SHENANDOAH ONCOLOGY

Specializing in Cancer Care & Diseases of the Blood

Welcome to Shenandoah Oncology and thank you for choosing us as your Oncology and Hematology provider. Our primary goal is to provide quality medical care which is easily accessible and responsive in your time of need. Whether you are seeing us for Oncology (cancer) or benign Hematology (non-cancer blood) concerns, our staff includes a comprehensive interdisciplinary team of medical and administrative professionals who will strive to exceed your expectations. We aim to ensure your experience with us is as comfortable and as stress free as possible.

At Shenandoah Oncology, we take a team approach to healthcare delivery. Each team consists of a board-certified hematologist oncologist, an office-based nurse practitioner, a dedicated inpatient nurse practitioner, a clinical medical assistant, and a dedicated scheduler. Additionally, we have a licensed social worker on staff who can help guide you through your emotional, social, and family concerns. If needed, you will also be assigned a nurse in our treatment room who specializes in the treatment and care of oncology and hematology patients.

Depending on your diagnosis, you will see either the doctor or office-based nurse practitioner at your first visit. Together, they will develop a plan of care for you that will best meet your individual needs. Your team will also assist in coordinating care with other providers, specialists and community resources as needed.

Enclosed you will find an appointment card with your provider's name, visit date and time. Again, thank you for choosing Shenandoah Oncology.

SHENANDOAH ONCOLOGY, P.C. & VALLEY HEALTH RADIATION ONCOLOGY NEW PATIENT HISTORY FORM

Patient Name: _____ _____
Last First M.I. Today's Date

_____ _____ _____ _____ _____
Referred By DOB Marital Status Height Weight

_____
Sex at Birth

Gender Identify (please check option below that applies):
☐Male ☐Female ☐Female-to-Male ☐Male-to-Female ☐Genderqueer ☐Choose not to disclose ☐Other (please specify here) _____

Sexual orientation ☐ Lesbian ☐ Gay or homosexual ☐Straight or heterosexual ☐ Bisexual ☐ Something else

Sex assigned at birth_____ **Race**_____

Ethnicity_____ **Disability Status**_____ **Preferred language**_____

HISTORY OF PRESENT ILLNESS: Please describe the problem for which you are referred today.

_____

_____

PAST HISTORY: If you need additional space, it is provided on the last page.

Surgeries (with dates)	Medical Conditions

Blood Transfusion History:

☐ Yes ☐ No If yes, when? _____

Reproductive History:

Number of pregnancies _____ Number of children: _____ Age at first pregnancy: _____

Age at first period _____ Age at last period: _____ Are you pregnant now ☐Y ☐N

Hysterectomy: ☐Y ☐N Ovaries removed ☐Y ☐N

Hormone use: ☐Y ☐N Oral contraceptive use ☐Y ☐N

Preventive Health Maintenance: Please provide dates for each answer or write "none"

Circle One: Male OR Female

Last mammogram: _____ Last pneumonia vaccine: _____

Last Pap smear: _____ Last Prostate exam: _____

Last colonoscopy: _____ Last PSA screening: _____

Last bone density scan: _____ Last Flu vaccine: _____

Activity: walking, running, cycling, yoga, swimming, other: _____

How often: daily, twice a week, three times a week, more: _____

SOCIAL HISTORY

Substance	Do you use?	What Type?	How Much?	How Often?	If quit, when?
Alcohol:	☐Y ☐N				
Tobacco:	☐Y ☐N				
Caffeine:	☐Y ☐N				
Recreational Drugs:	☐Y ☐N				

FAMILY HISTORY: **Please list any illnesses in your family including all cancers (i.e. breast cancer, ovarian cancer, etc.) and blood disorders (i.e. anemia, blood clotting disorders, etc.)**

Relationship	Illness	Diagnosis Age	Deceased	Relationship:	Illness	Diagnosis Age	Deceased
Mother:			☐Y ☐N	Brothers:			☐Y ☐N
Father:			☐Y ☐N				☐Y ☐N
Grandmother (P):			☐Y ☐N				☐Y ☐N
Grandfather (P):			☐Y ☐N	Sisters:			☐Y ☐N
Grandmother (M):			☐Y ☐N				☐Y ☐N
Grandfather (M):			☐Y ☐N				☐Y ☐N
				Children:			☐Y ☐N
							☐Y ☐N
							☐Y ☐N

REVIEW OF SYSTEMS

Constitutional		Eyes		ENT/Mouth	
Weight Loss	☐Y ☐N	Double Vision	☐Y ☐N	Ringing in Ears	☐Y ☐N
Poor Energy Level	☐Y ☐N	Vision Loss	☐Y ☐N	Hearing Loss	☐Y ☐N
Fever	☐Y ☐N	Flashing Lights	☐Y ☐N	Oral Ulcers	☐Y ☐N
Chills	☐Y ☐N			Mouth Pain	☐Y ☐N
Night Sweats	☐Y ☐N			Sore Throat	☐Y ☐N
				Difficulty Swallowing	☐Y ☐N
				Hoarseness	☐Y ☐N

Cardiovascular		Respiratory	
Chest Pain	☐Y ☐N	Cough	☐Y ☐N
Palpitations	☐Y ☐N	Wheezing	☐Y ☐N
Fainting Spells	☐Y ☐N	Shortness of Breath	☐Y ☐N
Leg Swelling/Pain	☐Y ☐N	Coughing Blood	☐Y ☐N
Arm Swelling/Pain	☐Y ☐N	Pain with Breathing	☐Y ☐N

Breast		Gastrointestinal	
Mass	☐Y ☐N	Nausea	☐Y ☐N
Pain	☐Y ☐N	Vomiting	☐Y ☐N
Nipple Discharge	☐Y ☐N	Jaundice	☐Y ☐N
Change in Size	☐Y ☐N	Abdominal Pain	☐Y ☐N
Change in Shape	☐Y ☐N	Maroon/Black Stool	☐Y ☐N
		Constipation	☐Y ☐N
		Diarrhea	☐Y ☐N
		Vomiting Blood	☐Y ☐N
		Difficulty Swallowing	☐Y ☐N

Urinary	
Painful Urination	☐Y ☐N
Blood in Urine	☐Y ☐N
Increased Frequency	☐Y ☐N
Loss of Control	☐Y ☐N
Impotence	☐Y ☐N

Gynecological	
Vaginal Discharge	☐Y ☐N
Pelvic Pain	☐Y ☐N
Abnormal Bleeding	☐Y ☐N

Musculoskeletal	
Muscle Pain	☐Y ☐N
Spine Tenderness	☐Y ☐N
Swollen Joints	☐Y ☐N
Joint Redness	☐Y ☐N
Bone Pain	☐Y ☐N

Skin	
Rash	☐Y ☐N
Nodules	☐Y ☐N
Itchiness	☐Y ☐N
Lesions	☐Y ☐N

Neurological	
Confusion	☐Y ☐N
Seizures	☐Y ☐N
Fainting Spells	☐Y ☐N
Tremors	☐Y ☐N
Speech Change	☐Y ☐N
Headache	☐Y ☐N
Abnormal Gait	☐Y ☐N
Weakness	☐Y ☐N
Sensory Change	☐Y ☐N

Psychiatric	
Anxiety	☐Y ☐N
Depression	☐Y ☐N

Endocrine	
Excessive Urine	☐Y ☐N
Excessive Thirst	☐Y ☐N
Hot Flashes	☐Y ☐N
Heat/Cold Intolerance	☐Y ☐N

Hematological	
Nose Bleeds	☐Y ☐N
Bleeding Gums	☐Y ☐N
Easy Bruising	☐Y ☐N

Lymphatic	
Enlarged Lymph Nodes	☐Y ☐N
Swelling in Arms/Legs	☐Y ☐N

Radiation/Chemo History:

Previous Radiation Therapy: ☐ Yes ☐ No If yes, where?_____

Previous Chemotherapy: ☐ Yes ☐ No If yes, where?_____

Patient Preferences:

Do you have any **special** cultural/religious belief/practices you would like the staff to be aware of?	☐ Yes	☐ No
Do you have a durable power of attorney or a living will?	☐ Yes	☐ No
Do you have a current Advanced Directive?	☐ Yes	☐ No
If Yes, please bring a copy in for our records.		
If No, you would like to make an appointment with a Nurse Practitioner to complete your advance directives.	☐ Yes	☐ No
Are there any language barriers that the staff needs to be aware of?	☐ Yes	☐ No
Do you feel unsafe or threatened by anyone?	☐ Yes	☐ No
Do you have any thoughts of hurting yourself or anyone else?	☐ Yes	☐ No

REFERRING PHYSICIANS: Please list all referring physicians and others you are currently seeing.

Physician	Address	Phone Number

PHARMACY: Please list your pharmacy information.

Pharmacy	Address	Phone Number

Are you a veteran? Yes or No If yes, which branch of military did you serve and in what years did you serve? _____

Have you ever accessed the VA for any services? Yes or No If so, what services did you use?

_____

Are you eligible for Veteran's Benefits due to a spouse's military service? Yes or No

ADDITIONAL NOTES: Please use this space to complete any additional notes that were not completed above.

_____

_____

_____

_____

_____

Patient Signature: _____

Patient Printed Name: _____

Date: _____

SHENANDOAH ONCOLOGY
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Current Medication Form

Name: _____
DOB: _____

Pharmacy Name: _____
Address: _____
Phone/Fax: _____

Allergies & Adverse Reactions

Medication	Reaction

Current Medications

Prescription, over-the-counter, and herbal remedies

Medication	Dose	Schedule

Reviewed By: _____ **Date:** _____

SHENANDOAH ONCOLOGY

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Acknowledgment of Receipt of Notice of Privacy Practices

Shenandoah Oncology, P.C. is committed to protecting your privacy and ensuring that your health information is used and disclosed appropriately. This notice of Privacy Practices identifies all potential uses and disclosures of your health information by our practice and outlines your rights with regard to your health information. Please sign the form below to acknowledge that you have received our Notice of Privacy Practices.

I acknowledge that I have received a copy of the Notice of Privacy Practices of Shenandoah Oncology, P.C.

Printed Name: _____ DOB: _____

Signature: _____

Name of Representative (if appropriate):

_____

Signature of Representative (if appropriate):

_____

Shenandoah Oncology, P.C. Use Only

Date acknowledgement received: _____

OR

Reason acknowledgement was not obtained and employee signature:

_____

_____

Signature:_____

AUTHORIZATION FOR RELEASE AND/OR DISCLOSURE OF MEDICAL INFORMATION

Patient Name **Date of Birth**

Please **REQUEST** Medical Information **FROM**:

_____
Person/Organization Name

_____
Address

_____
City, State, Zip Code

_____
Phone Number Fax Number

Please **SEND** Medical Information **TO**:

_____
Person/Organization Name

_____
Address

_____
City, State, Zip Code

_____
Phone Number Fax Number

I hereby authorize _____ to release and/or disclose the medical information as indicated below to the health care provider, entity, or person I have indicated above.

Treatment, payment, enrollment, or eligibility for benefits will not be conditioned on my providing or refusing to provide this authorization.

The health information will be released and/or disclosed for the following purpose(s):

☐ Treatment/Continuing Medical Care (e.g. Other Healthcare Providers, Hospital, Physicians)	☐ Legal purposes (e.g. Attorneys)	☐ Personal Use
☐ Billing or Claims	☐ Insurance (e.g. life insurance application)	☐ Disability Determination
☐ School	☐ Employment	
☐ Other, please specify:		

Check the box which type of information is to be released and/or disclosed:

☐ General Medical Information (from _____ to _____)
☐ Information regarding Specific Treatment (from _____ to _____)
☐ Lab Results (from _____ to _____)
☐ Other, please specify: _____
☐ Entire medical record (including genetic testing, alcohol and/or drug use or sexually transmitted diseases).

This authorization expires on/upon _____
(insert date or event that triggers expiration)

I understand that my health information may be re-disclosed by the persons or organizations receiving my medical information, and that it may no longer be protected by federal or state privacy laws.

I understand that I may revoke this authorization at any time by notifying the disclosing party in writing. Written revocation will not affect any action taken in reliance on this authorization before the written revocation was received.

_____ _____
Signature of Patient Date

If this authorization is signed by a patient's personal representative on behalf of the patient, please complete the following:

_____ _____
Name of Personal Representative Relationship to Patient

SHENANDOAH ONCOLOGY
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SHENANDOAH ONCOLOGY

Specializing in Cancer Care & Diseases of the Blood

Authorization of Release of Medical Information

Date: _____

I hereby authorize Shenandoah Oncology, P.C. to release information from the records of:

_____ _____

Patient Name Street Address

_____ _____

City, State, Zip Code Telephone Number

_____

Date of Birth

_____

Signature of Patient

You may release this information to the following individuals:

_____ _____

Name & Relationship Phone Number

_____ _____

Name & Relationship Phone Number

_____ _____

Name & Relationship Phone Number

SHENANDOAH ONCOLOGY
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ontadaHEALTH
www.ontadahealth.com

Ontada Health: Patient Portal Authorization Form

Our patient portal, Ontada Health, is your link to your health information from your physician. Your health record is always available when you want to see upcoming appointments, lab results, and medications, send a message to your care team, and more. Ontada Health is provided at no cost to you.

Please note, Ontada Health is a separate application from Valley Health's MyChart. Any services you have completed at Valley Heath will not be visible in our portal.

If you choose not to sign up for the portal, you will not have access to it. If you choose to submit this form, you are consenting for Shenandoah Oncology to email you a unique link that you will use to create a password to access your portal. If you are receiving access to the portal; the terms and conditions of the Ontada Health shall apply to this authorization form.

Please write legibly.

Patient Information

Name:_____ Date of Birth:_____
First *Last* *MI*

E-mail Address:_____

*Please ensure the email address you provide is not a duplicate email address in use by another patient here at Shenandoah Oncology.

Authorized User is:
Patient ☐
Patient's Designee ☐

Designee Name:_____ Relationship to Patient:_____
First *Last*

I am: ☐ A new user ☐ Updating my e-mail address ☐ Requesting reactivation of account

Patient Signature:_____ Date:_____

Designee Signature (if applicable): _____ Date:_____

Please look for an email from us within 24 hours of submitting this form.
For your protection, the link is designed to expire within 30 days.

-Office Use Only-

MRN		Staff Initials		Date	

SHENANDOAH ONCOLOGY

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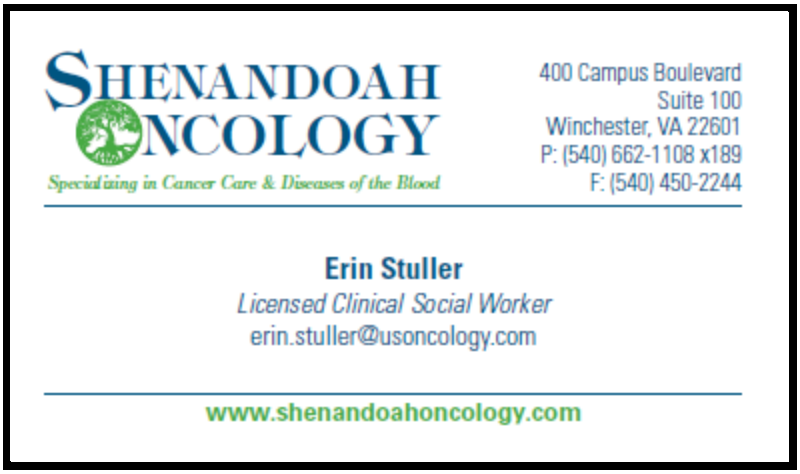
Erin Stuller, LCSW

Erin comes to Shenandoah Oncology, PC with more than 15 years of experience in the medical field. She worked as an LPN for ten years prior to pursuing a Master of Social Work degree from West Virginia University with a focus in clinical practice. Since graduation from WVU, Erin has provided psychotherapy services in primary care and behavioral health settings. At Shenandoah Oncology, PC, Erin can offer supportive counseling to patients and family members struggling to cope with a cancer diagnosis and the subsequent challenges that may arise. Benefits of her services include improved emotional and mental well-being, assistance accessing available resources, and opportunity for reflection. Erin is also available for coordination of care and Advanced Care Planning needs.

- Provides psychosocial support including counseling, information, and resources
- Promotes coordination of care
- Assists with financial guidance (in coordination with the patient financial counselors)
- Offers connections to community resources for transportation, housing and/or expenses
- Facilitates Advance Care Planning discussions
- Guides end of life discussions and hospice referral assistance



Information for Shenandoah Oncology Counseling Clients

We at Shenandoah Oncology strive to provide you with the highest level of professional services to help you and your family cope with cancer. Counseling services are provided by our staff of social workers who specialize in working with people with cancer. The duration of counseling depends on many factors, including type of cancer treatment, the nature of your cancer, and your needs. We generally restrict visits to 6-10 sessions, but your individual therapy plan will be decided by you and your counselor. Services are provided to you free of charge to the patient; insurance will be billed.

The information listed below is important for you to know as you participate in our counseling program.

Client / Counselor Relationship:

1) A plan for therapy will be developed between you and your social worker.
2) If at any time you have treatment concerns, discomfort, or questions regarding your therapy, please discuss them with your social worker.
3) You have the right to refuse treatment at any time, and/or request a referral to another counselor.

Risks and Benefits:

1) Some possible benefits from counseling can include improved personal relationships, reduced feelings of emotional distress, and specific problem solving.
2) Counseling is beneficial, but as with any treatment, there are inherent risks. During counseling you will have discussions about personal issues which may bring to the surface uncomfortable emotions. You may experience an increase in undesirable behaviors, emotional discomfort or temporary worsening of symptoms.
3) While it is important to expect benefits from treatment, please understand due to factors beyond our control, such benefits and desired outcomes cannot be guaranteed.

Confidentiality:

All records and information obtained during your course of counseling will be kept confidential. Your written consent is required to release information except in extreme circumstances. Social Workers, like many healthcare professionals, are mandatory reporters. Exceptions to confidentiality are:

1) If you disclose to us that you have harmed a child or elder by neglect and/or abuse or someone you know has harmed a child/elder, Virginia law requires that your social worker/counselor notify the proper authorities.
2) If evidence exists that you are in danger of hurting yourself or another person, the law requires your social worker/counselor to report this information to the appropriate authorities, including disclosure to a family member, friend, and/or authorities (police).
3) Legal cases when disclosure is requested by court order or when required by Virginia law.
4) Medical emergency.
5) In this clinical setting, counseling notes are documented in the medical chart and can be viewed by staff who have access to the chart.

Cancelling Appointments:

As professionals, we understand that situations come up that require you to cancel an appointment. If you need to cancel your appointment, please let us know 24 hours in advance so that we may allow someone else to use your time spot. Please contact your social worker/counselor directly to cancel an appointment time and let us know if you would like to reschedule.

Voicemail and Emergency Coverage:

Your social workers/counselors have confidential voicemail available for you to leave a message at any time. If you are experiencing a mental health emergency, please call the confidential Concern Hotline for this area at **540-667-0145, 9-1-1, or go to your local hospital emergency room.** Please utilize these numbers for after-hours care, including evenings and weekend. During the work day it is not always possible for your social worker/counselor to be available to you as we see many patients. If you believe you are experiencing a mental health emergency, please call one of the crisis line numbers and notify your social worker of your situation.

I have read, understand, and agree to the patient confidentiality, rights, and policies, as well as their meaning and ramifications provided to me in the Shenandoah Oncology document for new counseling patients.

_____ _____

Client Printed Name DOB

_____ _____

Client Signature Date

_____ _____

Erin Stuller, LCSW, LICSW Date

SHENANDOAH ONCOLOGY
Specializing in Cancer Care & Diseases of the Blood

Nicholas W. Gemma, M.D. Richard M. Ingram, M.D. • William A. Houck, III, M.D. • Lee P. Resta, M.D. Lindsey M. O'Brien, M.D. • M. Page Jones, M.D.
Rodney Huff, MSN, FNP-BC • Jonathan Hanson, MSN, FNP-BC
Risa Barton, MSN, FNP-BC • Kim Applegate, MSN, FNP-BC
Laurie Hudson, MSN, FNP-BC • Kendra Atherton, FNP-BC
540-662-1108 Fax: 540-667-3408

CONSENT TO TELEMEDICINE

By signing this document, you have agreed to receive care using telemedicine. Telemedicine enables health care providers at a different location than yourself to provide safe, effective, and convenient care using technology. There are risks associated with the use of telemedicine, including equipment failure and information security issues. You also understand that we cannot physically examine you.

We at Shenandoah Oncology often prefer face-to-face visits with our patients, however, sometimes the use of telemedicine is safer and more convenient; for example, in the event of an illness, COVID-19, inclement weather, etc.

By signing this document, you agree that you have access to a smart device with video and audio capabilities (such as a tablet, desktop computer, or smartphone) for the telemedicine visit.

Our providers are licensed in Virginia, so by signing this you are agreeing to accurately report your location for the telemedicine visit, which must be in Virginia.

By signing this you endorse understanding the potential risks of telehealth to include, but not limited to, distortion of images resulting from electronic transmission issues, delays in evaluations/treatments due technical difficulties or interruptions, unauthorized access to my information, or loss of information due to technical failures. I will not hold Shenandoah Oncology accountable for such issues or sequelae.

I also endorse understanding that my providers rely on the information provided by me in our telemedicine visit and that I must provide updated/accurate information about my current and past medical history.

If you are determined to be eligible for a telehealth visit, you will be provided information on how to log on to the platform. The use of this platform helps to protect your health information.

_____ _____

Signature of patient or representative Patient's DOB

_____ _____

Printed name of patient of representative Today's Date

Telehealth FAQs

What is telehealth?

- Telehealth is away to visit with a healthcare provider using technology.
- You can talk to your provider from any place, including your home.

How do I use telehealth?

- You talk to your provider by phone, computer, or tablet.
- You use video so you and your provider can see each other.

How does telehealth help me?

- You don't have to go to a clinic to see your provider.
- You won't risk getting sick from other people.

Can telehealth be bad for me?

- You and your provider won't be in the same room, so it may feel different.
- You will not have a full physical exam during a telehealth visit.
- Your provider may decide you still need an office visit in person in our office.
- Technical problems may interrupt or stop your visit before you are done (see consent for additional risks).

Will my telehealth visit be private?

- If people are close to you, they may hear something you did not want them to know. You should be in a private place, so other people cannot hear you.
- We use telehealth technology that is designed to protect your privacy.
- If you use the Internet for telehealth, use a network that is private and secure.
- There is a very small chance that someone could use technology or hear or see your telehealth visit.

How much does a telehealth visit cost?

- What you pay depends on your insurance, but a telehealth visit will not cost any more than an office visit.
- If your provider decides you need an office visit in addition to your telehealth visit, you may have to pay for both visits.

ATTENTION: If you speak Spanish, Korean, Vietnamese, Chinese, Arabic, Tagalog, Persian, Amharic, Urdu, French, Russian, Hindu, German, or Bengali, language assistance services, free of charge, are available to you. Call Front Office Supervisor at 540-662-1108

Atención: Si usted habla español, Coreano, vietnamita, Chino, Árabe, neerlandés, persa, amárico, Urdu, Francés, Ruso, hindú, alemán o bengalí, servicios de asistencia de idioma, de forma gratuita, están disponibles para usted. Llame al Supervisor de recepción en 540-662-1108

주의: 만약 당신이 말하는 스페인어, 한국어, 베트남어, 중국어, 아랍어, 타갈로그어, 페르시아어, Amhric, Urda, 프랑스어, 러시아어, 힌두교, 독일어, Dengali, 또는 크루, 언어 지원 서비스, 무료로, 당신이 사용할 수 있습니다. 티파니 Front Office Supervisor tai 540-662-1108에서 호출

Chú ý: Nếu bạn nói tiếng Tây Ban Nha, Hàn Quốc, Việt Nam, Trung Quốc, tiếng ả Rập, tiếng Tagalog, tiếng Ba tư, tiếng Amhara, tiếng Urdu, Pháp, Nga, Hindu, Đức hoặc tiếng Bengali, Dịch vụ hỗ trợ ngôn ngữ, miễn phí, có sẵn cho bạn. Gọi cho văn phòng mặt trận giám sát viên tại 540-662-1108

注意:**如果您**讲西班牙语、韩语、越南语、中文、阿拉伯语、塔加禄语、波斯语、阿姆法语、乌尔都语、法语、俄语、印度语、德语或孟加拉语,**您可以免**费获得语言协助服务。 **致**电前台主管 540-662-1108

تنبيه: إذا كنت أتكلم الإسبانية الكورية، الفيتنامية، الصينية، العربية، التغالوغيه، الفارسي، الأمهرية، الأردية، الفرنسية، الروسية، الهندوسية، أو الألمانية أو البنغالية، خدمات المساعدة اللغوية، مجاناً، تتوفر لك. استدعاء المشرف على مكتب الجبهة في 540-662-1108

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa Front Office Supervisor (540) 662-1108

ትኩረት: እናንተ ስፓንኛ መናገር ከሆነ, ኮሪያኛ, ቬትናምኛ, ቻይንኛ, አረብኛ, ታጋሎግ, የፋርስ, አማርኛ, Urda, ፈረንሳይኛ, ሩሲያኛ, የሂንዱ, ጀርመንኛ, ቤንጋሊ, ወይም Kru, የቋንቋ እርዳታ አገልግሎቶች, ከክፍያ ነፃ, ለእርስዎ የሚገኙ ናቸው. 540-662-1108 ላይ ቲፋኒ Front Office Supervisor ይደውሉ

توجه: اگر اسپانیایی کره ای، ویتنامی، چینی، عربی، تاگالوگی، فارس، امهری، اردو، فرانسوی، روسی، هندو، آلمانی یا بنگالی حرف زبان خدمات امداد، رایگان، به شما در دسترس هستند. سرپرست دفتر جلو در 540-662-1108 تماس بگیرید

ATTENTION : Si vous parlez espagnol, coréen, vietnamien, chinois, arabe, Tagalog, persan, amharique, ourdou, Français, russe, hindou, allemand, Bengali ou Kru, services d'assistance linguistique, gratuites, sont à votre disposition. Front Office Supervisor appel à 540-662-1108

ВНИМАНИЕ: Если вы говорите, испанский, корейский, вьетнамский, китайский, арабский, тагальский, Персидский, Турецкий, урду, французский, Русский, индуистской, немецкий, бенгальский или КРУ, языковых служб помощи, бесплатно, доступны для вас. Бриден Front Office Supervisor звонка в 540-662-1108

ध्यान: यदि आप स्पेनिश, कोरियाई, वियतनामी, चीनी, अरबी, तागालोग, फारसी, Amharic, उर्दू, फ्रेंच, रूसी, हिंदू, जर्मन, या बंगाली, भाषा सहायता सेवाओं, नि: शुल्क बोलते हैं, आप के लिए उपलब्ध हैं। 540-662-1108 पर फ्रंट कार्यालय पर्यवेक्षक कॉल करें

Achtung: Wenn Sie Spanisch, Koreanisch, Vietnamesisch, Chinesisch, Arabisch, Tagalog, Persisch, Amharisch, Urdu, Französisch, Russisch, Hindu, Deutsch oder Bengali sprechen, sind Sprache Assistance-Leistungen, unentgeltlich zur Verfügung. Rufen Sie Front-Office Supervisor bei 540-662-1108

দৃষ্টি আকর্ষণ: স্প্যানিশ, কোরিয়ান, ভিয়েতনামি, চাইনিজ, আরবি, ট্যাগালোগ, পারস্য, আমহারিক, উর্দু, ফরাসি, রুশ, হিন্দু, জার্মান বা বাংলা কথা বলে। তবে ভাষা সহায়তা, ফ্রি, তোমার কাছে পাওয়া যায়। ফ্রন্ট অফিসের পরিদর্শক 540-662-1108 এ কল