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

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, 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: _____

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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 TO DISCLOSE AND/OR RELEASE 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

400 Campus Boulevard, Suite 100
Winchester, VA 22601
P: (540) 662-1108
F: (540) 667-3408
www.shenandoahoncology.com

Specializing in Cancer Care & Diseases of the Blood

At **Shenandoah Oncology**, we are committed to alleviating the financial burden on our patients. Our dedicated team will diligently work to review and enroll eligible patients in various patient assistance programs. These programs are designed to provide financial relief by offering free or reduced-cost treatments. We strive to ensure that our patients have access to the necessary resources and support, allowing them to focus on their health and well-being without the added stress of financial concerns. Rest assured; we will explore all available options to assist you in managing your healthcare expenses.

AUTHORIZATION AND ATTESTATION FOR FINANCIAL ASSISTANCE

I understand that **Shenandoah Oncology** and its affiliates (including *The US Oncology Network and Annexus Health*) are acting solely as agents to help me find and apply for appropriate financial assistance, either in the form of free or reduced-cost treatment. In order for **Shenandoah Oncology** and its affiliates to provide me with financial assistance, I understand that they will need to obtain, review, use, and/or disclose my personal health information (PHI), information relating to my medical condition, and information that I otherwise provide to **Shenandoah Oncology** and its affiliates, including my name, address, and other personal identifying information.

I authorize **Shenandoah Oncology** to use my personal health information to complete phone, electronic or hardcopy applications and to sign online applications on my behalf to determine my eligibility. I also authorize my physician, pharmacy, insurance companies, and health plan(s) to disclose my personal health information to **Shenandoah Oncology** and its affiliates as necessary to complete applications on my behalf or to verify information on my application.

I understand that my physician and **Shenandoah Oncology** do not determine my eligibility for assistance. Eligibility for assistance is determined by the sponsors of the charitable foundations or product manufacturers (“Programs”) and is contingent upon the eligibility criteria set forth by the program. I understand that the charitable foundations and product manufacturers (“Programs”) may perform a “soft credit check” to obtain confirmation of household reported income.

By authorizing **Shenandoah Oncology** to submit my application, I attest that I understand and agree to the below statements.

- I understand **Shenandoah Oncology** and/or their affiliates may contact me to obtain any additional information needed to complete an application.
- I understand that the Program sponsor may request documentation to verify the accuracy of any information that I may provide for the application, including verification of my household income.
- If I do not provide documentation or information as requested by the Program, or if the Program determines I do not meet the Program eligibility requirements, my participation and all assistance may be terminated.
- I understand that all assistance from Programs is subject to availability of funds at the time funds are requested and that this Authorization is not a guarantee that I will receive or obtain any financial assistance.
- I agree that all information I provide to **Shenandoah Oncology** and applicable Programs, to the best of my knowledge, is true, accurate, and complete, and I will notify **Shenandoah Oncology** and any relevant Program of any changes to the information I provide.
- I agree and authorize **Shenandoah Oncology** and the Assistance Program Sponsor(s) to disclose, obtain, and discuss my medical, treatment, therapy, financial, and other personal information relating to my application with my providers, pharmacy, insurance company, and other organizations working on my behalf to obtain eligible treatment.
- I understand that my protected health information disclosed to Shenandoah Oncology, to a Program, or under an applicable application for my financial assistance may be re-disclosed by recipients of my health information for the purposes described in this Authorization and may no longer be protected by privacy laws, such as HIPAA.

- I understand that if I have applied for assistance elsewhere, I must disclose this to any other Foundation or Patient Assistance Program that approves me for funds or drug product.
- I understand that there is no fee or charge for this support service.
- I understand that the Program can at any time, and without notice, modify or discontinue all or any part of the Program and/or any assistance provided to me. The financial assistance or free product provided by any Program may not cover my entire liability for treatment. Some Programs limit assistance to the specific drugs that treat or cover only certain conditions. Should additional assistance be needed for continuity of treatment, I understand that **Shenandoah Oncology** will complete and submit applications to secondary Programs or submit renewal applications on my behalf.
- I understand and acknowledge that if I do not sign or provide this Authorization, my physician or **Shenandoah Oncology** cannot withhold or condition my healthcare or treatment based on my decision to not sign or provide this Authorization.
- I understand that this authorization is valid for 12 months. I (or my legally authorized representative) may cancel this Authorization at any time by mailing a written request for such cancellation to **Shenandoah Oncology**. However, I understand that any cancellation will not apply to any information already used or disclosed pursuant to this Authorization. I understand that I may request a copy of this Authorization once it has been signed.
- If applicable, I consent to the use of electronic signatures to complete, sign, and deliver this Authorization and agree that my electronic signature is as valid as if I signed the document in writing.

Patient Name (*print*): _____
Patient DOB: _____

PLEASE SIGN <u>ONE</u> OF THE SECTIONS BELOW

I agree and certify that I have read, understood, and will abide by the above attestation and authorize Shenandoah Oncology to proceed with applying for assistance on my behalf.

Effective Date: _____
Signature of Patient/Legally Authorized Representative: _____
Relationship to Patient (if Patient is not siging): _____

I choose to decline and/or retract my authorization for Shenandoah Oncology and the above listed affiliates to proceed with applying for assistance on my behalf.

Effective Date: _____
Signature of Patient/Legally Authorized Representative: _____
Relationship to Patient (if Patient is not siging): _____

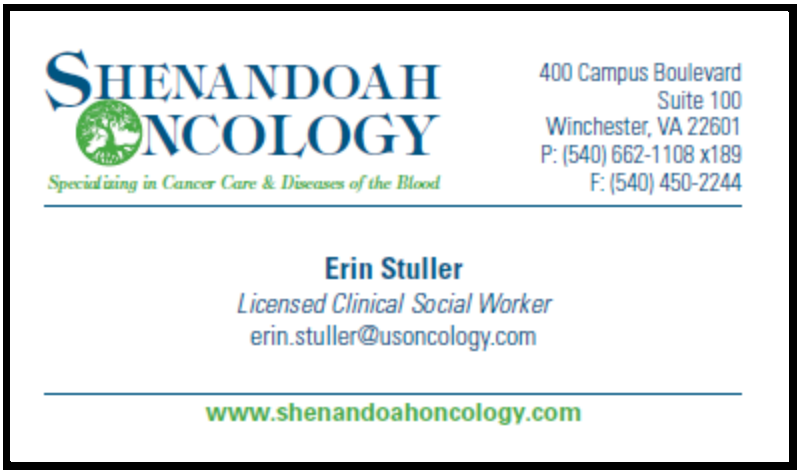
SHENANDOAH ONCOLOGY

Specializing in Cancer Care & Diseases of the Blood

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



SHENANDOAH ONCOLOGY
Specializing in Cancer Care & Diseases of the Blood

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 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