HAPY BEAR SURGERY CENTER, LLC

Today's Date: _____

Patient Information

☐ **Male** ☐ **Female** **Date of Birth**: _____

Patient Name: _____
Last First MI

Preferred **Address**: _____
Street City State Zip Code

Language: ☐ English (ENG) ☐ Spanish (SPA) ☐ Other: _____

Responsible Party's Information

Select One:

Biological	Step Parent	Foster Parent	Legal Guardian	Other
☐ Mom ☐ Dad	☐ Mom ☐ Dad	☐ Mom ☐ Dad	☐	☐

Name: _____ ☐ **Single** ☐ **Married** ☐ **Other**

Date of Birth: _____ **Social Security #:** _____

Mailing **Address**: _____
Street City State Zip Code

Place of Employment: _____
City

Home Phone: _____ **Work Phone**: _____ Ext.

Cell Phone: _____ Yes ☐ No ☐
May we communicate with you about your child's appointments by **Text Message**?

E-mail: _____ Yes ☐ No ☐
May we communicate with you about your child's appointments by **E-mail**?

Select One:

Biological	Step Parent	Foster Parent	Legal Guardian	Other
☐ Mom ☐ Dad	☐ Mom ☐ Dad	☐ Mom ☐ Dad	☐	☐

Name: _____ ☐ **Single** ☐ **Married** ☐ **Other**

Date of Birth: _____ **Social Security #:** _____

Mailing **Address**: _____
Street City State Zip Code

Place of Employment: _____
City

Home Phone: _____ **Work Phone**: _____ Ext.

Cell Phone: _____ Yes ☐ No ☐
May we communicate with you about your child's appointments by **Text Message**?

E-mail: _____ Yes ☐ No ☐
May we communicate with you about your child's appointments by **E-mail**?

HAPY BEAR SURGERY CENTER, LLC

Patient's Name: _____

FINANCIAL POLICY: Hapy Bear Surgery Center will bill the responsible party's insurance company for treatment rendered. We will also collect responsible party's co-payments, co-insurance, and/or deductibles at the time of service. The responsible party will be billed for any remaining charges not covered by the insurance, or a refund will be issued to the responsible party in the case that the insurance company pays more than expected.

PATIENT RESPONSIBILITY ESTIMATE: Any quotes regarding fees, and any amount collected before treatment, are estimated based on the information available to Hapy Bear Surgery Center at the time of service. We rely on information provided by the responsible party regarding insurance coverage. There will be an estimate given prior to the procedure date. **Please note this will only be an estimate.** If the treating dentist determines that a change to the original proposed treatment, or additional treatment, is needed, the responsible party will be informed and any changes in financial responsibility will be reviewed.

PLEASE NOTE: It is the patient's legal guardian's responsibility to provide the facility with a current valid Identification and proof of insurance.

COLLECTION ACTIVITY: Any account balance that is not paid within 90 days from the date billed may be forwarded to an outside agency for collection follow-up. Any account balance that remains unpaid after this transfer may be eligible for reporting to a credit bureau. Should litigation be necessary to collect an outstanding balance owed, the responsible party agrees to pay all costs of collections including, but not limited to, collection fees, attorney fees, interest, and court costs.

PAYMENT METHODS: We accept cash, cheque, Care Credit, and all major credit cards.

If you have any questions or concerns, please contact us as (559) 732-4279.

_____
Responsible Party's Name (Printed)

_____ _____
Responsible Party's Signature Date

HAPY BEAR SURGERY CENTER, LLC

PACIENT MEDICAL HISTORY

Last Name	First Name	Date of Birth	Age	Sex	Today's Date

Medical information given by:	Biological	Step Parent	Foster Parent	Guardian	Other:
	☐Mom ☐Dad	☐Mom ☐Dad	☐Mom ☐Dad	☐	☐_____

EMERGENCY CONTACT:
Name: _____ Phone #: (_____)_____ Relation to patient: _____

PATIENT HEALTH INFORMATION:

1. Does the patient <u>have or ever had</u> any of the following conditions? (PLEASE mark each answer individually)

Cardiovascular	Yes	No
High Blood Pressure	○	○
Congenital Heart Defects	○	○
Heart Murmur	○	○
Shortness of Breath	○	○
Rheumatic Fever/Heart Disease	○	○
Other (details below)	○	○
Details: _____		

Respiratory	Yes	No
Asthma	○	○
Seasonal Allergies	○	○
Snoring	○	○
Sleep Apnea	○	○
Tracheal/Airway Trauma	○	○
Other (details below)	○	○
Details: _____		

Renal/Gastrointestinal	Yes	No
Recurrent Urinary Tract Infection	○	○
Kidney Failure	○	○
Jaundice	○	○
Heartburn or Acid Reflux	○	○
Nausea/Vomiting	○	○
G-Tube/PEG Tube/J-Tube	○	○
Other (details below)	○	○

Endocrine	Yes	No
Diabetes	○	○
Hypoglycemia	○	○
Hyper/Hypothyroidism	○	○
Metabolic Syndrome	○	○
Adrenal insufficiency	○	○
Have you taken steroids?	○	○
If so, when? _____		
Other (details below)	○	○

Musculoskeletal	Yes	No
Cerebral Palsy	○	○
Muscular Dystrophy	○	○
Osteogenesis Imperfecta	○	○
Rheumatoid Arthritis	○	○
Scoliosis	○	○
Limited neck range of motion	○	○
Obese / Overweight	○	○
Other (details below)	○	○

Neurological	Yes	No
Seizures	○	○
Traumatic Brain Injury	○	○
Chronic Pain	○	○
Paralysis	○	○
Stroke	○	○
Numbness/Tingling	○	○
Swallowing Difficulty	○	○
Other (details below)	○	○

Mental Health	Yes	No
ADD/ADHD	○	○
Developmental Delay	○	○
Down Syndrome	○	○
Autism	○	○
Other (details below)	○	○
Details: _____		

Infectious/Chronic Illness	Yes	No
Tuberculosis (TB)	○	○
Hepatitis A, B or C	○	○
HIV/AIDS	○	○
Cancer	○	○
Type: _____		
Other (details below)	○	○

Hematology	Yes	No
Sickle Cell Disease	○	○
Prolonged Bleeding	○	○
Abnormal clotting (ie. PE, DVT)	○	○
Hemophilia	○	○
Other (details below)	○	○
Details: _____		

Has the patient had any other medical condition not covered above? ☐ Yes ☐ No
(ie. Congenital defects, hearing/eyesight issues, preterm labor, etc.) **<u>If yes</u>**, please explain below **or explain "Other" answers above.**

_____

_____

_____

2. Does the patient have ANY allergies? . . . . . ☐Yes ☐No

Allergy	Name	Type of Reaction
Medication		
Food		
Latex		
Other		

3. Is the patient under the care of a *Primary Physician* or *Medical Specialist*? . . ☐Yes ☐No **If yes**, please list.

NAME	SPECIALTY	PHONE NUMBER

4. Does the patient take medication? . . . . . ☐Yes ☐No **If yes**, please list.

MEDICATION NAME	INDICATION	DOSE	HOW OFTEN	HOW LONG	DOCTOR

5. Has the patient ever had an illness requiring hospitalization? . . . . . ☐Yes ☐No
If 'Yes', please explain: _____

6. Has the patient ever had surgery? . . . . . ☐Yes ☐No
If 'Yes', please explain: _____

7. Did the patient have a normal birth? . . . . . ☐Yes ☐No
If 'No', please explain: _____

8. Has the patient ever had anesthesia complications? . . . . . ☐Yes ☐No
☐ High Fever (MH) ☐Difficult Intubation ☐Trouble waking up ☐ Other: _____

9. Does the patient have or been treated recently for head lice? . . . . . ☐Yes ☐No

10. FEMALES ONLY:
Has the patient started her menstrual cycle? . . . . . ☐Yes ☐No Date of LMP: _____
Is there a possibility of the patient being pregnant? . . . . ☐Yes ☐No

I certify that I have provided all medical information accurately to the best of my knowledge. I understand that providing incorrect information can be dangerous to the patient's health. I authorize the doctor to release any information including diagnosis and records of any treatment or examination of the patient during the period of medical/dental care, to third payers' and/or health practitioners. I also grant permission to the doctor and staff to visually and physically examine the patient and take whatever records such as radiographs (x-rays), vital signs, etc. that might be necessary to enable the doctors to diagnose the patient's medical and dental condition and make a treatment plan. I have read this medical history form and understand it and all my questions have been answered.

Parent/Guardian (Print Name)	Parent/Guardian (Signature)	(Date)
Doctor (Print Name)	**Doctor (Signature)**	**(Date)**

HAPY BEAR SURGERY CENTER, LLC

Patient's Rights

1. Exercise these rights without regard to sex or cultural, economic, educational or religious background or the source of payment for his/her care.
2. Receive information from his/her Doctor about his/her illness, course of treatment and prospects for recovery in terms that he/she can understand.
3. Receive as much information about any proposed treatment or procedure he/she may need, to give informed consent or to refuse this course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved in this treatment, alternate course of treatment or non-treatment and the risks involved in each, and to know the name of the person who will carry out the procedure or treatment.
4. Participate actively in decisions regarding his/her medical care. To the extent permitted by law, this includes the right to refuse treatment.
5. Full consideration of privacy concerning his/her medical care program; case discussion, consultation, examination and treatment are confidential and shall be conducted discreetly. The patient has the right to be advised as to the reason for the presence of any individual.
6. Confidential treatment of all communications and records pertaining to his/her care and all records must stay in the center. His/her written permission shall be obtained before his/her medical records can be made available to anyone.
7. Reasonable responses to any request he/she may make for services, and access to records.
8. Leave the surgery center even against the advice of his/her Doctor; Reasonable continuity of care and to know in advance the time and location of appointment.
9. Be advised if the surgery center or personal Doctor proposes to engage in or perform human experimentation affecting his/her care or treatment. The patient has the right to refuse to participate in such research projects without compromising access to care.
10. Be informed by his/her Doctor, or a delegate of his/her Doctor, of the continuing health care requirements following his/her discharge from the surgery center.
11. Receive information regarding fees and payment schedule.
12. Examine and receive an explanation of his/her bill regardless of source of payment.
13. Know which surgery center rules and policies apply to his/her conduct while a patient.
14. Have all patient rights apply to the person who may have legal responsibility to make decisions regarding medical care on behalf of the patient.
15. Have the right to refuse care, treatment, and services in accordance with the law and regulations.
16. Have the right to be informed, and when appropriate their families, about the outcomes of care, treatment, and services, including unanticipated outcomes.
17. Have the right be free from mental, physical, sexual, and verbal abuse, neglect and exploitation.
18. The patient has the right of a qualified interpreters whenever a language or communication barrier exists.
19. All Hapy Bear personnel shall observe these patient's rights.

HAPY BEAR SURGERY CENTER, LLC

Patient Responsibilities

The patient is responsible to:

1. Provide complete and accurate information concerning the patient's present complaints, past medical history and any medications, including over-the-counter products and dietary supplements, allergies or sensitivities and other matters relating to the patient's health.
2. Inform the center about any living will, medical power of attorney, or other directive that could affect the patient's care.
3. Make it known whether he/she clearly comprehends the course of his/her medical treatment and what is expected of him/her.
4. Follow the treatment plan established by his/her Doctor, including the instructions of nurses and other health professionals, as they carry out the Doctor's orders.
5. His/her actions should he/she refuses treatment or not follow his/her Doctor's orders.
6. Accept financial obligations.
7. Have a responsible adult to transport him/her home from the facility and remain with him/her for 24 hours, if required by his/her provider.
8. Be respectful and considerate of all the rights of other patients and facility personnel.

Advance Directive

Hapy Bear Surgery Center, LLC does **NOT** honor "Do Not Resuscitate" orders. We will **always** resuscitate and transfer to a higher level of care should a patient suffer a cardiac or respiratory arrest or another life-threatening situation.

Hapy Bear Surgery Center, LLC Ownership Information

Dr. Kenneth D. Pierson and Jeremy Pierson own this surgical center. If you wish to speak with someone about the care provided, please contact Jeremy Pierson at (559) 732-4279 ext.151 or ext. 171.

Grievance Reporting

Hapy Bear Surgery Center, LLC is dedicated to the provision of quality care and your opinion of the care provided is important to us. If you would like to compliment us or if you feel you have been treated unfairly, without respect or inappropriately, please contact us within 60 days of the incident by phone at (559) 732-4279 ext. 106, or by mail at: 1979 Hillman St., Tulare, CA 93274. You can also contact the office of Medicare Ombudsman at *www.cms.hhs.gov/center/ombudsman.asp*. You can also notify the JCAHO Department of Quality Monitoring regarding your experience with our center at 1 (800) 994-6610 or by email: compliant@jcaho.org. We will listen to you, respond to your concern within 30 days, and direct your complaint or observation to the appropriate individual and/or committee for resolution.

Privacy Officer

Please direct matters relating to issues of privacy to the Privacy Officer, Janet Torres, by phone: (559) 732-4279 ext.106 or by e-mail: Janet@HapyBear.com

Printed Name	Signature	Date

NOTICE OF PRIVACY PRACTICES

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

PLEASE REVIEW IT CAREFULLY:

The privacy of your health information is important to us.

OUR LEGAL DUTY

Federal and state laws require us to maintain the privacy of your health information. We are also required to provide this Notice about our office's privacy practices, our legal duties, and your rights regarding your health information. We are required to follow the practices that are outlined in this Notice while it is in effect. This Notice takes effect **February 23, 2017** and will remain in effect until replaced.

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

For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

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

Treatment: We disclose medical information to our employees and others who are involved in providing the care you need. We may use or disclose your health information to another dentist or other healthcare providers providing treatment that we do not provide. We may also share your health information with a pharmacist in order to provide you with a prescription, or with a laboratory that performs tests or fabricates dental prostheses or orthodontic appliances.

Payment: We may use and disclose your health information to obtain payment for services we provide to you, unless you request that we restrict such disclosure to your health plan when you have paid out-of-pocket and in full for services rendered.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include, but are not limited to, quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

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

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. You have the right to request restrictions on disclosure to family members, other relatives, close personal friends, or any other person identified by you.

Unsecured Email: we will not send your unsecured emails pertaining to your health information without your prior authorization. If you do authorize communications via unsecured email, you have the right to revoke the authorization at any time.

Persons Involved in Care: We may use or disclose health information to notify or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, 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 health information based on a determination using your professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We may contact you about products or services related to your treatment, case management or care coordination, or to propose other treatments or health-related benefits and services in which you may be interested. We may also encourage you to purchase a product or service when you visit our office. If you are currently an enrollee of a dental plan, we may receive payment for communications to you in relation to our provision, coordination, or management of your dental care, including our coordination or management of your health care with a third party, our consultation with other health care providers relating to your care, or if we refer you for health care. We will not otherwise use or disclose your health information for marketing purposes without you written authorization. We will disclose whether we receive payments for marketing activity you have authorized.

Change of ownership: If this Surgery Center is sold or merged with another practice or organization, your health records will become the property of the new owner. However, you may request that copies of your health information be transferred to another Surgery Center.

Required by Law: We may use or disclose your health information when we are required to do so by law.

To School Nurse or Physician: We may disclose appointment dates and completion of treatment for your child to their school nurse or physician upon their request for the purpose of confirming the care and any school your child missed.

Public Health: We may, and are sometimes legally obligated, to disclose your health information to public health agencies for purposes related to preventing or controlling disease, injury or disability; reporting abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. Upon reporting suspected elder or dependent adult abuse or domestic violence, we will promptly inform you or your personal representative unless we believe the notification would place you at risk of harm or would require informing a personal representative, we believe is responsible for the abuse or harm.

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

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

Appointment Reminders: We may contact you to provide you with appointment reminders via voicemail, postcards, or letters. We may also leave a message with the person answering the phone if you are not available.

Sign-In Sheet and Announcement: Upon arriving at our office, we may use and disclose medical information about you by asking that you sign an intake sheet at our front desk. We may also announce your name when we are ready to see you.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by contacting our office. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter. If you request copies, there may be a charge for time spent. If you request an alternate format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us for a full explanation of our fee structure.

Disclosure Accounting: You have a right to receive a list of instances in which we disclosed your health information for purposes other than treatment, payment, healthcare operations and certain other activities for the last six 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.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in emergency). In the event you pay out-of-pocket and in full for services rendered, you may request that we not share your health information with your health plan. We must agree to this request.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location and provide satisfactory explanation about how payments will be handled under the alternative means or location you request.

Breach Notification: In the event your unsecured protected health information is breached, we will notify you as required by law. In some situations, you may be notified by our business associates.

Amendment: You have the right to request that we 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.

Research: Your health information may be disclosed to researchers for research purposes. In this situation written authorization is not required as approved by an Institutional Review Board or privacy board.

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

QUESTIONS AND COMPLAINTS

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

Privacy Officer: Janet Torres Telephone: (559) 732-4279 Fax: (559) 636-4455

Address: 1979 Hillman Street, Tulare, CA 93274 E-mail: Janet@Hapybear.com

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may send a written complaint to our office or to the U.S. Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

I have received a copy of the Notice of Privacy Practices for Hapy Bear Surgery Center.

Name: _____ **Date:** _____

Signature: _____

Race and Ethnicity Self-Identification, Learning Style, and Education Level

Hospitals and other healthcare facilities are required by law to provide the California Office of Statewide Health Planning and Development (OSHPD) with information regarding the race and ethnicity of their patient population. (California Health and Safety Code Division 107, Part 5, Sections 128735, 128736, and 128737.) The data will be used for health projects including diagnostic research, identification and correction of disparities in healthcare access and outcomes, management of healthcare delivery and public health programs, quality of care, healthcare trends, and supporting informed decisions. Individually identifiable patient information is protected and encrypted within the State system.

Each patient's **self-reporting** of their Ethnicity and Race supports integrity and quality of demographic data. When the patient is not capable of providing information, the patient's family member or guardian shall complete this information.

Please select options in EACH box as it pertains to the PATIENT (*Please mark clearly*):

STEP 1: Choose **one (1)** Ethnicity category:

- ☐ HISPANIC or LATINO
- ☐ NON-HISPANIC or NON-LATINO
- ☐ Decline to Specify

STEP 2: Choose **as many as apply** in the Race category:

- ☐ AMERICAN INDIAN or ALASKA NATIVE
- ☐ ASIAN
- ☐ BLACK or AFRICAN AMERICAN
- ☐ NATIVE HAWAIIAN or PACIFIC ISLANDER
- ☐ WHITE
- ☐ OTHER - Any race not covered above.

  Patients who identify with more than one race may choose to mark 'Other' or one of the other categories above.
- ☐ Decline to Specify

In compliance with requirements from the Federal Department of Health and Human Services (HHS) and Centers for Medicare and Medicaid Services (CMS), and to more effectively interact with the parents/guardians of our patients, **please answer the following questions as it pertains to the PARENT/GUARDIAN of the patient:**

STEP 3: How do you prefer to learn?

- ☐ Auditory (Listening)
- ☐ Visual (Pictures or Demonstrations)
- ☐ Written (Reading)

STEP 4: What level of formal education have you completed?

- ☐ None
- ☐ Grade School
- ☐ High School
- ☐ College or higher

Hapy Bear Surgery Center, LLC provides the use of qualified interpreters whenever a language or communication barrier exists. For patients that are minors or incapacitated, the preferred language of the patient's parent(s), guardian, or surrogate decision maker will also be determined.

Español (Spanish)
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-808-9008

繁體中文 (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

Tiếng Việt (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

Tagalog (Filipino)
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

한국어 (Korean)
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다1-888-808-9008 번으로 전화해 주십시오

Հայերեն (Armenian)
ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 1-888-808-9008

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

हिंदी (Hindi)
ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-888-808-9008 पर कॉल करें।

فارسی (Farsi)
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-888-808-9008 تماس بگیرید.

日本語 (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。

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

ខ្មែរ (Cambodian)
ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ សាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-888-808-9008។

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