friends: UNITED ABILITY may release protected health information about you to a friend or family member *who is involved* in your medical care. We may also give information to someone who helps pay for your care, and we may also tell your family or friends of your condition and that you are at UNITED ABILITY. We will give you an opportunity to agree or object to these disclosures.

Payment: UNITED ABILITY may release protected health information about you for the purposes of determining coverage, billing, claims management, medical data processing, and reimbursement. For example, the information may be released to an insurance company, third party payer or other entity (or their authorized representatives) involved in the payment of your medical bill and may include copies of your medical record needed to pay your account.

Healthcare Operations: UNITED ABILITY may use and disclose your protected health information during routine healthcare operations. These operations may include quality assurance, utilization review, medical review, internal auditing, accreditation, certification, licensing or credentialing activities, management and administration of UNITED ABILITY, and educational purposes.

Appointment Reminders/Communications: UNITED ABILITY may use and disclose protected health information to contact you as a reminder that you have an appointment for treatment, medical care or follow-up and may leave a message for you at the number that UNITED ABILITY has listed for you. Also, UNITED ABILITY may use and disclose your protected health information via email or text. If you prefer for UNITED ABILITY not to use such communication, you may request that in writing on the Request for Restrictions form.

UNITED ABILITY may also use and disclose your protected health information without your authorization for the following purposes:

Health Related Business, Services and Treatment Alternatives - Your medical information may be used or disclosed to tell you of health-related benefits or services provided by UNITED ABILITY that may be of interest to you and your particular medical condition.

Alternatives - Your medical information may be used or disclosed to tell you of health-related benefits or services provided by UNITED ABILITY that may be of interest to you and your particular medical condition.

Regulatory Agencies - Your medical information may be disclosed to a health oversight agency for activities authorized by law including, but not limited to, licensure, certification, audits, investigations and inspections.

Law Enforcement/Litigation - Your medical information may be disclosed to a law enforcement official for law enforcement purposes as required by law or in response to a valid subpoena or court order.

Public Health - Your medical information may be disclosed to public health or legal authorities charged with preventing or controlling disease, injury or disability.

Serious Threat to Health or Safety - Your medical information may be used or disclosed to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public.

Military/Veterans/National Security - Your medical information may be disclosed, as required by military command authorities, if you are a member of the armed forces. In addition, UNITED ABILITY may disclose your medical information to federal officials for intelligence and national security activities authorized by law.

Required by Law - Your medical information may be used or disclosed when required to do so by law.

Coroners, Medical Examiners, Funeral Directors - Your medical information may be disclosed to a coroner, medical examiner, or to funeral directors as necessary to carry out their duties.

Research - Your medical information may be used or disclosed for research purposes in certain limited circumstances.

Workers Compensation - Your medical information may be used or disclosed to release medical information about you for workers' compensation or similar programs as required under Alabama law.

YOUR AUTHORIZATION IS NEEDED FOR OTHER USES AND DISCLOSURES

We will not use or disclose your health information for any other purpose not described in this Notice unless you give us written authorization to do so. A signed authorization is necessary for most uses and disclosures related to psychotherapy notes (where appropriate). Uses and disclosures of protected health information for marketing purposes and disclosures that constitute a sale of protected health information also require an authorization. If you give us written authorization to use or disclose your health information for a purpose that is not described in this Notice, then you may revoke it in writing at any time. Your revocation will be effective for all your health information that we maintain, unless we have taken action in reliance on your authorization. We may engage in fundraising activities from time to time. You have the right to opt out of receiving any communications from us regarding fundraising.

YOUR INDIVIDUAL RIGHTS

You have the following rights concerning your medical information. Please note that to exercise any of the privacy rights described below, you must complete a written request and send it to the UNITED ABILITY's Privacy Officer. **You have the right to:**

1. Request that UNITED ABILITY communicate with you about your health and related issues in a particular manner or at certain locations;
2. Inspect and copy your health record as provided by the HIPAA Privacy Rule in 45 C.F.R. § 164.524;
3. Obtain an accounting of the use or disclosure of your health information as provided in 45 C.F.R. § 164.528;
4. Request restrictions on certain uses and disclosures of your medical information. UNITED ABILITY may not agree to honor your request for restrictions. We are not required to agree to your request for a restriction, and in some cases the restriction you request may not be permitted under law. *If we do agree to your request to restrict the use and disclosure of health information, we will be bound by our agreement unless the information is needed to provide you with emergency treatment or comply with the law.* Please note that we must agree to your request to restrict disclosure of your health information to a health plan if (a) the request is for the purpose of carrying out payment or health care operations and is not otherwise required by law; and (b) the information pertains solely to a health care item or service for which you have already paid us in full.
5. Receive a paper copy of this Privacy Notice, upon request;
6. Revoke any authorization allowing UNITED ABILITY to use or disclose your medical information except to the extent that action has already been taken by UNITED ABILITY; and
7. Amend your health record as provided in 45 C.F.R. § 164.526.

FOR MORE INFORMATION OR TO REPORT A PROBLEM: If you have questions and would like additional information or if you believe your privacy rights have been violated, please contact our Privacy Officer, Gary Edwards, at **UNITED ABILITY**, 100 Oslo Circle, Birmingham, Alabama 35211. All complaints must be submitted in writing. There will be no retaliation for filing a complaint or expressing a concern. You may also file a complaint with to the Region IV, Office of Civil Rights, U.S. Department of Health and Human Services, 61 Forsyth Street, SW-Suite 3B70, Atlanta, GA 30323. Voice Phone 800-368-1019, Fax 404-562-7881, TDD 800-537-7697 or via http://www.hhs.gov/civil-rights/filing-a-complaint/index.html.

CHANGES TO THIS NOTICE: UNITED ABILITY reserves the right to change the terms of its Privacy Notice and to make the new Notice provisions effective for all individually identifiable health information that it maintains.

EFFECTIVE DATE: The effective date of the Privacy Notice is **SEPTEMBER 2014.**

UNITED ABILITY

ACKNOWLEDGEMENT OF RECEIPT
HIPAA - NOTICE OF PRIVACY PRACTICES

Patient Name: _____ Date of Birth: _____

By signing this document, I acknowledge that I have received a copy of UNITED ABILITY's Notice of Privacy Practices.

_____
Printed Name

_____
Signature

_____
Date

FOR USE BY UNITED ABILITY

Date Acknowledgement Received _____
-OR-
Reason acknowledgement was not obtained:

_____

_____

Revised 3/19

UNITED ABILITY

REQUEST FOR RESTRICTIONS OR CONFIDENTIAL COMMUNICATIONS

I, _____ (print name of patient) understand that as a part of my care, United Ability receives, originates, discloses, and uses individually identifiable health information, including, but not limited to, health records and other health information describing my health history, symptoms, examination and test results, diagnoses, treatment, treatment plans, and billing and health insurance information. **I consent to the use and disclosure of health information about me by UNITED ABILITY, its employees and staff, including information about notifiable diseases, sexually transmitted diseases, acquired human immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV) and psychological or psychiatric treatment to perform the following:**

Diagnose my medical/psychiatric/psychological condition, plan and provide my care and treatment, communicate with other health professionals concerning my care, document services for payment/reimbursement, conduct routine health care operations, such as quality assurance (the process of monitoring the necessity for, the appropriateness of, and the quality of care provided) and peer review (the process of monitoring the effectiveness of health care personnel), reports as required by law or to protect others.

I understand that I do not have to sign this consent, but that if I do not consent, UNITED ABILITY may refuse to provide me health care services unless applicable state or federal law requires it to provide such services.

I acknowledge that I have been provided a *Notice of Privacy Practices* that fully explains the uses and disclosures that UNITED ABILITY may make with respect to my individually identifiable health information ("PHI"). *_____ **INITIAL HERE**

I understand that I have the following rights:

1. To request restrictions on the use or disclosure of my PHI to carry out treatment, payment, or health care operations. I further understand that UNITED ABILITY is not required to agree to the requested restriction but that, if it does agree, it must honor the restriction unless I request that it stop doing so or UNITED ABILITY notifies me that it is no longer going to honor the request. I request the following restrictions on the use or disclosure of my protected health information (none, if left blank).

_____

2. To request confidential communications. For example, I might request that all medical bills be mailed to a certain post office box rather than to my home, or that I do not want communications via email or text. I further understand that UNITED ABILITY does not have to honor this request, and that it will tell me whether or not it will honor the request. I further understand that UNITED ABILITY can decide at any time not to honor the request and that it must tell me if this happens. I request the following: (none, if left blank).

_____

I understand that I may revoke this consent in writing but that the revocation will not be effective to the extent that UNITED ABILITY has already taken action in reliance on it.

_____ _____

Signature of Patient or Personal Representative Date

_____ _____

Relationship of Personal Representative to the Patient Signature of Witness

_____

Print Personal Representative's Name

For UNITED ABILITY use only:

Circle One:

- ☐ Accepted
- ☐ Rejected
- ☐ Accepted, but with the following limitations:

_____

This form to be retained by UNITED ABILITY for not less than six (6) years from the most recent date noted above.

Revised 3/19

UNITED ABILITY

PATIENT AUTHORIZATION FORM FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient's Name: _____ Date of Birth: _____

Consistent with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I hereby authorize the use, release and/or disclosure of my protected health information as described below:

Person/Organization Sending the Information:

United Ability
100 Oslo Circle
Birmingham, Al 35211

Person/Organization Receiving the Information:

_____
_____
_____

Person/Organization Sending the Information:

_____
_____
_____

Person/Organization Receiving the Information:

UNITED ABILITY
100 Oslo Circle
Birmingham, Alabama 35211

For the purpose of: _____

Specific Dates of Service: from _____ to present

I understand that I may not authorize disclosure of genetic information to a health plan for underwriting purposes, except as permitted for long-term care policies. If this disclosure is for marketing purposes, it will involve financial remuneration to UNITED ABILITY. I understand that if this disclosure constitutes a "sale" of my protected health information that the disclosure will result in remuneration to the covered entity.

This authorization shall be updated annually for all patients.

I understand that I may revoke this authorization at any time in writing except to the extent that UNITED ABILITY has already relied upon this authorization. Written revocation must be sent to UNITED ABILITY's Privacy Officer. I further understand that treatment and payment may not be conditioned upon a signed authorization. I understand that information authorized to be used, released, and disclosed pursuant to this authorization may be subject to re-disclosure by the recipient. Any such re-disclosure is not protected by this authorization or the HIPAA Privacy Rule.

_____ _____
Patient Signature Date

_____ _____
Personal Representative Date

_____
Relationship to Patient/Authority to Release Protected Health Information

_____ _____
Witness Signature Date

This form must set forth a specific description of the information to be used, released or disclosed and the specific individual, entity or agency receiving the protected health information.

Revised 3/19

UNITED ABILITY

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION (PHI)
for Education, Marketing or Media Purposes

Consumer Name: _____ Date of Birth: _____

I, the undersigned, agree and authorize disclosure of protected health information to _____ for the purpose(s) that may include, but are not limited to, news releases, website content, printed marketing materials, training/educational/promotional videos, social media, or other authorized forms of organizational communication.

Specific Dates of Service: from _____ to _____

Please indicate any type or use of PHI you do NOT want disclosed:

❑ Photo	❑ Name
❑ Story/Background Information	❑ Voice
❑ Printed Materials	❑ Video Footage
❑ News Interview	❑ Website and Social Media
❑ Other:	

I understand that:

1. This information about the consumer is protected under federal law.
2. I may refuse to sign the authorization.
3. I have the right to revoke this authorization in writing, but if I do it will not have any effect to the extent that UNITED ABILITY has taken action in reliance on it.
4. This authorization will expire 5 years from the date signed or will be valid from the specific dates of From: _____ To: _____
5. UNITED ABILITY is not responsible once PHI is posted on YouTube or other social media if it is then asked to be removed.
6. By signing below, I recognize that the protected health information used or disclosed under this authorization may be subject to re-disclosure by the recipient of this disclosure and may no longer be protected under federal law.
7. Treatment or payment will not be based on my signing this authorization.
8. I will receive a copy of this authorization if I request it.

_____ _____
Signature of Consumer or Legal Guardian Date

_____
Print Name of Consumer or Legal Guardian/Relationship to the Consumer

_____
Witness

UNITED ABILITY

HIPAA
MESSAGING RELEASE FORM

Patient Name: _____
Date of Birth _____

We are unable to discuss your treatment with anyone unless the patient or patient's guardian grants United Ability written permission.

( ) I authorize the release of information including the diagnosis, records, images, examination rendered and claims information. This information may be released to:

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Name Relationship

❑ Information is not to be released to anyone.

The release of information will remain in effect unless terminated in writing.

From time to time, it is necessary for our service providers to reach patients while in route to a designated appointment or leave message if our providers are unable to reach patients when they are called. If we are unable to speak directly to you concerning matters pertaining to your care or the care of your dependent, please check one of the following preferences:

❑ You may leave a detailed message.

❑ Please leave a message asking me to return your call.

❑ Other_____

The best phone number to reach me: _____ or _____.

United Ability may also send correspondence (including personal health information) to the following email address(es):

Email 1: _____
Email 2: _____

Signature: _____ Date: ___/_____/_____

Witness: _____ Date: ___/____/_____

Revised 04/19

UNITED ABILITY
Formerly UCP of Greater Birmingham

TELEMEDICINE RECIPIENT CONSENT FORM

I (name) _____ agree to receive this health care service, **MEDICAL APPOINTMENT**, as a telemedicine service. I understand that the health care practitioner is located in another location: **120 Oslo Circle, Birmingham, AL 35211.** A telemedicine service means that my visit with a practitioner at the distant site will happen by using special audiovisual equipment. This consent is valid for **six** months for follow-up telemedicine services with the health care provider, medical treatment, provider payment, and health care operations. The original document is retained in the medical record, and the recipient receives a copy. I also understand that:

- I can decline the telemedicine service at any time without affecting my right to future care or treatment, and any program benefits to which I would otherwise be entitled cannot be taken away.
- I may have to travel to see a health care practitioner in-person if I decline the telemedicine service.
- If I decline the telemedicine services, the other options/alternatives available for me, including in person services, are as follows:

1- The same confidentiality protections that apply to my other medical care also apply to the telemedicine service.
2- I will have access to all medical information resulting from the telemedicine service as provided by law.
3- The information from the telehealth service (images that can be identified as mine or other medical information from the telehealth service) cannot be released to researchers or anyone else without my additional written consent.
4- I will be informed of all people who will be present at all sites during my telemedicine service.
5- I may exclude anyone from any site during my telehealth service.
6- I may see an appropriately trained staff person or employee in-person immediately after the telemedicine service if an urgent need arises **OR** I will be told ahead of time that this is not available.
7- I may contact the healthcare provider at phone number **205-944-3944** for any questions I have related to medical services received through a telemedicine provider/site.

I have read this document carefully, and my questions have been answered to my satisfaction.

Signature of Recipient: _____ Date:_____

Signature of Parent or Legal Representative: _____ Date: _____

TELEMEDICINE CONSENT

Signature of Person Obtaining Consent:_____
Date:_____

Facility Name: Ability Clinic Facility Address: 120 Oslo Circle, Birmingham, AL 35211