

CONFIDENTIAL PATIENT INFORMATION
PLEASE PRINT

DATE ___/___/___

PATIENT INFORMATION:

FULL NAME _____ DATE OF BIRTH ___/___/___ AGE ___ Male Female
Physical Address _____ Box # _____ SSN ___-___-___
CITY _____ STATE _____ ZIP CODE _____ HOME PHONE (____) _____
ALTERNATE PHONE (CELL): (____) _____ EMAIL ADDRESS: _____
EMPLOYER'S NAME _____ OCCUPATION _____
WORK ADDRESS _____ CITY _____ STATE _____ ZIP _____
WORK PH. # (____) _____ EXT. _____ DATE SYMPTOMS BEGAN: ___/___/___
MARITAL STATUS: SINGLE MARRIED WIDOWED HOW DID YOU HEAR ABOUT US? _____
EMERGENCY CONTACT _____ PHONE _____

CLAIM INFORMATION:

IS YOUR CONDITION DUE TO AN AUTO ACCIDENT A PERSONAL INJURY A WORK INJURY OTHER
TYPE OF CLAIM: CASH GROUP HEALTH INS PERSONAL INJURY WORKER'S COMP MEDICARE
I WILL BE PAYING TODAY BY CASH CHECK VISA MASTERCARD AMEX DISCOVER OTHER

INSURANCE INFORMATION:

RELATIONSHIP TO INSURED? SELF SPOUSE OTHER CHILD Insured's Name _____
INSURED'S EMPLOYER, SAME AS ABOVE _____
INSURED'S SSN SAME AS ABOVE SSN ___-___-___ INSURED'S DOB SAME AS ABOVE ___/___/___
PRIMARY INSURANCE CO. _____ ADDRESS _____
CITY _____ STATE _____ ZIP CODE _____ PHONE#(____) _____
POLICY NUMBER _____ GROUP NUMBER _____

SECONDARY INSURANCE CO. _____ ADDRESS _____
CITY _____ STATE _____ ZIP CODE _____ PHONE#(____) _____
POLICY NUMBER _____ GROUP NUMBER _____

AUTHORIZATIONS:

A. I hereby authorize release of any medical information necessary to process this claim and request payment of insurance benefits either to myself or to the party who accepts assignment.
B. I authorize payment of any medical benefit from third-parties for benefits submitted for my claim to be paid directly to this office. I authorize the direct payment to this office of any sum I now or hereafter owe this office by my attorney, out of proceeds of any settlement of my case and by any insurance company contractually obligated to make payment to me or you based upon the charges submitted for products and services rendered.
C. I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for products or professional services rendered will be immediately due and payable.

Patient's Signature: _____ Date: _____
Guardian Signature: _____ Date: _____

Health History

What treatment have you already received for your condition? Medications Surgery Physical Therapy

Chiropractic Services None Other _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____

Spinal Exam _____ Chest X-Ray _____ Urine Test _____

Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

- | | | | | | | | | | | | |
|---------------------|------------------------------|-----------------------------|------------------|------------------------------|-----------------------------|----------------------|------------------------------|-----------------------------|--------------------|------------------------------|-----------------------------|
| AIDS/HIV | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Diabetes | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Migraine | | | Rheumatic Fever | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Alcoholism | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Emphysema | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Headaches | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Scarlet Fever | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Allergy Shots | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Epilepsy | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Miscarriage | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Stroke | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Anemia | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Fractures | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Mononucleosis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Suicide Attempt | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Anorexia | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Glaucoma | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Multiple Sclerosis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Thyroid Problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Appendicitis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Goiter | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Mumps | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tonsillitis | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Arthritis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Gonorrhea | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Osteoporosis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tuberculosis | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Asthma | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Gout | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Pacemaker | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tumors, Growths | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bleeding Disorders | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Heart Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Parkinson's Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Typhoid Fever | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Breast Lump | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hepatitis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Pinched Nerve | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Ulcers | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bronchitis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hernia | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Pneumonia | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Vaginal Infections | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bulimia | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Herniated Disk | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Polio | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Venereal Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cancer | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Herpes | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Prostate Problem | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Whooping Cough | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cataracts | <input type="checkbox"/> Yes | <input type="checkbox"/> No | High Cholesterol | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Prosthesis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Other _____ | | |
| Chemical Dependency | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Kidney Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Psychiatric Care | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | | |
| Chicken Pox | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Liver Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Rheumatoid Arthritis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | | |
| | | | Measles | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | | | | | |

<p>EXERCISE</p> <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Daily <input type="checkbox"/> Heavy	<p>WORK ACTIVITY</p> <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Light Labor <input type="checkbox"/> Heavy Labor	<p>HABITS</p> <input type="checkbox"/> Smoking <input type="checkbox"/> Alcohol <input type="checkbox"/> Coffee/Caffeine Drinks <input type="checkbox"/> High Stress Level	<p>Packs/Day _____</p> <p>Drinks/Week _____</p> <p>Cups/Day _____</p> <p>Reason _____</p>
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Are you pregnant? Yes No Due Date _____

Injuries/Surgeries you have had	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

Medications	Allergies	Vitamins/Herbs/Minerals
_____	_____	_____
_____	_____	_____
_____	_____	_____
Pharmacy Name _____	_____	_____
Pharmacy Phone (____) _____	_____	_____

CONSENT TO TREATMENT WITHOUT X-RAYS

I hereby authorize Outback Chiropractic/Dr. Crockett and whomever he may designate as his assistants to administer treatment to me as he deems necessary. I give consent for this treatment without receiving chiropractic x-rays. I agree to follow his treatment plan recommendations and will give at least 24 hours notice of cancellation of any scheduled appointments.

Signature of patient _____ date ___/___/___

ACKNOWLEDGMENT OF PREGNANCY

I hereby acknowledge that: (Females Only)

___ I am pregnant ___ I am Not pregnant

I authorize Dr. Crockett/Outback Chiropractic and whomever he designates as his assistants to administer treatment as he deems necessary in light of this information.

Signature of patient _____ date ___/___/___

CONSENT TO TREATMENT OF A MINOR

I hereby authorize Dr. Crockett/Outback Chiropractic and whomever he may designate as his assistants to administer treatment as he deems necessary to my (daughter/son).

Patient name _____

Signature of parent/guardian _____ date ___/___/___

Acknowledgment of Receipt of Notice of Privacy Practices

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practice. I understand that this form will be placed in my patient file and maintained for six years.

Patient signature _____

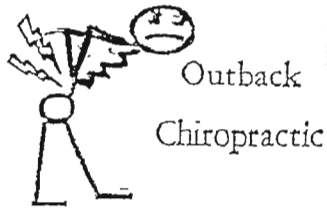
Authorization for appointment reminders and mailings

It is our desire for our staff to use your name, address, and/or telephone number for the purpose of contacting you to remind you about scheduled appointments, and advise you about health related meetings, workshops. If you choose not to authorize this information your decision will have no adverse effect on your care from Outback Chiropractic.

Your signature indicates your authorization _____

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POLICIES & PROCEDURES REGARDING PAYMENT

Date: ____/____/____ Patient Name: _____

Eligibility and benefits will be determined at the time your claims are processed.

Deductible amount: _____ Has it been met? Yes or No

Policy covers chiropractic? Yes or No Number of visits per year _____

\$ Maximum per year _____ Estimated Co-pay _____

1. We will make every effort to verify your coverage with your carrier and inform you of your deductible and co-payment responsibilities. We verify benefits as a courtesy to our patients and we are at no time held responsible if incorrect information has been obtained. Please remember that the information we get from your carrier is only an estimated, and we cannot be sure of the exact amount until we submit a claim and receive and Explanation of Benefits.

2. Once your deductible, if any, is met, we will collect only your estimated co-payment and will bill your insurance carrier for the balance. We will make every reasonable effort to assist in expediting insurance payment; however, you will be responsible for negotiating any payment disputes directly with your insurance company.

3. Outback Chiropractic will carry your account for 60 days. If your insurance company has not acknowledged any portion of your account within 60 days, the balance is due and payable in full. You will be responsible for the entire debt incurred for services rendered. Accounts remaining outstanding after 60 days will be subject to a 2% per month late charge. Unpaid accounts will be turned over for collection that may include small claims proceedings. Any and all collection/court fees will become the responsibility of the patient.

4. You are responsible for paying your co-payments at the time of each visit. If you cannot do this, you must make special financial arrangements with our business office. Failure to meet your financial responsibilities may result in termination of your treatment.

There will be a \$25.00 charge for NO SHOW appointments or cancellations with less than 24 hours notification. You will be personally responsible for any cancellation fees.

ASSIGNMENT OF BENEFITS: I authorize payment of medical benefits from my insurance company to Outback Chiropractic for services rendered. I also authorize the release of any medical or other information necessary to process insurance claim.

I have read and fully understand all of the above information and hereby agree to comply as outlined.

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Patient Signature _____ Date ____/____/____

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Protocol for Preservation of Patient Records

Pursuant to ARS 32-3210 and the requirements of the State of Arizona for the preservation of patient records, this document is intended to inform all patients of Outback Chiropractic of their rights and obligations.

Patients or their representatives may request copies of their records, in writing. Dr. Crockett agrees to comply with Arizona law for the production of these records and will timely respond to any reasonable requests.

Dr. Crockett will maintain your records for a period of 7 years following your last date of service. After 7 years from the last date of service, Dr. Crockett reserves the right to destroy your records. Should Dr. Crockett exercise that right, Dr. Crockett will first attempt to contact you and inform you of your right to obtain a copy of these records. Dr. Crockett will attempt to contact you by regular mail, at your last known address, and will give you thirty days to request that your records not be destroyed. If you do not respond to this notice, you will be waiving your rights to have your records preserved.

Should Dr. Crockett retire, cease to practice, or sell his practice to another health care professional, Dr. Crockett will notify all eligible patients, by regular mail, concerning the location of their records and how they may request copies of those records. The required notice will be sent to each eligible patient's last known address.

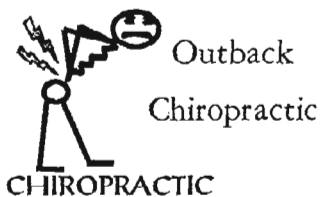
Signature of Patient

Acknowledgement and Agreement: Patient's Protocol for Records Preservation

I, _____, patient of Dr. Crockett, do hereby acknowledge I have read and understand the doctor's protocol for the preservation of patient records. I agree to inform Dr. Crockett's office of any address changes and acknowledgement that all requests for records, either by me or by my representatives, must be in writing. I agree that the doctor's office may comply with all statutory notification requirements to me by regular mail to indicated address.

Signature of Patient

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Doctor-Patient Relationship in Chiropractic Informed Consent

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It is important to acknowledge the difference between the health care specialties of chiropractic, osteopathy & medicine. Chiropractic health care seeks to restore health through natural means without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of chiropractic doctor's procedures often depends on environment, underlying causes, physical and spinal conditions. It is important to understand what to expect from chiropractic health care services.

ANALYSIS

A doctor of chiropractic conducts a clinical analysis for the express purpose of determining whether there is evidence of Vertebral Subluxation Syndrome (VSS) or Vertebral Subluxation Complexes (VSC). When such VSS and VSC complexes are found, chiropractic adjustments and ancillary procedures may be given in an attempt to restore spinal integrity. It is the chiropractic premise that spinal alignment allows nerve transmission throughout the body and gives the body an opportunity to use its inherent recuperative powers. Due to the complexities of nature, no doctor can promise you specific results. This depends upon the inherent recuperative powers of the body.

DIAGNOSIS

Although doctors of chiropractic are experts in chiropractic diagnosis of the VSS and VSC, they are not internal medical specialists. Every Chiropractic patient should be mindful of his/her own symptoms and should secure other opinions if he/she has any concern as to the nature of his/her total condition. Your doctor of chiropractic may express an opinion as to whether or not you should take this Step, but you are responsible for the final decision.

INFORMED CONSENT FOR CHIROPRACTIC CARE

A patient, in coming to the doctor of chiropractic, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give a chiropractic adjustment, or health care, if he/she is aware that such care may be contraindicated. Again, he/she is suffering from latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the doctor of chiropractic. The patient should look to correct specialist for the proper diagnostic and clinical procedures. The doctor of chiropractic provides a specialized, non-duplicating health service. The doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

RESULTS

The purpose of chiropractic services is to promote natural health through the reduction of the VSS and the VSC. Since there are so many variables, it is difficult to predict the time schedule or efficacy of the chiropractic procedures. Sometimes the response is phenomenal. In most cases there is a more gradual, but quite satisfactory response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same chiropractic care. Many medical failures find quick relief through chiropractic. In turn, we must admit that conditions, which do not respond to chiropractic care, may come under the control or be helped through medical science. The fact is that the science of chiropractic and medicine may never be so exact as to provide definite answers to all problems. Both have made great strides in alleviating pain and controlling disease.

TO THE PATIENT

Please discuss any questions or problems with the doctor before signing this statement of policy.

I have read, and understand the foregoing.

Signature: _____ Date: ____/____/____

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Request Amendment. You have the right to request that we amend your medical information if you feel that it is incomplete or inaccurate. You must make this request in writing to our practice manager, stating exactly what information is incomplete or inaccurate and the reasoning that supports your request.

We are permitted to deny your request if it is not in writing or does not include a reason to support the request. We may also deny your request if:

- The information was not created by us, or the person who created it is no longer available to make the amendment.
- The information is not part of the record which you are permitted to inspect and copy.
- The information is not part of the designated record set kept by this practice or if it is the opinion of the opinion of the health care provider that the information is accurate and complete.

Request Restrictions. You have the right to request a restriction of how we use or disclose your medical information for treatment, payment, or health care operations. For example – you could request that we not disclose information about a prior treatment to a family member or friend who may be involved in your care or payment for care. Your request must be made in writing to our practice manager.

We are not required to agree to your request if we feel it is in your best interest to use or disclose that information. If we do agree, we will comply with your request except for emergency treatment.

An Accounting of Disclosures. You have the right to request a list of the disclosures of your health information we have made outside of our practice that were not for treatment, payment, or health care operations. Your request must be in writing and must state the time period for the requested information. You may not request information for any dates prior to April 14, 2003, nor for a period of time greater than six years (our legal obligation to retain information).

Your first request for a list of disclosures within a 12-month period will be free. If you request an addition list within 12-months of the first request, we may charge you a fee for the costs of providing the subsequent list. We will notify you of such costs and afford you the opportunity to withdraw your request before any costs are incurred.

Request Confidential Communications. You have the right to request how we communicate with you to preserve your privacy. For example – you may request that we call you only at your work number, or by mail at a special address or postal box. Your request must be made in writing and must specify how or where we are to contact you. We will accommodate all reasonable requests.

File a Complaint. If you believe we have violated your medical information privacy rights, you have the right to file a complaint with our practice or directly to the Secretary of Health and Human Services.

To file a complaint with our manager, you must make it in writing within 180 days of the suspected violation. Provide as much detail as you can about the suspected violation and send it to our Privacy Officer.

Uses or Disclosures Not Covered

Uses or disclosures of your health information not covered by this notice or the laws that apply to us may only be made with your written authorization. You may revoke such authorization in writing at any time and we will no longer disclose health information about you for the reasons stated in your written authorization. Disclosures made in reliance on the authorization prior to the revocation are not affected by the revocation.

For More Information

If you have questions or would like additional information, you may contact our Privacy Officer.

Effective Date: April 14, 2003

Notice of Privacy Practices

OUTBACK CHIROPRACTIC

L. Craig Crockett D.C.
1200 West Cleveland Ave.
St. Johns, AZ 85936

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.

We are required by law to provide you with this notice that explains our privacy practices with regard to your medical information and how we may use and disclose your protected health information for treatment, payment, and for health care operations, as well as for other purposes that are permitted or required by law. You have certain rights regarding the privacy of your protected health information and we also describe those rights in this notice.

Ways in Which We May Use and Disclose Your Protected Health Information:

The following paragraphs describe different ways that we use and disclose your protected health information. We have provided an example for each category, but these examples are not meant to be exhaustive. All of the ways we are permitted to use and disclose your health information fall within one of these categories.

Treatment. We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. We will also disclose your health information to other physicians who may be treating you. Additionally we may from time to time disclose your health information to another physician whom we have requested to be involved in your care. For example – we would disclose your health information to a specialist to whom we have referred you for a diagnosis to help in your treatment.

Payment. We will use and disclose your protected health information to obtain payment for the health care services we provide you. For example — we may include information with a bill to a third-party payer that identifies you, your diagnosis, procedures performed, and supplies used in rendering the service.

Health Care Operations. We will use and disclose your protected health information to support the business activities of our practice. For example — we may use medical information about you to review and evaluate our treatment and services or to evaluate our staff's performance while caring for you. In addition, we may disclose your health information to third party business associates who perform billing, consulting, or transcription, or other services for our practice.

Other Ways We May Use and Disclose Your Protected Health Information:

Appointment Reminders. We will use and disclose your protected health information to contact you as a reminder about scheduled appointments or treatment.

Treatment Alternatives. We will use and disclose your protected health information to tell you about or recommend possible alternative treatments or options that may be of interest to you.

Others Involved in Your Care. We will use and disclose your protected health information to a family member, a relative, a close friend, or any other person you identify that is involved in your medical care or payment for care.

Research. We will use and disclose your protected health information to researchers, provided the research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

As Required by Law. We will use and disclose your protected health information when required to by federal, state, or local law.

To Avert a Serious Threat to Public Health or Safety. We will use and disclose your protected health information to public health authorities permitted to collect or receive the information for the purpose of controlling disease, injury, or disability. If directed by that health authority, we will also disclose your health information to a foreign government agency that is collaborating with the public health authority.

Worker's Compensation. We will use and disclose your protected health information for worker's compensation or similar programs that provide benefits for work-related injuries or illness.

Inmates. We will use and disclose your protected health information to a correctional institution or law enforcement official if you are an inmate of that correctional institution or under the custody of the law enforcement official. This information would be necessary for the institution to provide you with health

care; to protect the health and safety of others; or for the safety and security of the correctional institution.

Your Health Information Rights

Although your health record is the physical property of the practitioner or facility that compiled it, the information belongs to you. You have the right to:

A Paper Copy of This Notice. You have the right to receive a paper copy of this notice upon request. You may obtain a copy by asking our receptionist at your next visit or by calling and asking us to mail you a copy.

Inspect and Copy. You have the right to inspect and copy the protected health information that we maintain about you in our designated record set for as long as we maintain that information. This designated record set includes your medical and billing records, as well as any other records we use for making decisions about you. Any psychotherapy notes that may have been included in records we received about you are not available for your inspection or copying, by law. We may charge you a fee for the costs of copying, mailing, or other supplies used in fulfilling your request.

If you wish to inspect or copy your medical information, you must submit your request in writing to our Privacy Officer: Attention: Privacy Officer, PO Box 2578 St Johns AZ, 85936: (928) 337-2796. You may mail your request, or bring it to our office. We will have 30 days to respond to your request for information that we maintain at our practice site. If the information is stored off-site, we are allowed up to 60 days to respond but must inform you of this delay.