WELCOME TO OUR OFFICE

EYELUX OPTOMETRY

Today's Date: _____

PATIENT INFORMATION

Last: _____
First: _____ MI: _____
Patient's SSN: _____
Date of Birth: _____ Age: _____
Gender: ○ Male ○ Female
Street: _____
City: _____ State: ____ Zip Code: _____
Race: _____ Ethnicity: _____
Primary Language: ○ English ○ Other: _____
Telephone Number: ( ) _____
Secondary Number: ( ) _____
Email: _____
Guardian's Name: _____
Guardian's Number: ( )_____

WHOM SHOULD WE NOTIFY IN CASE OF AN EMERGENCY?

_____ ( ) _____ _____
Name Telephone Relationship

What is the major purpose of this visit?

- _____

Any problems with your current contact lenses or glasses?

- _____

Interested in LASER Vision Correction? (LASIK)

- _____

VERY IMPORTANT!

Primary Care Doctor: _____
Phone Number: ( ) _____
Preferred Pharmacy: _____
Pharmacy Phone (if known) ( ) _____
Optometrist (eye doctor):_____
City: _____ State: _____

At EyeLux Optometry, we are professionals committed to providing you with the most comprehensive eyecare available in a respectful and compassionate atmosphere. We also, promise to educate you thoroughly regarding your vision and eye health needs.

We are dedicated to actively advancing our knowledge and expertise in the field of eyecare so we can offer you leading-edge technology and products, thus maximizing your quality of life.

As a result of our united efforts, we will provide you with the highest level of service and value to ensure that our relationship with you, your family and your friends last for many years to come.

INSURANCE INFORMATION

Vision Insurance: _____
Subscriber Name: _____
Subscriber SSN: _____
Subscriber Birth date: _____

Primary Medical Insurance: _____
Subscriber Name: _____
Subscriber SSN: _____
Subscriber Birth Date: _____

I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY CHARGES NOT COVERED BY MEDICAL OR VISION INSURANCE:

_____
(SIGNATURE) (DATE)

How did you choose our office?

○ Current Patient
○ Insurance List
○ Email
○ Social Media: Instagram Facebook Other: _____
○ Other: _____

EYELUX OPTOMETRY

PATIENT HISTORY

Patient Name: _____

Birth Date: _____

A PAST OCULAR HISTORY AND PROCEDURES:

Have you been diagnosed with ANY eye problems, or had ANY ocular surgeries or procedures?
(cataracts, cataract surgery, glaucoma, glaucoma surgery, macular degeneration, retinal problems, LASIK, etc.)

Yes No

Please list all OCULAR PROBLEMS and PROCEDURES:	Date	Left Eye/Right Eye/Both?

B FAMILY HISTORY

Do any of your family members have ANY medical or eye diseases?
If YES, please note the relationship to the patient.

Disease	Yes	No	Relationship
Macular degeneration	◯	◯	
Glaucoma	◯	◯	
Retinal Problems	◯	◯	
Diabetes	◯	◯	

Comments:_____

_____

_____

C SOCIAL HISTORY

Yes No

Do you smoke? ◯YES ◯NO

If yes, how much? _____ packs per day

Former smoker? ◯ YES ◯ NO

If yes, when did you quit? _____

EYELUX OPTOMETRY

PATIENT HISTORY

Patient Name: _____

Birth Date: _____

D REVIEW OF THE SYSTEMS

Do you currently have any of the following problems?

	Questions	Yes	No	If YES, please explain
1	Do you have any allergies to any medications?	○	○	
2	Constitutional (fever, weight loss, fatigue, other)	○	○	
3	Ear | Nose | Mouth | Throat (hearing loss, sinus problems, sore throat, difficulty breathing)	○	○	
4	Cardiovascular (heart problems, chest pain, irregular heartbeat, heart surgery, blood disorders, chest pain, etc.)	○	○	
5	Respiratory (asthma, shortness of breath, wheezing, coughing)	○	○	
6	Gastrointestinal (heartburn, abdominal pain, diarrhea, vomiting)	○	○	
7	Genitourinary (urinary problems, blood in urine)	○	○	
8	Skin/Musculoskeletal (skin rashes, excessive dryness, muscle aches, joint pain, swollen joints)	○	○	
9	Neurological (numbness, weakness, headaches, paralysis)	○	○	
10	Allergic/ Immunologic (hay fever, allergies)	○	○	
11	Endocrine (thyroid problems, diabetes, autoimmune disease)	○	○	
12	Cancer | Trauma | Injury	○	○	

EYELUX OPTOMETRY

PATIENT HISTORY

Patient Name: _____

Birth Date: _____

E CURRENT MEDICATIONS

Are you currently taking ANY medications or vitamins/supplements?
If YES, please list all with included milligrams and times per day, if known

Medication Name	Strength (mg.)	Frequency Taken

Please sign below to consent to the collection of information about prescriptions that have been filled at any pharmacy or covered by any health insurance plan.

Patient Signature: _____ Date: _____

Thank you!

CONSENT FOR CARE AND TREATMENT:

I understand that Patient, which may be defined as me, my child, or a child for whom I have legal responsibility, needs medical care and treatment and I consent to such treatment at Inland Eye Specialists DBA EyeLux Optometry. Treatment provided by medical providers, nurses, and medical assistants at Inland Eye Specialists DBA EyeLux Optometry may include evaluation and management, laboratory and other testing; routine medical, nursing, and medical assistant care and procedures. I understand that photos or video of Patient may be taken in connection with such treatment and for operational, and quality improvement.

No Guarantee: I acknowledge that no guarantees or warranties have been made with respect to treatment or services to be provided by Inland Eye Specialists DBA EyeLux Optometry. I understand that all supplies, medical devices, and other goods provided to Patient are provided by Inland Eye Specialists DBA EyeLux Optometry AS IS and Inland Eye Specialists DBA EyeLux Optometry disclaim any expressed or implied warranties.

Patient Rights: I understand that a copy of Patient Rights and Responsibilities is available upon request. This information tells me how to register a complaint or grievance that I might have relating to Patient's care at Inland Eye Specialists DBA EyeLux Optometry.

Communicable Disease Testing: I agree that if an Inland Eye Specialists DBA EyeLux Optometry employee or provider is exposed to Patient's blood or other bodily fluid, pursuant to state law, Inland Eye Specialists DBA EyeLux Optometry may test Patient to determine the presence of communicable diseases including Human Immunodeficiency Virus (HIV) and hepatitis. I understand that these test results will be kept confidential.

Specimen Disposal: I acknowledge that Inland Eye Specialists DBA EyeLux Optometry may, in its sole discretion, remove, retain, or dispose of any tissue or body parts removed from Patient.

Text Messaging: I understand that Inland Eye Specialists DBA EyeLux Optometry can provide notifications to my cell phone. These texts are Do Not Reply texts for informational purposes only and are not intended as a form of two-way communication. I acknowledge that standard text messaging rates and fees will apply. Messages may include private health and billing information protected under federal and state law. Messaging utilizes a public telephone network and full encryption and security is not guaranteed, and any person with access to my phone will be able to see these messages unless I take steps to protect my phone with a password or PIN. I will have the ability to opt out of text messages at any time by using the STOP function.

Accessing Pharmacy Information: I agree that if an Inland Eye Specialists DBA EyeLux Optometry employee or provider needs to access my pharmacy information that they have my permission to do so.

Non-Discrimination: Inland Eye Specialists DBA EyeLux Optometry complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin (including limited English proficiency and primary language), age, disability, or sex (consistent with scope of sex discrimination described at§ 92.101(a)(2)). Inland Eye Specialists DBA EyeLux Optometry does not exclude people or treat them less favorably because of race, color, national origin, age, disability or sex. I acknowledge that I have been given a full copy of the Non-Discrimination and Language Assistance Notice, and that I may request an additional copy at any time

Notice of Language Assistance Services & Auxiliary Aids and Services: Inland Eye Specialists DBA EyeLux Optometry provides reasonable modifications for individuals with disabilities, and appropriate auxiliary aids and services in compliance with Section 1557, including qualified interpreters for individuals with disabilities and information in alternate formats, including but not limited to large print, Braille, recorded audio, and accessible electronic formats, free of charge and in a timely manner, when such modifications are necessary. Inland Eye Specialists DBA EyeLux Optometry also provides language assistance services, including electronic and written translated documents and oral interpretation, free of charge and in a timely manner, to those with limited English proficiency. I understand and acknowledge that a copy of the full Non-Discrimination and Language Assistance Notice has been provided to me at least annually and/or upon my request and in the language or other format that I require, and that I have the option to opt out of receiving this full notice. I understand that Inland Eye Specialists DBA EyeLux Optometry does not condition the receipt of any aid or benefit on my decision to opt-out. I also understand that opting out of receiving the Notice is not a waiver of my right to receive assistance services or auxiliary aids. I acknowledge that should I decide to opt out of receiving the Notice that Inland Eye Specialists DBA EyeLux Optometry will document my decision to opt out in my patient file. I acknowledge that Inland Eye Specialists DBA EyeLux Optometry will document my primary language and any appropriate auxiliary aids and services that I require and will provide those services to me as needed.

I consent to receiving my eyeglasses and/or contact prescription electronically via the patient portal. I understand that I can also request a paper copy of my prescription any time after it is finalized in my medical record and that I may revoke this consent at any time.

☐ Yes ☐ No

Alternative Contact/Preferred Method of Communication Form

Patient Name: _____. **Date of Birth:** _____.

We at Inland Eye Specialists DBA EyeLux Optometry take your medical confidentiality very seriously. We will not and cannot release information without your written authorization.

This authorization allows our staff to speak with only an individual(s) you designate in the event you are not available to receive phone calls, or you have an adult member that helps coordinate your medical care. You should not designate your doctor.

As part of our Patient Privacy Policy, we will not leave any health information with any other person unless you specifically authorize below:

☐ I **do NOT** authorize anyone to receive information regarding my medical care.

☐ I authorize my physician and the employee of this clinic to speak with:

1. _____, my _____, their phone number is:
   NAME OF AUTHORIZED PERSON RELATIONSHIP TO PATIENT
   _____, regarding my **APPOINTMENTS AND ACCOUNT/BILL**

2. _____ _____, my _____, their phone number is:
   NAME OF AUTHORIZED PERSON RELATIONSHIP TO PATIENT
   _____, regarding my **MEDICAL CARE AND TREATMENT** (including Test Results and Lab Results).

Electronic Communication is my preferred method **____Yes** **____No**

(In order to electronically communicate with you or anyone you designate; we are required to have your written permission. Communication may be in the following forms: Home Phone/Answering Machine, Cell Phone: Voicemail, Cell Phone Text-Messaging, E-mail, Mail, or Work Phone.)

This authorization will remain in effect unless changed by me while I am a patient at this office. It is my responsibility to notify this office of changes and to complete a new form. Any problems and/or questions concerning this form are to be referred to the Privacy Officer.

I agree that should I desire to revoke this authorization, I will give written notice.

PRIVACY PRACTICES ACKNOWLEDGEMENT

Notice of Privacy Practices

Our "Notice of Privacy Practices" policy, available at the reception desk and also online at our website, provides detailed information about how we may use and disclose protected health information about you. The details of this policy are in full compliance with all provisions, including those most recently updated, of the Health Insurance Portability and Accountability Act passed in 1996 (HIPPA). Our "Notice of Privacy Practices" states that we reserve the right to change terms within our policy. Should this happen, we will display, and make available, the new policy and its perspective date of implementation. You have the right to request restrictions on how your protected health information may be used or disclosed for treatment, payment, or healthcare operations. We are not required to agree with your restrictions; however, if we do, we are bound by our agreement with you.

NOTICE OF BILLING PRACTICES:

THIS NOTICE DESCRIBES OUR BILLING PRACTICES, PLEASE REVIEW IT CAREFULLY.

By signing below, I acknowledge receipt of "Notice of Privacy Practices" and consent to your use and disclosure of protected health information about me for treatment, payment, and healthcare operations. I have the right to revoke this consent, in writing, except where the practice has already made disclosures in trust on my prior consent.

At Inland Eye Specialists DBA EyeLux Optometry, you can expect to receive medical services in a professional and caring manner. We are committed to providing you with the highest level of service and quality care. In return, it is your responsibility to provide your insurance information. Please have your photo identification and current insurance information available at your visit to ensure that your claim can be processed promptly.

1. APPOINTMENTS: We request that you keep scheduled appointments and arrive at the appointed time. If you are unable to keep your appointment, please give at least 48 hours' notice. [Cancellations of less than 24 hours prior to your appointment, or a No-Show for your appointment, will result in a minimum $35 fee per patient, excluding Medicaid patients.] We reserve the right to not make additional routine appointments for you should you have any remaining balance for previous treatment you received with our offices. Additionally, any outstanding balance will need to be addressed before checking in for an appointment.

2. CO-PAYS: According to your insurance contract, you are obligated to pay any co-pay (a small fixed amount required by your health insurer), deductible (amount you are liable before your health insurer will make payment), or co-insurance(percentage of the total cost of medical expenses after your deductible has been reached) due at the time of service. If you are unable to pay the co-pay at the time of service,

we retain the right to cancel or reschedule your appointment to a time when you are prepared to pay your co-pay. Furthermore, if your appointment is kept without payment of the co-pay at the time of service, we retain the right to levy an administrative charge of $10 to your account in order to defray the cost of securing the co-pay.

3. PRESCRIPTION REFILLS/FORMS: Please request any prescription refills and present any forms that need to be completed at the start of your examination. At that time, we have full access to your complete record and can fulfill your request. We reserve the right to charge the state allowable amount for filling out and completing forms or attorney requests for your various needs (i.e., SSI, disability, etc.).

4. EYE EXAMS & GLASSES: This policy will only apply if you need to purchase eyeglasses and/or contact lenses. You may request a copy of the full policy/procedure for your records.
   - One Rx check within 90 days of original exam
   - One Rx remake within 90 days of original order date
   - One lens remake is allowed during 1 year warranty period
   - One frame restyle allowed within 30 days including a fee of $50
   - Frames carry a manufacturer warranty against defects for 1 year
   - All eyewear and/or contact lens orders must be paid in full prior to submitting to vendor
   - All sales are final

5. REFERRALS: If your insurance plan requires a referral, the referral must be presented before seeing a physician. If you do not have the required referral, we reserve the right to reschedule your appointment or you will have to be willing to be responsible for the entire cost of the examination. You will be presented with a waiver acknowledging your acceptance as self-pay, and payment will need to be made at the time of service.

6. RETURNED CHECKS: Any payment made by check that does not clear our bank account will result in a fee for insufficient funds. Our fee for insufficient funds is $25 and will be added to your account for each bounced check.

7. OTHER INSURANCE: I understand that Inland Eye Specialists DBA EyeLux Optometry participates with multiple insurance plans and that not all Doctors in the Practice participate with all plans or products within the plans. I understand that it is my responsibility to verify with my insurance carrier that my physician currently participates with my plan. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by Inland Eye Specialists DBA EyeLux Optometry if I belong to a plan with which Inland Eye Specialists DBA EyeLux Optometry does not participate.

8. NON-COVERED SERVICES: I understand that Inland Eye Specialists DBA EyeLux Optometry contracts with health care service plans related only to items and services which are covered by the health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care service plans not to be covered. **Examples of non-covered services include but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or** in **the benefit summary the health care plan service plan furnishes to the patient (i.e. refraction, contact lens fittings) and treatment or tests not authorized by the health care service plan.** The undersigned agrees to cooperate with **Inland Eye Specialists DBA EyeLux Optometry** to obtain necessary health care service plan authorizations.

9. FINANCIAL AGREEMENT: I agree that in return for the services provided to me by Inland Eye Specialists DBA EyeLux Optometry, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Inland Eye Specialists DBA EyeLux Optometry for payment. I understand and agree that if my account is delinquent and sent to collections, I may be charged up to 35% in administrative fees.

If the account is sent to an attorney to assist with collections, I agree to pay collection expenses and reasonable attorney fees. Any benefits of any type under any policy of insurance insuring the patient, or any other party liable to the patient, is hereby assigned to Inland Eye Specialists DBA EyeLux Optometry If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Inland Eye Specialists DBA EyeLux Optometry. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill. I further understand and agree that if I ignore statements of attempts to collect past due amounts, I may have my ability to schedule appointments and/or receive future services from Inland Eye Specialists DBA EyeLux Optometry limited including possible dismissal as a patient from the practice.

10. PATIENT STATEMENTS: At Inland Eye Specialists DBA EyeLux Optometry, all accounts are payable within 30 days after you receive your first statement. Credit is extended as a courtesy and arrangements will be based on demonstrated needs. Payments keep your account current only when arrangements have been made. Please call customer service to set up payment arrangements. As a result of costs associated with sending statements, Inland Eye Specialists DBA EyeLux Optometry does not send statements to patients for balances under
$20. Billing statements are suppressed until the patient's balance becomes $20 or more inpatient responsibility. As a result, you may receive a statement long after your last appointment or may be asked to pay small balances when presenting for an appointment without having received a statement. Patients should remit small balances owed to Inland Eye Specialists DBA EyeLux Optometry upon receipt of their explanation of benefits from their insurance.

11. PATIENT DISMISSAL: I agree and understand that Inland Eye Specialists DBA EyeLux Optometry may initiate separation and/or dismissal of me as a patient of the practice for any of the following non-exclusive reasons:

    (a) Disruptive, aggressive, violent, and/or threatening behavior towards physicians, staff, and/or other patients;
    (b) Repeated failure to attend scheduled appointments;
    (c) Non-compliance with physician instructions and recommended treatment and/or other erosion of physician/patient relationship; and
    (d) Non-payment of past due amounts and/or failure to pay any past due amounts as agreed in any payment arrangement you entered with Inland Eye Specialists DBA EyeLux Optometry Please note, making payments that are less than an agreed amount per payment arrangement will be considered, and treated as non-payment for purposes of this provision.

Patients who are dismissed from the practice will be notified in writing and will be given 30 days to find alternative vision care. Appointments for emergency visits will be allowed during the 30 days but payment of an emergency visit will be collected at check-in with any additional amounts due collected at check-0ut

The physicians and staff at Inland Eye Specialists DBA EyeLux Optometry appreciate your confidence in allowing us to participate in your eye care.

Your signature indicates that you have read, understand, and agree to the financial responsibilities policies and procedures of our office.

PATIENT'S NAME: _____

PATIENT'S DATE OF BIRTH: _____

PATIENT/GUARDIAN SIGNATURE: _____

DATE: _____ TIME: _____

ATTENTION: If you speak English or American Sign Language, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Please speak to your provider.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Por favor hable con su proveed

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Bitte sprechen Sie mit Ihrem Provider.

注意：如果您说**[中文]，我**们将免费为您提供语言协助服务。我们还免费提 **供适当的**辅助工具和服务，以无障碍格式提供信息。请与您的提供商联系。

注意：如果您說[中文]，我們可以為您提供免費語言協助服務。也可以免費 提供適當的輔助工具與服務，以無障礙格式提供資訊。請與您的提供者聯絡。

LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Hãy nói chuyện với nhà cung cấp của bạn.

ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Veuillez en parler à parlez à votre fournisseur.

ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Пожалуйста, поговорите со своим провайдером.

تنبيه: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية المجانية متوفرة
متاح لك. المساعدات والخدمات المساعدة المناسبة لتوفير المعلومات
التنسيقات التي يمكن الوصول إليها متاحة أيضًا مجانًا. يرجى التحدث إلى مزود الخدمة الخاص بك.

주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 귀하의 서비스 제공자에게 문의하십시오.

PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Makipag-usap sa iyong provider.

ATTENZIONE: se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Si prega di parlare con il proprio fornitore.

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd aladispozisyon w gratis pou lang ou pale a. Èd ak sèvis siplemantè apwopriye pou bay enfòmasyon nan fòma aksesib yo disponib gratis tou. Tanpri pale ak founisè w la.

ማሳሰቢያ፡- አማርኛ የሚናገሩ ከሆነ፣ የቋንቋ ድጋፍ አገልግሎት በነፃ ይቀርብልዎታል። መረጃን በተደራሽ ቅርጸት ለማቅረብ ተገቢ የሆኑ ተጨማሪ እገዛዎች እና አገልግሎቶች እንዲሁ በነፃ ይገኛሉ። እባክዎን አቅራቢዎን ያነጋግሩ።

सावधान: यदि तपाईंनेपाली भाषा बोल्नुहुन्छ भनेतपाईंका लादि दन:शुल्क भादषक सहायता सेवाहरू उपलब्ध छन्। पहुुँचयोग्य ढाुँचाहरूमा जानकारी प्रिान िननउपयुक्त सहायता र सेवाहरू पदन दनि:शुल्क उपलब्ध छन्। कृपया आफ्नो प्रदायकसँग कुरा गर्नुहोस्।

MAKINIKA: Ikiwa wewe huzungumza Kiswahili, msaada na huduma za lugha bila malipo unapatikana kwako. Vifaa vya usaidizi vinavyofaa na huduma bila malipo ili kutoa taarifa katika mifumo inayofikiwa pia inapatikana bila malipo. Tafadhali zungumza na mtoa huduma wako.

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਉਪਲਬਧ ਹੁੰਦੀਆਂ ਹਨ। ਪਹੁੰਚਯੋਗ ਫਾਰਮੈਟਾਂ ਵਿੱਚ ਜਾਣਕਾਰੀ ਪ੍ਰਦਾਨ ਕਰਨ ਲਈ ਢੁਕਵੇਂ ਪੂਰਕ ਸਹਾਇਕ ਸਾਧਨ ਅਤੇ ਸੇਵਾਵਾਂ ਵੀ ਮੁਫ਼ਤ ਵਿੱਚ ਉਪਲਬਧ ਹੁੰਦੀਆਂ ਹਨ। ਕਿਰਪਾ ਕਰਕੇ ਆਪਣੇ ਪ੍ਰਦਾਤਾ ਨਾਲ ਗੱਲ ਕਰੋ।

注：日本語を話される場合、無料の言語支援サービスをご利用いただけます。アクセシブル（誰もが利用できるよう配慮された）な形式で情報を提供するための適切な補助支援やサービスも無料でご利用いただけます。プロバイダーにご相談ください。

توجه :اگر فارسی صحبت می کنید، خدمات کمک زبان رایگان است
در دسترس شماست .کمک‌ها و خدمات کمکی مناسب برای ارائه اطلاعات در قالب‌های قابل دسترس نیز به صورت رایگان
در دسترس هستند .لطفاً با ارائه‌دهنده خود صحبت کنید.

LUS CEEV TSHWJ XEEB: Yog hais tias koj hais Lus Hmoob muaj cov kev pab cuam txhais lus pub dawb rau koj. Cov kev pab thiab cov kev pab cuam ntxiv uas tsim nyog txhawm rau muab lus qhia paub ua cov hom ntaub ntawv uas tuaj yeem nkag cuag tau rau los kuj yeej tseem muaj pab dawb tsis xam tus nqi dab tsi ib yam nkaus. Thov nrog koj tus kws kho mob tham.

ATENÇÃO: Se você fala [inserir idioma], serviços gratuitos de assistência linguística estão disponíveis para você. Auxílios e serviços auxiliares apropriados para fornecer informações em formatos acessíveis também estão disponíveis gratuitamente. Por favor, fale com seu provedor.

ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। कृपया अपने प्रदाता से बात करें.।

UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Proszę porozmawiać ze swoim dostawcą.

মনোযোগ দিন: যদি আপনি বাংলা বলেন তাহলে আপনার জন্য বিনামূল্যে ভাষা সহায়তা পরিষেবাদি উপলব্ধ রয়েছে। অ্যাক্সেসযোগ্য ফরম্যাটে তথ্য প্রদানের জন্য উপযুক্ত সহায়ক সহযোগিতা এবং পরিষেবাদিও বিনামূল্যে উপলব্ধ রয়েছে। আপনার প্রদানকারীর সাথে কথা বলুন।

توجہ دیں: اگر آپ اردو بولتے ہیں، تو آپ کے لیے زبان کی مفت مدد کی خدمات دستیاب ہیں۔ براہ کرم اپنے فراہم کنندہ سے بات کریں۔ معلومات فراہم کرنے کے لیے مناسب معاون امداد اور خدمات بھی مفت دستیاب ہیں۔