

NeuroScience Associates

Timothy J. Johans, M.D.

Thomas C. Manning, M.D., Ph.D.

Paul J. Montalbano, M.D.

Richard A. Lochhead, M.D.

Michael V. Hajjar, M.D.

Dear Patient:

We look forward to seeing you on _____ at _____

To help us prepare for your visit, please fill out the enclosed patient information form and health history questionnaire and bring the completed forms with you at the time of your appointment. Should you not complete the forms prior to coming to the office we will request that you complete them before being seen by the provider. If this is necessary, please allow extra time before your appointment.

If you have had x-rays taken anywhere other than Saint Alphonsus RMC, St Lukes RMC, or Intermountain Medical Imaging (IMI), please bring them with you to your appointment. If you take any prescription medications, please ask your pharmacist for a list of your current medications and bring it to your appointment.

Our Notice of Privacy Practices can be found on our website at www.idneuro.com. If you would like a paper copy of the Notice of Privacy Practices, please ask the receptionist at the time of your appointment. All healthcare facilities are required to provide you with this notice regarding your rights to your medical record and our duty to manage the information. Please sign and return the acknowledgement form in the new patient packet at the time of your appointment stating you have reviewed the notice.

Also enclosed is a copy of our Financial Policy. Please review so that we may help with any questions you may have prior to your appointment.

Please bring your insurance card with you. Our policy requires a copy of your card to insure that we submit the claim correctly on your behalf. Please be prepared to pay your co-pay at the time of your visit. If you have not met your deductible or do not have insurance coverage, we ask that you pay \$275.00 as a deposit for your first visit. First visit fees range between \$383.00 and \$703.00. Should your insurance plan require a referral authorization for your visit please be sure that your primary care physician provides us with the referral authorization form.

To schedule a visit for a Worker's Compensation injury we require written verification of acceptance by the insurance company responsible for your claim. Please bring the insurance company name and address for submission of your claim. This process will help protect you should your claim be denied and we need to submit a claim to your primary insurance company.

Our website www.idneuro.com has maps to all the locations where we provide services.

If you have a question regarding your office appointment please call (208) 327-5600 and ask to speak with the receptionist for the physician you will be seeing. Should you have a medical question please ask to speak to the physician's medical support staff.

Appointments with Dr. Lochhead please ask for Christina.

Appointments with Dr. Johans please ask for Kelly.

Appointments with Dr. Hajjar please ask for Aimee.

Appointments with Dr. Montalbano please ask for Preston.

Appointments with Dr. Manning please ask for Brianna.

Thank you, we look forward to caring for your neurosurgical needs.

6140 W. Curtisian, Suite 400, Boise, ID 83704

Phone: 208.327.5600 | Fax: 208.327.5602

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WWW.IDNEURO.COM

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Today's date:		Primary Care Physician:		Referred to clinic by: Dr.	
PATIENT INFORMATION					
Patient's Legal Name: (Last) (First) (Middle)			<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/> Ms.		Marital status (circle one)
Preferred Name:					Single / Mar / Div / Sep / Wid
Ethnicity (circle one) Hispanic/Latino : Caucasian : Asian : Other : Unknown		Race (circle one) White : Asian : African American : Pacific Islander : American Indian : Other : Unknown			
Language (circle one) Arabic : Bulgarian : Central Khmer : Chinese : English : French : German : Haitian : Hebrew : Hindi : Italian : Japanese : Korean : Polish : Portuguese : Russian : Spanish			Birth date:		Age:
			/ /		
Mailing address:		Social Security Number:		Home Phone : ()	
				Cell Phone : ()	
City:	State:	ZIP Code: (+4) -	E-Mail Address:		
Occupation:		Employer:		Employer phone : ()	
Employer Address:		City:		State:	
If patient is a minor, Responsible party:					
Pharmacy:		Pharmacy Location:			
SPOUSE INFORMATION					
Spouse's Legal Name: (Last) (First) (Middle)			<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/> Ms.		Birth date:
					Sex <input type="checkbox"/> M <input type="checkbox"/> F
Occupation:		Employer:		Employer Phone: ()	
Spouse's Cell Phone: ()		Other family members seen here:			
NEAREST RELATIVE NOT LIVING WITH YOU					
Name:				Phone: ()	
Address:					

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Patient Name: _____ Date: _____

PERSONAL INSURANCE INFORMATION			
PRIMARY INSURANCE NAME		SECONDARY INSURANCE NAME	
SUBSCRIBER'S NAME		SUBSCRIBER'S NAME	
POLICY ID NUMBER	GROUP NUMBER	POLICY ID NUMBER	GROUP NUMBER
RELATIONSHIP TO PATIENT <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER:		RELATIONSHIP TO PATIENT <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER:	
POLICY HOLDER'S DATE OF BIRTH		POLICY HOLDER'S DATE OF BIRTH	
WORKER'S COMPENSATION INSURANCE INFORMATION			
WORKER'S COMP INSURANCE CARRIER			
ADDRESS (street-city-state-zip)		PHONE NUMBER	
DATE OF INJURY	TIME OF INJURY	STATE WHERE INJURY OCCURRED	
HAVE YOU FILED A WORKER'S COMP CLAIM <input type="checkbox"/> YES <input type="checkbox"/> NO		CLAIM NUMBER	
LIABILITY INSURANCE INFORMATION			
YOUR LIABILITY CARRIER		OTHER PARTY'S LIABILITY CARRIER	
ADDRESS (street-city-state-zip)		ADDRESS (street-city-state-zip)	
HAVE YOU FILED A CLAIM WITH A LIABILITY CARRIER <input type="checkbox"/> YES <input type="checkbox"/> NO		NAME OF OTHER PARTY	
CLAIM NUMBER / TIME OF INJURY		CLAIM NUMBER / TIME OF INJURY	
STATE / DATE OF INJURY		STATE / DATE OF INJURY	

I hereby verify that all of the above information is correct to the best of my knowledge and understand that if any information is to change, it is my responsibility to inform NSA before any services are provided. Worker's Compensation and Personal Auto Medical Insurer is primary payer only for those services related to the accident. Liability insurance is primary payer only for those services related to the liability settlement, judgment or award; a lien will be filed with the Third Party carriers with all liability claims.

Signature _____ Date _____

PATIENT HEALTH HISTORY

Patient Name: _____ Today's Date: _____
Date of Birth: _____

Patient Height _____ Patient Weight _____

Chief Complaint

Reason for today's visit: _____

Has Physical therapy been initiated? ☐ Yes ☐ No

Facility _____ Phone Number _____

Have other Conservative treatments (i.e Injections, chiropractic) been ordered? ☐ Yes ☐ No

If Yes, Please list: _____

Current problem is the result of a(n): Check all that apply

☐ Car Accident ☐ Work Accident ☐ Accident ☐ Other _____

Date of onset _____

Past Medical History

Please list any medical conditions (i.e hypertension, diabetes, etc) or major injuries: _____

Surgeries/Hospitalizations	Year	Complications

Have you ever had an antibiotic resistant infection? ☐ Yes ☐ No

If Yes, was it MRSA (Methicillin Resistant Staphylococcus Aureus) or VRF (Vancomycin Resistant Enterococcus)? (Please circle)

Have you ever had problems with anesthesia? ☐ Yes ☐ No

Do you take Aspirin? ☐ Yes ☐ No If Yes, how often : _____

Current Medications Including Over the Counter	Dose	Frequency

Patient Name: _____

ALLERGIES/TYPES OF REACTIONS				
Please circle: Latex Yes No Iodine Yes No Shellfish Yes No Asthma Yes No				

Family Member	Alive	Deceased	Age	Health status or cause of death
Grandmother (mom's)	A	D		
Grandfather (mom's)	A	D		
Grandmother (dad's)	A	D		
Grandfather (dad's)	A	D		
Father	A	D		
Mother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		

SOCIAL HISTORY

Do you have children? ☐ Yes ☐ No How many? _____

Do you live alone? ☐ Yes ☐ No Who lives with you? _____

Do you smoke? ☐ Yes, I've smoked _____ packs of cigarettes per day for _____ years.

☐ Yes, I smoke cigars or a pipe.

☐ No, I have never smoked.

☐ No, I quit _____ years ago. At that time I was smoking _____ packs per day for _____ years.

Do you drink alcohol? ☐ No, never (or rarely) ☐ No, but I used to

☐ Yes ☐ Daily ☐ 1 or more times a week ☐ 1 or more times a month

Are you at risk for AIDS (e.g., sexual orientation, drug abuse, previous blood transfusion)?

☐ No ☐ Yes, please explain _____

☐ Deferred by patient: Signature _____

NeuroScience Associates

Patient Name: _____ Date: _____

REVIEW OF SYSTEMS

Check button if you currently have any of the following problems:

CONSTITUTIONAL

- ☐ Chills
- ☐ Fatigue
- ☐ Fever
- ☐ Weight loss/Weight gain
- ☐ Other:

CARDIOVASCULAR

- ☐ Chest Pain
- ☐ High Blood Pressure
- ☐ Edema
- ☐ Palpitations
- ☐ Other:

REPRODUCTIVE

- ☐ Vaginal discharge
- ☐ Irregular menses
- ☐ Erectile dysfunction
- ☐ Penile discharge
- ☐ Other:

PSYCHIATRIC

- ☐ Anxiety
- ☐ Depression
- ☐ Insomnia
- ☐ Paranoia
- ☐ Other:

HEENT

- ☐ Dental Problems
- ☐ Hearing Loss
- ☐ Nasal drainage/Sinus
- ☐ Blurred/Double vision
- ☐ Glaucoma
- ☐ Other:

GASTROINTESTINAL

- ☐ Incontinence
- ☐ Change in stool
- ☐ Constipation
- ☐ Nausea
- ☐ Vomiting
- ☐ Other:

INTEGUMENTARY

- ☐ Redness
- ☐ Rash
- ☐ Hives
- ☐ Skin lesion
- ☐ Hair loss
- ☐ Other:

METABOLIC/ENDO

- ☐ Nipple Discharge
- ☐ Heat/Cold intolerance
- ☐ Diabetes
- ☐ Excessive Thirst
- ☐ Excessive Hunger
- ☐ Other:

RESPIRATORY

- ☐ Chronic cough
- ☐ Shortness of Breath
- ☐ Wheezing
- ☐ Asthma
- ☐ Other:

GENITOURINARY

- ☐ Urinary frequency
- ☐ Urinary incontinence
- ☐ Urinary retention
- ☐ Painful Urination
- ☐ Other:

NEUROLOGICAL

- ☐ Dizziness
- ☐ Numbness
- ☐ Weakness
- ☐ Tingling
- ☐ Gait disturbance
- ☐ Headache
- ☐ Memory loss/confusion
- ☐ Tremor
- ☐ Seizures
- ☐ Other:

MUSCULOSKELETAL

- ☐ Back pain
- ☐ Neck pain
- ☐ Joint pain
- ☐ Joint swelling
- ☐ Muscle weakness
- ☐ Other:

HEMATOLOGIC/LYMPH

- ☐ Easy bleeding
- ☐ Easy bruising
- ☐ Other:

IMMUNOLOGIC

- ☐ Seasonal allergies
- ☐ Food allergies
- ☐ Other:

The above information is accurate to the best of my knowledge.

Patient / Guardian Signature

Date

Oswestry Disability Questionnaire

This questionnaire has been designed to give us information as to how your back or leg pain is affecting your ability to manage in everyday life. Please answer by checking **one box in each section** for the statement which best applies to you. We realize you may consider that two or more statements in any one section apply but please check the one box that indicates the statement **which most clearly describes your problem**.

Section 1: Pain Intensity

- ☐ I have no pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain is moderate at the moment.
- ☐ The pain is fairly severe at the moment.
- ☐ The pain is very severe at the moment.
- ☐ The pain is the worst imaginable at the moment.

Section 2: Personal Care (washing, dressing, etc.)

- ☐ I can look after myself normally without causing extra pain.
- ☐ I can look after myself normally but it causes extra pain.
- ☐ It is painful to look after myself and I am slow and careful.
- ☐ I need some help but can manage most of my personal care.
- ☐ I need help every day in most aspects of self-care.
- ☐ I do not get dressed, was with difficulty and stay in bed.

Section 3: Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it gives me extra pain.
- ☐ Pain prevents me lifting heavy weights off the floor but I can manage if they are conveniently on the edge of a table.
- ☐ Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can only lift very light weights.
- ☐ I cannot lift or carry anything.

Section 4: Walking

- ☐ Pain does not prevent me walking any distance.
- ☐ Pain prevents me from walking more than 1 mile.
- ☐ Pain prevents me from walking more than ½ mile.
- ☐ Pain prevents me from walking more than 100 yards.
- ☐ I can only walk using a stick or crutches.
- ☐ I am in bed most of the time.

Section 5: Sitting

- ☐ I can sit in any chair as long as I like.
- ☐ I can only sit in my favorite chair as long as I like
- ☐ Pain prevents me sitting more than one hour.
- ☐ Pain prevents me from sitting more than 30 minutes.
- ☐ Pain prevents me from sitting more than 10 minutes.
- ☐ Pain prevents me from sitting at all.

Section 6: Standing

- ☐ I can stand as long as I want without extra pain.
- ☐ I can stand as long as I want but it gives me extra pain.
- ☐ Pain prevents me from standing for more than 1 hour.
- ☐ Pain prevents me from standing for more than 30 minutes.
- ☐ Pain prevents me from standing for more than 10 minutes.
- ☐ Pain prevents me from standing at all.

Section 7: Sleeping

- ☐ My sleep is never disturbed by pain.
- ☐ My sleep is occasionally disturbed by pain.
- ☐ Because of pain I have less than 6 hours of sleep.
- ☐ Because of pain I have less than 4 hours of sleep.
- ☐ Because of pain I have less than 2 hours of sleep.
- ☐ Pain prevents me from sleeping at all.

Section 8: Sex Life (if applicable)

- ☐ My sex life is normal and causes no extra pain.
- ☐ My sex life is normal but causes some extra pain.
- ☐ My sex life is nearly normal but is very painful.
- ☐ My sex life is severely restricted by pain.
- ☐ My sex life is nearly absent because of pain.
- ☐ Pain prevents any sex life at all.

Section 9: Social Life

- ☐ My social life is normal and gives me no extra pain.
- ☐ My social life is normal but increases the degree of pain.
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests like sports.
- ☐ Pain has restricted my social life and I do not go out as often.
- ☐ Pain has restricted my social life to home.
- ☐ I have no social life because of pain.

Section 10: Traveling

- ☐ I can travel anywhere without pain.
- ☐ I can travel anywhere but it gives me extra pain.
- ☐ Pain is bad but I manage journeys over 2 hours.
- ☐ Pain restricts me to journeys of less than 1 hour.
- ☐ Pain restricts me to short necessary journeys under 30 minutes.
- ☐ Pain prevents me from traveling except to receive treatment.

Patient Signature: _____ Date: _____

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Initial

_____ **Medication Refill Policy:** Pain management during your recovery is very important to us. Careful management of narcotic medication is an essential component of a successful recovery. Therefore, we have implemented the following policy:

- The Physician "on call" will not refill medications. No refills will be given outside of office hours. Office hours are from 9:00am to 5:00pm Monday through Friday.
- Refills must be received between 9:00am and 3:00pm Monday through Friday.
- Refill requests must be received by fax from your pharmacy. Allow 72 hours for refills to be processed, excluding weekends and holidays.
- It is illegal to drive under the influence of drugs or alcohol. **Do not** drive after you take a narcotic prescribed by this office and while you are under the influence of narcotics. Please consult with the provider who wrote the prescription, for each narcotic, to assess when you are legal to drive.

I authorize access to my medication history from any prescriber within SureScripts to assist in preventing adverse drug reactions.

_____ **Medicare Payment Authorization:** I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Johans, Dr. Montalbano, Dr. Hajjar, Dr. Manning, or Dr. Lochhead. I also further authorize and direct any holder of medical information about me to release such information to the Centers of Medicare and Medicaid Services; formerly the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. This authorization shall remain in full force and effect until revoked in writing by myself. A copy of this authorization shall be as valid as the original.

_____ **Ownership Disclosure:** As a patient of NeuroScience Associates, your physician may order tests, images, and/or schedule procedures to be performed at local hospitals and/or imaging facilities. These include (but are not limited to) MRI's, X-rays, CT scans, laboratory tests, and surgical procedures.

The physicians of NeuroScience Associates have ownership interest in St. Luke's Medical Center, Treasure Valley Hospital and Sage Diagnostic Imaging, locations where you may receive these services. Our providers have privileges at St. Luke's Boise and Meridian, St. Alphonsus Boise and Nampa and West Valley Medical Center. You have the right to have your services performed at any facility of your choosing.

This form is to confirm you have been informed of NeuroScience Associates ownership interest and to inform you of your right to choose the facility where you would like to receive your services.

_____ **Acknowledgement:** I acknowledge that I have reviewed the Notice of Privacy Practices on our website at www.idneuro.com. If a paper copy of the Notice of Privacy Practices is preferred, I will request a copy from the receptionist at the time of my appointment and review it before I sign below.

Signature: _____ Date: _____

Print patient / representative name: _____ Relationship: _____

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How the Payment Process Works at NeuroScience Associates

We agree to submit your medical bill for payment to the insurance carrier who is primarily responsible for payment and agree to receive payment directly from the responsible insurance carrier. Responsible insurance carriers may be your personal medical plan or health insurance, your auto or homeowner's liability insurance, your employer's workers' compensation insurance plan, or a third party liability insurance carrier. If your medical plan or health insurance includes a deductible and co-insurance provision, we will bill the patient or guarantor as directed by your plan or policy. Responsibility for payment begins the date services are provided. A billing statement will be sent to advise you of any amounts due.

In cases where a third party liability insurance carrier is involved, such as in an auto accident, a lien may be placed, in accordance with Idaho Code § 45-701, *et seq.*, with the third party liability insurance carrier.

Provisions in our participating provider contracts with health insurance company's request, permit, and, in many instances, direct us to send your bill to the third party liability insurance carrier for full payment before we send it to your medical plan or health insurance for payment. For example, if your treatment was for injuries caused by someone else, we will submit your bill to the other person's insurance company (third party liability insurance carrier) for payment in full, **before** we send your bill to your health insurance to pay. If the total unadjusted amount of your bill is \$10,000, for example, we will ask the other person's insurance company to pay the entire \$10,000. No health insurance contractual adjustments will be made to your bill prior to submitting it to the other person's insurance company – we will submit the full, unadjusted amount for payment.

Co-pays, deductibles, limits, and contractual adjustments only apply to bills sent directly to your medical plan or health insurance for payment. They do not apply to bills sent to third party liability carriers for payment. If you do not have health insurance, we ask that you pay \$275.00 as a deposit for your first visit.

If you are injured in a work-related accident, we will submit your bill directly to the workers' compensation insurance carrier. If your worker's compensation claim has been properly filed with and accepted by the Idaho Industrial Commission, there will be no charges incurred by you. If your claim is denied or is not paid in accordance with IDAPA 17.02.09, any remaining balance will be your responsibility.

If you have a balance due after all possible insurance carriers have paid, or if you do not have insurance, the following options are offered:

- Online payments at: www.idneuro.com
- Payments by cash, check or credit card;
- Short term internal payment plans not to exceed three (3) months; or
- Long term payment plans through DL Evans Bank for plans beyond three (3) months. These payment plans are administered by DL Evans Bank on behalf of your physician.
- We reserve the right to charge interest on balances over 120 days old from date of service. The fee is assessed annually at 12% or a monthly interest rate of 1%.

Patients with financial constraints should speak to a financial counselor for assistance. We will not deny critical care to anyone due to inability to pay or lack of insurance. If surgery is indicated and a financial hardship is determined, we will assist in obtaining available coverage, such as county assistance or Medicaid.

If you have the ability to pay your bill but refuse to pay under the terms defined above, your account may be turned over to a collection agency.

I have read the information about how the payment process works at NeuroScience Associates. I understand and agree that I am financially responsible for the payment of medical charges incurred on my behalf as outlined above.

Signature: _____ Date: _____

FMLA, DISABILITY, MISC. Form Completion Agreement

We are happy to complete forms for you; however, due to the volume of patients who require paperwork to be completed and signed by the provider, we have adopted the following guidelines to assist in rapid processing of these important forms:

1. All forms are completed in the order they are received. Due to the volume of forms, it may not be possible to complete your form immediately.
2. All patient information must be completed before we can accept the forms, and all pages of the form need to be provided.
3. Please allow **7 business days** for completion and plan accordingly.
4. Some forms cannot be completed until your most recent office note has been dictated and transcribed. This may increase the time it takes to complete the form.
5. There is a fee **per form** which must be paid before the forms will be completed.
 - No charge for 1 page (except Activity Restriction form; \$25.00 fee)
 - \$25.00 for 2-5 pages
 - \$50.00 for 6+ pages
6. Payment is the patient's responsibility and will not be submitted to insurance.
7. When forms are completed they will be mailed to the patient's home address unless other arrangements have been made.
8. The authorization for disclosure of protected health information must be signed if forms are to be mailed or faxed to anyone other than the patient.
9. Urgent forms may be completed in 48 business hours at the rate of \$50.00 for 2-5 pages and \$75 for 6+ pages.
10. **NO FORMS MAY BE GIVEN TO THE PHYSICIAN AT ANY TIME.**

I have read and understand the form Completion Policy.

Print Name

Signature

Date

Thank you for your cooperation

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Richard A. Lochhead, M.D.

Medical Record Release

Patient Name: _____ Date of Birth: _____
(Please print) Social Security No: _____

Authorization for medical information regarding the above patient to be released.

From: _____
Name
Street Address
City State Zip Phone#

To: _____
Name
Street Address
City State Zip Phone #

Purpose for release _____

Information Requested to be released:

Chart Notes: _____	Hospital records: _____
X-ray films: _____	X-Ray results: _____
Lab results: _____	All Records: _____
Itemized billing: _____	

I hereby consent to release the above stated information.

Signature: _____ Date: _____

Relationship to Patient: _____

I understand that my records may contain information regarding the diagnosis or treatment of HIV (AIDs virus), other sexually transmitted diseases, drug or alcohol abuse, mental illness or psychiatric treatment. I give my specific authorization for these records to be released.

Signature: _____ Date: _____

Relationship to Patient: _____

This authorization is valid for 180 days and may be revoked at any time by written request.

Date Mailed or Faxed: _____ Date Hand Carried: _____

6140 W Curtisian Ave. Suite 400, Boise, ID 83704 (208) 327-5600 Fax (208) 327-5602

www.idneuro.com

NEUROSCIENCE ASSOCIATES

SPANISH

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-808-9008.

CHINESE

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-808-9008。

SERBO-CROATIA

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-xxx-xxx-xxxx (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 1-888-808-9008.

KOREAN

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-808-9008 번으로 전화해 주십시오.

NEPALI

ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-888-808-9008 ।

VIETNAMESE

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-808-9008.

ARABIC

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-808-9008 (رقم هاتف الصم والبكم).

GERMAN

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-888-808-9008.

TAGALOG

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-808-9008.

RUSSIAN

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-808-9008.

FRENCH

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-808-9008.

JAPANESE

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-888-808-9008 まで、お電話にてご連絡ください。

ROMANIAN

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-888-808-9008.

BANTU

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