



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

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:	_____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N	Brothers:	_____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N
Father:	_____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N		_____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N
Grandmother (P):	_____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N		_____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N
Grandfather (P):	_____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N	Sisters:	_____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N
Grandmother (M):	_____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N		_____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N
Grandfather (M):	_____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N		_____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N
				Children:	_____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N
					_____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N
					_____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N

REVIEW OF SYSTEMS

Constitutional		Breast		Skin	
Weight Loss	<input type="checkbox"/> Y <input type="checkbox"/> N	Mass	<input type="checkbox"/> Y <input type="checkbox"/> N	Rash	<input type="checkbox"/> Y <input type="checkbox"/> N
Poor Energy Level	<input type="checkbox"/> Y <input type="checkbox"/> N	Pain	<input type="checkbox"/> Y <input type="checkbox"/> N	Nodules	<input type="checkbox"/> Y <input type="checkbox"/> N
Fever	<input type="checkbox"/> Y <input type="checkbox"/> N	Nipple Discharge	<input type="checkbox"/> Y <input type="checkbox"/> N	Itchiness	<input type="checkbox"/> Y <input type="checkbox"/> N
Chills	<input type="checkbox"/> Y <input type="checkbox"/> N	Change in Size	<input type="checkbox"/> Y <input type="checkbox"/> N	Lesions	<input type="checkbox"/> Y <input type="checkbox"/> N
Night Sweats	<input type="checkbox"/> Y <input type="checkbox"/> N	Change in Shape	<input type="checkbox"/> Y <input type="checkbox"/> N		
Eyes		Gastrointestinal		Neurological	
Double Vision	<input type="checkbox"/> Y <input type="checkbox"/> N	Nausea	<input type="checkbox"/> Y <input type="checkbox"/> N	Confusion	<input type="checkbox"/> Y <input type="checkbox"/> N
Vision Loss	<input type="checkbox"/> Y <input type="checkbox"/> N	Vomiting	<input type="checkbox"/> Y <input type="checkbox"/> N	Seizures	<input type="checkbox"/> Y <input type="checkbox"/> N
Flashing Lights	<input type="checkbox"/> Y <input type="checkbox"/> N	Jaundice	<input type="checkbox"/> Y <input type="checkbox"/> N	Fainting Spells	<input type="checkbox"/> Y <input type="checkbox"/> N
		Abdominal Pain	<input type="checkbox"/> Y <input type="checkbox"/> N	Tremors	<input type="checkbox"/> Y <input type="checkbox"/> N
		Maroon/Black Stool	<input type="checkbox"/> Y <input type="checkbox"/> N	Speech Change	<input type="checkbox"/> Y <input type="checkbox"/> N
		Constipation	<input type="checkbox"/> Y <input type="checkbox"/> N	Headache	<input type="checkbox"/> Y <input type="checkbox"/> N
		Diarrhea	<input type="checkbox"/> Y <input type="checkbox"/> N	Abnormal Gait	<input type="checkbox"/> Y <input type="checkbox"/> N
		Vomiting Blood	<input type="checkbox"/> Y <input type="checkbox"/> N	Weakness	<input type="checkbox"/> Y <input type="checkbox"/> N
		Difficulty Swallowing	<input type="checkbox"/> Y <input type="checkbox"/> N	Sensory Change	<input type="checkbox"/> Y <input type="checkbox"/> N
ENT/Mouth		Urinary		Psychiatric	
Ringing in Ears	<input type="checkbox"/> Y <input type="checkbox"/> N	Painful Urination	<input type="checkbox"/> Y <input type="checkbox"/> N	Anxiety	<input type="checkbox"/> Y <input type="checkbox"/> N
Hearing Loss	<input type="checkbox"/> Y <input type="checkbox"/> N	Blood in Urine	<input type="checkbox"/> Y <input type="checkbox"/> N	Depression	<input type="checkbox"/> Y <input type="checkbox"/> N
Oral Ulcers	<input type="checkbox"/> Y <input type="checkbox"/> N	Increased Frequency	<input type="checkbox"/> Y <input type="checkbox"/> N		
Mouth Pain	<input type="checkbox"/> Y <input type="checkbox"/> N	Loss of Control	<input type="checkbox"/> Y <input type="checkbox"/> N		
Sore Throat	<input type="checkbox"/> Y <input type="checkbox"/> N	Impotence	<input type="checkbox"/> Y <input type="checkbox"/> N		
Difficulty Swallowing	<input type="checkbox"/> Y <input type="checkbox"/> N				
Hoarseness	<input type="checkbox"/> Y <input type="checkbox"/> N				
Cardiovascular		Gynecological		Endocrine	
Chest Pain	<input type="checkbox"/> Y <input type="checkbox"/> N	Vaginal Discharge	<input type="checkbox"/> Y <input type="checkbox"/> N	Excessive Urine	<input type="checkbox"/> Y <input type="checkbox"/> N
Palpitations	<input type="checkbox"/> Y <input type="checkbox"/> N	Pelvic Pain	<input type="checkbox"/> Y <input type="checkbox"/> N	Excessive Thirst	<input type="checkbox"/> Y <input type="checkbox"/> N
Fainting Spells	<input type="checkbox"/> Y <input type="checkbox"/> N	Abnormal Bleeding	<input type="checkbox"/> Y <input type="checkbox"/> N	Hot Flashes	<input type="checkbox"/> Y <input type="checkbox"/> N
Leg Swelling/Pain	<input type="checkbox"/> Y <input type="checkbox"/> N			Heat/Cold Intolerance	<input type="checkbox"/> Y <input type="checkbox"/> N
Arm Swelling/Pain	<input type="checkbox"/> Y <input type="checkbox"/> N				
Respiratory		Musculoskeletal		Hematological	
Cough	<input type="checkbox"/> Y <input type="checkbox"/> N	Muscle Pain	<input type="checkbox"/> Y <input type="checkbox"/> N	Nose Bleeds	<input type="checkbox"/> Y <input type="checkbox"/> N
Wheezing	<input type="checkbox"/> Y <input type="checkbox"/> N	Spine Tenderness	<input type="checkbox"/> Y <input type="checkbox"/> N	Bleeding Gums	<input type="checkbox"/> Y <input type="checkbox"/> N
Shortness of Breath	<input type="checkbox"/> Y <input type="checkbox"/> N	Swollen Joints	<input type="checkbox"/> Y <input type="checkbox"/> N	Easy Bruising	<input type="checkbox"/> Y <input type="checkbox"/> N
Coughing Blood	<input type="checkbox"/> Y <input type="checkbox"/> N	Joint Redness	<input type="checkbox"/> Y <input type="checkbox"/> N		
Pain with Breathing	<input type="checkbox"/> Y <input type="checkbox"/> N	Bone Pain	<input type="checkbox"/> Y <input type="checkbox"/> N		
				Lymphatic	
				Enlarged Lymph Nodes	<input type="checkbox"/> Y <input type="checkbox"/> N
				Swelling in Arms/Legs	<input type="checkbox"/> Y <input type="checkbox"/> 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, would you 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

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: _____



Current Medication Form

Name: _____

DOB: _____

Pharmacy Name:

Address: _____

Phone/Fax: _____

Allergies & Adverse Reactions

Medication	Reaction

Current Medications

Prescription, over-the-counter, and herbal remedies

[illegible]

Reviewed By:

Date: _____



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 TO DISCLOSE AND/OR RELEASE MEDICAL INFORMATION

Patient Name

Date of Birth

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

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

Person/Organization Name

Person/Organization Name

Address

Address

City, State, Zip Code

City, State, Zip Code

Phone Number

Fax Number

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):

<input type="checkbox"/> Treatment/Continuing Medical Care (e.g. Other Healthcare Providers, Hospital, Physicians)	<input type="checkbox"/> Legal purposes (e.g. Attorneys)	<input type="checkbox"/> Personal Use
<input type="checkbox"/> Billing or Claims	<input type="checkbox"/> Insurance (e.g. life insurance application)	<input type="checkbox"/> Disability Determination
<input type="checkbox"/> School	<input type="checkbox"/> Employment	
<input type="checkbox"/> 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



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

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 Health 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	
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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





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. • Michael G. McCusker, M.D.
Christian M. Barlow, M.D. • Kristine G Reed, 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
Lee Staley, FNP-BC • Jill Defibaugh, FNP-BC
Jessica Fauver, FNP-C
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 Date of Birth

Printed name of patient or 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 à 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، التغالوغي، الفارسي، الأمهرية، الأردنية، 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 ስንገኛ መናገር ከሆነ, ኮሪያኛ, ቪትናምኛ, 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 ተፋኒ 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. Бريدن 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

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