

PATIENT REGISTRATION**Patient Information** (Please print clearly) Name must match what is on your insurance card(s) or we may not be able to bill.

Last Name: _____ First: _____ M: _____
 Birthdate: _____ Sex: F M SSN# _____ Marital Status: S M D W SEP
 Mailing Address: _____ City: _____ ST: _____ Zip: _____
 Physical Address (if different): _____ City: _____ ST: _____ Zip: _____
 Home Phone: _____ Work: _____ Cell: _____
 Message#: _____ Email Address: _____
 Preferred Method of Contact: Home Phone Work Cell Message Phone Text Okay to Leave Message?: Yes No
 Emergency Contact: _____ Phone: _____
 Relationship: _____ Does this person know that you are a patient at Hill Country? Yes No

Parent or Guardian (if patient is minor)

Parent/Guardian Name: _____ Date of Birth: _____
 Address: _____ Relationship to Minor: _____
 Home Phone: _____ Cell Phone: _____ Work Phone: _____
 Parent/Guardian Name: _____ Date of Birth: _____
 Address: _____ Relationship to Minor: _____
 Home Phone: _____ Cell Phone: _____ Work Phone: _____

Patient Demographics: To enable us to qualify for our grants and meet our Federal and State reporting requirements, along with possibly allowing us to offer more services, we must ask for the following information. Your answers are strictly confidential. Your name will not be used. Please Circle or Check the appropriate box.

Language Spoken in your Home: English Spanish Other: _____
 Race (Check all that apply): White Black/African American Native Hawaiian/Pacific Islander Asian Chinese
 American Indian/Alaskan Native Filipino Japanese Korean Other Declined
 Ethnicity: Hispanic/Latino Non-Hispanic/Latino Declined
 Sexual Orientation: Lesbian, Gay or Homosexual Straight or Heterosexual Bisexual Don't Know
 Choose not to disclose Other: _____
 Gender Identity: Male Female Transgender Male/ Female-to-Male Transgender Female/ Male-to-Female
 Genderqueer Neither Exclusively Male Nor Female Choose Not To Disclose Other: _____
 Are you a Veteran?: Yes No Agricultural (Farm) Worker?: Yes No If yes, are you: Seasonal Migrant
 Homeless: Yes No If yes, currently living in: Shelter Transitional Housing Doubled Up Street Other
 Family Size: _____ What is your Average Monthly Income: _____ Declined to provide information

SIGNATURE: _____ DATE: _____

The preceding information is true to the best of my knowledge.

**Round Mountain Location**

Medical, Dental, Counseling,
 Chiropractic
 29632 HWY 299 East,
 Round Mountain, CA 96084
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 F: (530) 337-6655

Gold Street Location

Medical, Counseling
 1401 Gold Street Suite A,
 Redding, CA 96001
 P: (530) 319-7066
 F: (530) 319-7061

Redding Location

Medical, Counseling,
 Chiropractic
 317 Lake Blvd. Suite A,
 Redding, CA 96003
 P: (530) 241-4100
 F: (530) 241-4117

PATIENT CONSENTS

Consent for Medical/Dental Treatment

Patient Name: _____ Date of Birth: _____

ADULT : I hereby authorize Hill Country Community Clinic and all persons acting as agents thereof, as well as all medical/dental personnel to whom I am referred, to furnish all forms of reasonable diagnostic, preventive, therapeutic, medical and dental treatment to me.

If MINOR: I, as the parent/guardian (circle one) of the above named minor, hereby authorize Hill Country Community Clinic medical/dental personnel to whom said minor is referred, to furnish all forms of reasonable diagnostic, preventive, therapeutic, medical and dental treatment to said minor. This consent shall remain in force until a written revocation is filed at the clinic.

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Notice of Privacy Practices

We are committed to protecting your personal health information in compliance with the law.

Our Notice of Privacy Practices states:

- Our obligations under the law with respect to your personal health information.
- How we may use and disclose the health information that we keep about you.
- Your rights relating to your personal health information.
- Our rights to change our Notice of Privacy Practices.
- How to file a complaint if you believe your privacy rights have been violated.
- The conditions that apply to uses and disclosures not described in this Notice.
- The person to contact for further information about our privacy practices.

We are required by law to provide you a copy of this notice and to obtain your written acknowledgement that you have received a copy of this Notice.

Patient Acknowledgement of Receipt/Opt Out

I have been provided a copy of the health center's Notice of Privacy Practices

I have been offered, but have chosen not to receive copy of the health center's Notice of Privacy Practices

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Confidential Health History

Chart # _____

Patient Name: _____ Date of Birth: _____

I. CIRCLE APPROPRIATE ANSWER (Leave blank if you do not understand the question)

1. Yes / No Is your general health good?
If NO, explain: _____
2. Yes / No Has there been a change in your health within the last year?
If YES, explain: _____
3. Yes / No Have you gone to the hospital or emergency room or had a serious illness in the last three years?
If YES, explain: _____
4. Yes / No Are you being treated by a physician now? If YES, explain: _____
Date of last medical exam? _____ Reason for exam: _____
5. Yes / No Have you had problems with prior dental treatment?
If YES, explain: _____
Date of last dental exam: _____ Name of last treating dentist: _____
6. Yes / No Are you in pain now?
If YES, explain: _____

II. HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING? (Please circle Yes or No for each)

- | | | |
|---|-----------------------------------|----------------------------------|
| Yes / No Chest pain (angina) | Yes / No Blood in stools | Yes / No Frequent vomiting |
| Yes / No Fainting spells | Yes / No Diarrhea or constipation | Yes / No Jaundice |
| Yes / No Recent significant weight loss | Yes / No Frequent urination | Yes / No Dry mouth |
| Yes / No Fever | Yes / No Difficulty urinating | Yes / No Excessive thirst |
| Yes / No Night sweats | Yes / No Ringing in ears | Yes / No Difficulty swallowing |
| Yes / No Persistent cough | Yes / No Headaches | Yes / No Swollen ankles |
| Yes / No Coughing up blood | Yes / No Dizziness | Yes / No Joint pain or stiffness |
| Yes / No Bleeding problems | Yes / No Blurred vision | Yes / No Shortness of breath |
| Yes / No Blood in urine | Yes / No Bruise easily | Yes / No Sinus problems |
- Other: _____

III. HAVE YOU EVER HAD OR DO YOU HAVE ANY OF THE FOLLOWING? (Please circle Yes or No for each)

- | | | |
|--|--|-------------------------------------|
| Yes / No Heart disease | Yes / No AIDS/HIV | Yes / No Psychiatric care |
| Yes / No Family history of heart disease | Yes / No Surgeries | Yes / No Osteoporosis |
| Yes / No Heart attack | Yes / No Hospitalization | Yes / No Thyroid disease |
| Yes / No Artificial joint | Yes / No Diabetes | Yes / No Asthma |
| Yes / No Stomach problems or ulcers | Yes / No Family history of diabetes | Yes / No Hepatitis |
| Yes / No Heart defects | Yes / No Tumors or cancer | Yes / No Sexual transmitted disease |
| Yes / No Heart murmurs | Yes / No Chemotherapy | Yes / No Herpes |
| Yes / No Rheumatic fever | Yes / No Radiation | Yes / No Canker or cold sores |
| Yes / No Skin disease | Yes / No Arthritis, rheumatism | Yes / No Anemia |
| Yes / No Hardening of arteries | Yes / No Emphysema or other lung disease | Yes / No Liver disease |
| Yes / No High blood pressure | Yes / No Kidney or bladder disease | Yes / No Eye disease |
| Yes / No Seizures | Yes / No Stroke | Yes / No Transplants |
| Yes / No Cosmetic surgery | Yes / No Eating disorders | Yes / No Tuberculosis |
- Other: _____

IV. ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING?

(Please circle Yes or No for each)

Yes / No Aspirin	Yes / No Valium or other sedatives	Yes / No Codeine or other narcotics
Yes / No Penicillin or other antibiotics	Yes / No Latex	Yes / No Food
Yes / No Nitrous oxide	Yes / No Local anesthetic	Yes / No Metal

Others: _____

V. ARE YOU TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING IN THE LAST THREE MONTHS?

(Please circle Yes or No for each)

Yes / No Recreational drugs	Yes / No Tobacco in any form	Yes / No Antibiotics
Yes / No Over-the-counter medicines	Yes / No Alcohol	Yes / No Supplements
Yes / No Weight loss medications	Yes / No Bisphosphonate (Fosamax)	Yes / No Aspirin
Yes / No Anti-Depressants	Yes / No Herbal Supplements	

Please list all prescription medications: _____

VI. WOMEN ONLY (Please circle Yes or No for each)

Yes / No Are you or could you be pregnant? If YES, what month? _____

Yes / No Are you nursing? _____

Yes / No Are you taking birth control pills? _____

VII. ALL PATIENTS. (Please circle Yes or No for each)

Yes / No Do you have or have you had any other diseases or medical problems NOT listed on this form?
If YES, please explain: _____

Yes / No Have you ever been pre-medicated for dental treatment? If YES, why: _____

Yes / No Have you ever taken Fen-Phen? If YES, when: _____

Yes / No **Is there any issue or condition that you would like to discuss with the dentist in private?**

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically compromised situation, medical consultation may be needed prior to commencement of dental treatment.

I authorize the dentist to contact my physician.

Patient's Signature: _____ Date: _____

Physician's Name: _____ Phone Number: _____

Whom would you like us to contact in case of an emergency?

Name: _____ Relationship: _____ Phone Number: _____

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient (Parent or Guardian)

Date

Signature of Dentist

Date

PATIENT FINANCIAL AGREEMENT**Medical & Dental Insurance Policies****Primary MEDICAL Insurance**

Name: _____

Policy ID# _____ Group # _____ Effective Date: _____

Guarantor Name: _____ Relationship to patient: _____

Date of Birth: _____ SSN#: _____ Sex: F M

Address: _____ Phone: _____

Secondary MEDICAL Insurance

Name: _____

Policy ID# _____ Group # _____ Effective Date: _____

Guarantor Name: _____ Relationship to patient: _____

Date of Birth: _____ SSN#: _____ Sex: F M

Address: _____ Phone: _____

DENTAL Insurance

Name: _____

Policy ID# _____ Group # _____ Effective Date: _____

Guarantor Name: _____ Relationship to patient: _____

Date of Birth: _____ SSN#: _____ Sex: F M

Address: _____ Phone: _____

**PLEASE PROVIDE YOUR PRESCRIPTION COVERAGE CARD IF DIFFERENT FROM THE
INFORMATION PROVIDED ABOVE****Round Mountain Location**

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Medicare Beneficiary Screening

Please answer the following questions ONLY if you have Medicare Insurance

As a direct result of mandated Medicare Secondary Payer (MSP) Regulations, HCCC is required to gather information to determine if Medicare is your primary insurance.

1. Is this visit due to an automobile accident, liability accident or Workman's Compensation? Yes No
2. Is this visit covered by the Black Lung Program, Veterans Administration program or a Government Research Program? Yes No
3. Under 65 and an end stage renal patient in your first 36 months of Medicare entitlement? Yes No
4. If under age 65, is your Medicare coverage due to disability? Yes No
5. Are you covered by a health plan through your employer or spouse's employer? Yes No

=

Office use only:

A. If patient responds "no" to questions 1-5, Medicare is primary.

B. If patient responds "yes" to any questions 1-5 and there is a second insurance (other than "Medicare Supplemental plan, Part D or Medi-Cal), Medicare is secondary and primary insurance information must be obtained.

Payment and Billing Policy

- **You are responsible for all charges incurred on your account.** Payment is expected at time of service for fees that have been determined to be the responsibility of the patient.
- **Medi-Cal/CMSP:** Hill Country accepts Medi-Cal and CMSP. A current card must be presented at each visit.
- **Medicare:** We are required to collect additional information to determine coverage.
- **Insurance Plan:** We are contracted with many but not all insurance carriers. If we don't appear on your insurance carriers provider list this may affect how your insurance plan pays for your care and you may be required to pay at time of service.
- **Payment Methods:** Hill Country Community Clinic accepts cash, personal checks, debit cards, Visa and MasterCard. A \$10.00 service fee will be charged for bounced checks.

A sliding fee discount is available for qualifying patients who are unable to afford care

- I hereby authorize the release of any and all information, acquired in the course of my examination/treatment as required by my insurance carrier.
- I hereby authorize and request the payment of benefits be sent directly to Hill Country Community Clinic for services rendered.
- These assignments will remain in effect until revoked by me in writing. A copy of this agreement is considered as valid as the original.

I have read the above Patient Financial Agreement and agree by signing below.

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Da _____

ADDITIONAL CONSENTS OR DISCLOSURES

Patient Consent for the Release of Information on Voicemail or Answering Machine

I, _____, give my permission for the following normal information (Lab results, Pap test results, Pathology reports, X-ray results) and Referrals, Prescriptions, and Appointment information to be left on the voicemail/answering machine of my choice.

I understand I also have the option to review or request some of this information via the Patient Portal.

Please select all that apply:

- Home Phone: _____
- Work Phone: _____
- Cell Phone: _____
- Other: _____

This authorization is effective until rescinded by myself in writing.

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Parental Delegation of Authority to Seek Health Care Services for Minor Dependent

I, _____ of _____
Parent or Legal Guardian Relationship to Minor

_____ give authorization
Minor Date of Birth

for _____ to bring
Print Name Relationship to Parent/Guardian

minor to **Hill Country Community Clinic** for medical and/or dental treatment in the event that I am unavailable to do so. **This authorization is effective until rescinded by myself in writing.**

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____



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Patient Consent to Obtain Medication History

As a user of an electronic medical record, your Hill Country provider would like to include your medication history in your record. A medication history is a list of prescription medicines that we or other doctors have prescribed for you. This list is collected from several sources, including your pharmacy and your health insurance.

An accurate medication history is **very important** to help us treat you and to avoid potentially dangerous drug interactions.

Your medication history might not include over the counter medicines, supplements or herbal remedies. **It is still very important for us to take the time to discuss everything you are taking**, and for you to tell us about any errors in your medication history.

Please initial your choice and sign below.

_____ **I give permission** for Hill Country Health and Wellness Center to obtain my medication history from my pharmacy, my health insurance (including state and federal benefits programs) and any other healthcare providers or drug and alcohol treatment programs. This information will become part of your electronic medical record, should your provider feel it is important to your medical care.

OR

_____ **I DO NOT give permission** for Hill Country Health and Wellness Center to obtain my medication history from my pharmacy, my health insurance nor my other healthcare providers.

By signing this consent form without making a selection, you are consenting to giving permission to Hill Country Community Clinic to obtain medication history from locations stated above.

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Conflict of Interest Disclosure

If there is anyone employed at Hill Country Community Clinic that you do not want to have access to your medical, dental, or behavioral health records, please list their names and the reason why:

1. _____

2. _____

A representative from our office may contact you for more information. All information disclosed is kept confidential and used only to keep your personal information secure.

HILL COUNTRY HEALTH AND WELLNESS CENTER

Sliding Fee Scale Discount Program

Hill Country (HCCC) offers a "Fee Discount" program. Many individuals qualify for the Sliding Fee Scale Program and can receive low cost health services. To qualify, an individual must meet federal family income criteria.

Requirements of the Sliding Fee Scale program:

1. You must complete the Financial Information/Program Application form annually to determine your eligibility and discount. This information includes:
 - a. Your total household income from all income sources before taxes
 - b. Number of family members living in your household
2. At our discretion, we may require proof of information stated on the Sliding Fee Scale Program application.
3. Your discount may vary if your income changes.
4. Your fee is due at each visit.
5. Sliding Fee Scale payments are refundable whenever HCCC receives payment from the insurance for that date of service.
6. Services offered under the HCCC Sliding Fee Scale program are limited to those deemed medically necessary by appropriate Clinic staff. Cosmetic and elective health services do not qualify for the program.

Important Note: Some services may include additional charges and may not be subject to the discount.
Medical Service Discounts and Exclusions

1. **LAB SERVICES:** If your health care provider orders lab work, (blood or urine test, etc.), you will get a discount if they are basic lab tests performed at HCCC or at any LabCorp facility. There is a fee for all lab charges, payable at the time of the visit. It will be your responsibility to pay 100% of the charge if any other lab is used or for any lab work that must be sent away for testing. The laboratory staff can tell you what the tests will cost.
2. **X-RAY SERVICES:** If your health care provider orders x-rays, you will get a discount only if they are performed at Medical Doctors Imaging (MDI).
3. **SPECIAL STUDIES:** Your health care provider may order special diagnostic studies (such as a sonogram or CT). You will be responsible for 100% of these charges and must make arrangements to pay the facilities that provide them.

Please let us know if you have any questions about our programs or services. We are here to assist you.

If you choose to NOT apply for this program, please check the box below, sign and date.

I choose not to participate in this program. I understand that I will not receive any additional discounts for services that are not covered by my health plan.

Signature: _____ Date: _____

Please complete and sign the other side of this form if you want to participate in the Sliding Scale Program



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Hill Country Health & Wellness Center
Photo Release Form

I hereby give Hill Country Health & Wellness Center consent to record, videotape and photograph my image and/or voice to be used in the following ways:

- Company intranet accessible by employees only
- Company internet accessible via the World Wide Web to anyone
- Printed employee newsletters
- Printed customer newsletter, marketing materials, ads
- Video, audio or photo ads, commercials, marketing
- Cavity Free Club

I understand that photographs and/or video taken of me will be kept confidential and only shared with the appropriate people. My personal information will be kept anonymous if my photograph and/or video are used in a presentation.

I further understand that no special compensation will be provided to me for use of my image and that I may not be informed in advance of the specific use of my image.

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____



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Parent Guidelines

At Hill Country Health and Wellness Center we have your child's best interest at heart. The agreement below will help your child be healthy, safe and happy at his or her next dental visit.

Can I be in the treatment room with my child?

You may choose whether or not you accompany your child to his/her dental appointment. Although we sense that ***some children do better without parents present***, we are open to having you with your child. If you choose to be present, we suggest the following guidelines to improve chances of having a positive outcome.

1. Please be a *silent* observer.

- This allows us to maintain communication with your child.
- Children will normally listen to their parent instead of us and may not hear our guidance.
- You might have incorrect or misleading information.

2. If asked to leave the room, be ready to immediately walk away.

- Many children will try to control the situation.
- "Acting out" is normal, but unacceptable during dental procedures.
- This is intended to "short circuit" the control attempt.
- We will continue to support your child at all times.

3. Please use our terminology:

In order to improve the chances of your child having a positive experience in our office, we are selective in our use of words. We avoid using words that scare children. Please support us by using positive words that are often used for dental care.

These include:

Positive Words
(use these words)

- Sleepy Juice
- Whistle
- Polish Tooth
- Wiggle
- Sugar Bugs
- Tickle Teeth

Negative Words
(do not use these words)

- Needle or Shot
- Drill
- Drill on Tooth
- Pull or Yank Tooth
- Decay or Cavity
- Teeth Cleaning

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

HILL COUNTRY HEALTH AND WELLNESS CENTER SHARED HEALTH INFORMATION PROTECTION POLICY & INFORMED CONSENT

Hill Country's Electronic Health Record system enables our team of health care providers and staff to efficiently share patient information with each other, which means better communication between all of your providers and more comprehensive care for you. **Our goal is to provide you the best possible care, which means that your medical, dental and behavioral health providers will all have access to certain information about your health and treatment.**

Hill Country also shares your health information using the regional Health Information Exchange, SacValley Med Share. This important feature allows your doctors at other locations (such as hospitals and emergency rooms) to quickly access to your health records even when our offices are closed. Hill Country and SacValley MedShare use the highest standards to ensure the safety and privacy of your records in this process. For more information about SacValley MedShare see their website at <http://sacvalleyms.org/>

The items that may be shared with your Hill Country healthcare teams and SacValley MedShare are identified in the follow table:

Hill Country Providers Only

- Physical and Mental health conditions, history, including symptoms and diagnoses, prognoses
- Treatment goals and plan, including medications and other recommendations
- Results of test or other evaluations used to diagnose or develop interventions
- Specific concerns about your health, safety or emergency needs
- Follow up plan, including referrals for other care types or specialties
- Updates regarding your health status, functioning, participation and progress

SacValley MedShare (HIE)

- Allergies, Adverse Reactions
- Problems list
- Medications list
- Vitals Signs
- Encounter codes and procedure codes
- Lab Results

IMPORTANT NOTE ABOUT BEHAVIORAL HEALTH INFORMATION: Other than the information listed above, the specific contents and analysis of conversations between you and your therapist during a psychotherapy session is **not** shared. This information has special protection under the law and a separate consent form must be signed by you before such information can be shared.

Please read the following options carefully and check one box:

I authorize Hill Country Health and Wellness Center to share my health information with my providers at Hill Country **AND** SacValley MedShare as stated above.

OR

I authorize Hill Country Health and Wellness Center to share my health information **ONLY** with my providers at Hill Country. I **DO NOT** allow my records to be shared using SacValley MedShare. Opt-Out form provided _____

Signature _____

Witness (if required) _____

Date _____

For Minors, Signature of Parent /Guardian (please state relationship) _____

Date _____



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