FAMILY CARE CENTER
THOMAS KELLY DO
KHRISTINA COKER FNP-C
1500 S MAIN ST
EATON RAPIDS MI 48827
PH:517-663-2705
Fax:517-663-9470

Enclosed please find the New Patient information that needs to be filled out completely and brought with you at the time of your appointment. (You could also drop it off at the office prior to your appointment.)

At the time of your appointment we will need to have your Insurance Card, Prescription Card and Driver's License presented with your paperwork.

If this paper work is not presented at the time of your appointment, or is not completely filled out, we will have to reschedule your appointment to the next available opening.

Thank you for your assistance.

Family Care Center Staff

PATIENT MEDICAL HISTORY

THOMAS KELLY, DO; ABEM
1500 S Main St
Eaton Rapids, MI 48827
Telephone #: 517-663-2705

TODAY'S DATE: ___/___/___
NAME: ____________________
DOB: ___/___/___
Age: __________
Sex: Male ( ) Female ( )

What are the health concerns which brought you to see the doctor?

____
____
____
____

CURRENT MEDICATIONS

List all medication you are taking now including those you buy without a doctor's prescription (i.e., aspirin or cold tablets). **If none check here____**

NAME OF MEDICATION STRENGTH OF MEDICATION	HOW MANY TIMES A DAY	HOW LONG
1.		
2.		
3.		
4.		
5.		

***If this medication list does not match the medication list given during the new patient screening process, then the physician has the right to refuse you as a patient.**

ALLERGIES AND SENSITIVITIES

List anything you are allergic to such as certain foods, medication, dust, chemicals or soaps, household items, pollen, bee stings etc...; **If none check here____**

ALLERGIC TO	REACTION	ALLERGIC TO	REACTION
1.		3.	
2.		4.	

IMMUNIZATIONS

Are you up to date with your immunization: Yes___ No____

IMMUNIZATION	YEAR OF BOOSTER
Hepatitis	
Pneumonia	
TB Test	
Tetanus	
Zostavax (Shingle vaccine)	

CURRENT MEDICAL PROBLEMS

Are you being treated for any other illnesses or medical problems by another physician?
If none check here____.

ILLNESS OR MEDICAL PROBLEM	PHYSICIAN TREATING YOU

HOSPITALIZATIONS/ SURGERIES

If none check here____

OPERATION/ ILLNESS	YEAR	WHICH HOSPITAL

ILLNESSES AND MEDICAL PROBLEMS

Please mark with an (X) any of the following illnesses and medical problems you have or have had and indicate the year when each started. If you are not certain when an illness started, write down an approximate year. **If none check here____**

ILLNESS	(X)	YEAR	ILLNESS	(X)	YEAR
AIDS/ Positive HIV			Heart Murmur		
Allergies			Hepatitis		
Anemia			High Blood Pressure		
Arthritis			High Cholesterol		
Asthma			Kidney/ Bladder Diseases		
Bleeding Disorder			Mental Illness		
Cancer or Tumor			Migraine Headaches		
Colitis			Mononucleosis		
Convulsions or Seizures			Pneumonia		
Diabetes			Rheumatic Fever		
Eating Disorders			Stomach Ulcers		
Heart Disease			Thyroid Problem		

WOMEN ONLY	(X)	YEAR	MEN ONLY	(X)	YEAR
Abnormal Pap Test			Cancer of Prostate		
Cancer of Breast, Cervix, Ovary, Uterus or Vagina			Hernia		
Endometriosis			Lump in testicles		
Irregular Menstruation			Pain in testicles		
Menopause			Problems with Erection		

SOCIAL HISTORY/ HABITS

1. Do you live alone? Yes __ No __ If no, do you live with: Spouse __ Children __ Other __

2. Do you work? Yes __ No __ # of hours per week ____

3. Do you smoke cigarettes? Yes __ No __ Packs per day ____
   Have you ever smoked? Yes __ No __ # of years you have smoked ____
   Do use any form of tobacco? Yes __ No __ If already quit when? ______

4. Do you consume coffee/ soda? Yes __ No __ Amount _________/day / week /

5. Do you consume alcoholic beverages? Yes __ No __ Amount _________/day / week / month

6. Do you use recreational drugs? Yes __ No __ Amount /Name:_________

7. Do you exercise 2+ times per week? Yes __ No __

8. History of sexual assault or abuse? Yes__ No __

9. Have you ever been sexually active? Yes __ No __

   -If yes, with: men __ women __ or both __

10. Do you use seatbelts while riding or driving a vehicle? Yes__ No__
11. Do you use helmet while riding bicycle? Yes__ No__
12. Do you have an Advanced Directive? Yes__ No__ if no, you may obtain information from us of at www.michbar.org/elderlaw/adpamphlet.cfm

FAMILY HEALTH

Please give the following information about your immediate family.

RELATIONSHIP	AGE IF LIVING	AGE AT DEATH	STATE OF HEALTH OR CAUSE OF DEATH
Father:			
Mother:			
Siblings:			
Spouse:			
Children			

SYSTEM REVIEW: Put an 'X' next to each symptom you have now. Fill in the blank spaces.

GENERAL:
☐ Chills, Fever
☐ Night sweats
☐ Change in weight
☐ Change in appetite
☐ Fainting spells
☐ Fatigue
☐ Swollen lymph nodes

SKIN:
☐ Rash or hives
☐ Change in color of mole

NERVOUS SYSTEM:
☐ Frequent, severe headaches
☐ Dizziness
☐ Double vision
☐ Numbness
☐ Loss of coordination
☐ Seizures

LUNGS:
☐ Persistent cough
☐ Wheezing
☐ Shortness of breath
☐ Problem breathing at night or when lying down
☐ Spitting up blood
☐ Positive TB test
- Last chest x-ray date: ___/___/___

HEART:
☐ Chest Pain
☐ Palpitations (heart racing)
☐ Irregular heartbeat/skipping a beat
☐ Heart murmur

GASTROINTESTINAL:
☐ Stomach pain/abdominal pain
☐ Indigestion/heartburn
☐ Difficulty swallowing
☐ Vomiting/Nausea
☐ Changes in bowel habits
☐ Blood in stools

URINARY:
☐ Pain/burning on urination
☐ Blood in urine
☐ Frequent urination
☐ Previous infections
☐ Kidney stones

EYES:
☐ Glasses/Contacts
☐ Eye pain
☐ Change in vision
- Last eye exam date ___/___/___

EARS:
☐ Loss of hearing
☐ Ringing
☐ Drainage

NOSE/THROAT/SINUSES:
☐ Hoarseness
☐ Nasal stuffiness or runny nose
☐ Sinus pressure/infection
☐ Sore throat

MOUTH:
☐ Bleeding gums
☐ Toothache
- Last dental exam ___/___/___

JOINTS & BACK:
☐ Pain
☐ Swelling
☐ Stiffness
☐ Deformity

MUSCLES:
☐ Pain
☐ Weakness
☐ Twitching

ENDOCRINE:
☐ Heat/Cold intolerance
☐ Excessive thirst
☐ Excessive hunger

BLOOD
☐ Easy bruising
☐ Anemia

PSYCHOLOGICAL:
☐ Nervousness/anxiety
☐ Depression
☐ Unable to sleep
☐ Memory loss

FEMALE:
☐ Vaginal itching or burning
☐ Vaginal Discharge
☐ Problem with menstrual periods
☐ Last menstrual period date: __________
☐ Last Pap smear date: ______________
☐ Lumps in breast
☐ Discharge from nipple
- Last mammogram date: ___/___/___

Menstrual History:
- Age menses began: __
- # of days between cycles: __
- Number of days of menstrual flow: __

☐ Severe menstrual cramps
☐ Pain with intercourse
☐ Any bleeding between periods

SEXUAL HISTORY:
☐ Sexually transmitted disease
☐ Sexual difficulties
☐ Condom use: Yes No

SLEEP:
☐ Snoring
☐ Not feeling fresh on awakening in the morning
☐ Unusual movement or behavior during sleep

MALE:
☐ Hernia
☐ Discharge from penis
☐ Pain in testicles
☐ Lump in testicles
☐ Problems with Erection

Our mutual goal is to keep you in the best possible health. In order to achieve that we need your cooperation to do the following:

1. Regular exercise at least 5 days a week equivalent to 2 miles of brisk walking at a speed of 4 miles/hr.
2. Drink plenty of ice cold water, about 2 quarts/day, unless advised to do otherwise. Avoid high calorie nutrient poor beverages (e.g., soda, fruit punch, etc.)
3. Try to maintain ideal body weight to avoid complications related to being overweight.
4. If you smoke cigarettes you are advised to quit as soon as possible. Even exposure to second-hand cigarette smoke is harmful so you should try to minimize that exposure.
5. If you drink alcohol, you are advised to limit your consumption to ≤ 2 drinks/day if you are a male or ≤1 drinks/day if you are a female.
6. Always try to have 7-8 hours of sleep per night.
7. Use a seatbelt when riding in or driving a vehicle.
8. Wear a helmet when riding a bicycle.
9. Poison prevention: Keep National Poison Control numbers readily accessible; use child resistant containers; dispose of expired and unused medications.
10. Burn prevention: Install smoke and carbon monoxide detectors and test them bi-annually.
11. Injury prevention: Safely store firearms out of the reach of children.
12. And finally, always find a reason to smile and laugh and be helpful to others!

MEDICAL PROVIDER COMMENTS

____

____

____

____

____

____

I did review the above information in detail:	**I did review the above information with the patient in detail:**
______________________	______________________
Patient Signature	**Physician Signature**

THOMAS A KELLY DO, KHRISTINA COKER FNP-C
PATIENT INFORMATION
(PLEASE PRINT)

Patient Information

Patient's Name: ____ Sex: ☐M ☐F
(Last) (First) (M)

Address: ____________________ City: ____________________ State: ______ Zip Code: __________

Home Phone #: (____) ______________ Cell Phone # (____) ______________ Employer: ____________________

Work Phone #: (____) ______________ Ext: ______ Email address: ______________________________

Social Security #: ____________________ Date of Birth: ______________ Marital Status: ☐M ☐D ☐S ☐W ☐Sep

Spouse's Name: ______________________________ Cell Phone #: (____) ______________

Work Phone #: (____) ______________ Ext: ______ Employer: ______________________________

Spouse's Date of Birth: ______________ Social Security #: ______________________________

Nearest Relative not living with you: ______________________________ Phone: (____) ______________

Cell Phone: (____) ______________

Nearest friend not living with you: ______________________________ Phone: (____) ______________

Cell Phone: (____) ______________

Whom may we contact in the case of an emergency? ______________________________ Phone: (____) ______________

Cell Phone: (____) ______________

Legal Guardian Information

Name: ______________________________ Relationship: __________ Date of Birth: ______________
(Last) (First) (M)

Address: ____________________ City: ____________________ State: ______ Zip Code: __________

Home Phone # :(____) ______________ Cell Phone #: (____) ______________ Work # :(____) ______________ Ext______

Social Security #: ____________________ Employer: ______________________________

Did you sustain an injury at work? Y N **<u>If you marked "yes", please see Receptionist for Worker's Compensation Form that must be filled out for us to bill this.</u>**

Are your injuries accident related? Y N **<u>If you marked "yes", please see Receptionist for Auto Form that must be filled out for us to bill this</u>**

Are you covered under an employer or union policy? Y N **Is your spouse or other family member employed? Y N**

Are you currently employed: Y N **Do you have a secondary insurance policy? Y N**

Are you covered under any other health care plan? Y N

I am a new patient to this practice and am in a preexisting provision with my insurance carrier. Y N

Who is responsible for this bill? ______________________________

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on both sides of this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

Patient/Legal Guardian Signature: ______________________________ Date: ______________

Thomas Kelly DO, Khristina Coker FNP-C
1500 S Main St
Eaton Rapids MI 48827
517-663-2705

PATIENT NAME: ____
(PLEASE PRINT)

CONSENT FOR TREATMENT, FINANCIAL AUTHORIZATION, RELEASE OF INFORMATION

1. Consent to Treatment: I hereby voluntarily request ,consent to and authorize the physician, his/her associates, assistants or other practitioners to provide medical and minor surgical treatment, including but not limited to diagnostic procedures, medication administration, physical examination and screening services, including drug/alcohol screening, as is deemed necessary and advisable. I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me as to the results or examination and treatment, which I have hereby authorized.

2. Authorization to release information: I recognize that the doctors may release information from my medical record including: information about communicable diseases and serious communicable diseases and infections as defined by statute and Michigan Department of Public Health rules (which include Venereal Disease, Tuberculosis, Hepatitis B, Human Immunodeficiency virus, Acquired immunodeficiency Syndrome, and Aids related complex): substance abuse treatment information protected by 42 Code of Federal Regulations Part 2; psychological and social services information including communications made by me to a psychologist or social worker to:
    a. Any third party payor, or insurance company or other individual who may be responsible in whole or in part for paying my physicians bill so that the physician may be paid for their services: and any independent auditors/reviewers retained by any third party payor, private health insurers or any employer providing health insurance benefits to me so that these independent auditors can analyze the physicians charges as is necessary to obtain payment for the services and required review or audit of that payment by the payor.
    b. Any health care facility or physician to which I am referred for continuity of care.

With respect to substance abuse information (if any), this consent may be revoked at any time, unless the Physician has already released information in reliance upon it, or if payment for services rendered would be interrupted by such revocation.

3. Statement to Permit Payment: I assign and authorize direct payment of all health care benefits and other forms of payment of any kind which relate to the care provided to me by the physician for application to my bill. I assume full financial responsibility for payment of all expenses associated with my care and treatment, including any portion of physician charges not paid by insurance or worker's compensation, and agree to pay the same. I have been given the opportunity to pay my estimated deductible and co-insurance at the time of service. I have chosen to assign the benefits, knowing that the claim must be paid within all state or federal prompt payment guidelines. I will provide all relevant and accurate information to facilitate the prompt payment of the claim by my insurance. I also understand that if the insurance company should send the payment to me, I will forward the payment to the physician within 48 hours. I agree that if I fail to send the payment to the provider and they are forced to proceed with the collections process; I will be responsible for any cost incurred by the office to retrieve their monies.

    I authorize the provider to initiate a complaint to the insurance commissioner for any reason on my behalf and I personally will be active in the resolution of claims delay or unjustified reductions or denials.

    Interest will incur if a balance remains unpaid after 60 days.

4. Miscellaneous Forms, Additional Information and Authorizations: We will provide all necessary information to have you benefits released. However, if it becomes necessary to submit redundant or unnecessary information for the completion of claim forms for school, sports, or extra-curricular activities there will be an administrative fee, not to exceed $35.00, for the additional information.

5. Missed Appointments: We require notice of cancellations 24 hours in advance. This allows us to offer the appointment to another patient. If you fail to keep your appointments without notifying us in advance: a missed appointment fee will apply. These fees are typically $20.00 for a regular appointment or $50.00 for a physical appointment, but not to exceed half of the cost of your scheduled appointment. Repeated missed appointments without notification may cause you to be discharged from the practice so that we can provide care to other patients.

6. Medical Records Fees: Patient are entitled under federal law to have access to their protected health information and we follow all rules, guidelines and exceptions to ensure compliance to patient rights. However, providers also have the right to compensation for records and our fees are a reasonable cost-based fee for copies including the copying, supplies,, labor and postage of the files, and or summaries.

We realize that temporary financial problems may affect timely payment of your account, if this should occur, please contact us for assistance in the management of your account. Our goal is to provide quality care and service. Please let us know immediately if you require any assistance or clarification from anyone within our business.

7. Timeliness of Appointments: We try to see everyone in a timely manner, but if we are taking too long, please let our receptionist know so we can best serve your needs and reschedule you if necessary.

8. I understand the content and significance of this form, and my questions have been answered. I understand I will be responsible for the fee charged by the collection agency for costs of collections if such action becomes necessary.

9. Notice of Privacy Practices: I have received a copy of the Doctor's Notice of Privacy Practices.

   □ Received today   □ Previously received   ______________ Patient initials

10. Health Information Exchange: I have received information regarding the Health Information Exchange.

    □ Received today   □ Previously received   __________ Patient initials

11. PCMH Brochure: I have received the PCMH Brochure.

    □ Received today   □ Previously received   __________ Patient initials

12. In order for our office to release medical information, including test results, to anyone else in your family, including your spouse, a medical release needs to be signed. Please list the person (s) that you would like your case discussed with, along with the relationship to you.

______________________________   ______________________________
NAME   RELATIONSHIP

______________________________   ______________________________
NAME   RELATIONSHIP

______________________________   ______________________________
NAME   RELATIONSHIP

Information regarding my medical condition, including but not limited to test results, may be given to the above stated person (s) until further notice. This release may be voided at any time with written instructions.

THIS FORM HAS BEEN FULLY EXPLAINED TO ME AND I AM SATISFIED THAT I UNDERSTAND ITS CONTENT AND SIGNIFICANCE.

____   __________
Signature of Patient   Date

____   __________
Witness   Date

IF PATIENT IS A MINOR OR UNABLE TO CONSENT, COMPLETE THE FOLLOWING:

Patient is a minor of _____ year(s) of age OR is unable to consent because ____________________________

____.   __________
Date

____   __________
Signature of Legal Guardian or Closet Available Relative   Date

____   __________
Witness   Date

NOTICE

If another person has a percutaneous, mucous membrane, or open wound exposure to my blood or other body fluids, Thomas A Kelly DO, Khristina Coker FNP-C or Eaton Rapids Medical Center may perform, but not be limited to, the following tests: an HIV, hepatitis screen, and other blood borne pathogen tests, as needed, without any additional consent. Public Act # 488 of 1988 of the State of Michigan states that an HIV test may be performed upon me without any additional consent if a health professional or employee has a percutaneous, mucous membrane or open wound exposure to my blood or other body fluids.

FAMILY CARE CENTER
Thomas A. Kelly, D.O.
Khristina Coker FNP-C
1500 S Main St
Eaton Rapids, MI 48827

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for the Family Care Center (FCC) to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). The Family Care Center's Notice or Privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing the consent. The Family Care Center reserves the right to revise its Notice of Privacy Practices at any time. A reviewed Notice of Privacy Practices may be obtained by forwarding a written request to the Family Care Center Privacy Officer at 101 E. Spicerville Hwy., Eaton Rapids, MI 48827.

With this consent, the Family Care Center may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With the consent, The Family Care Center may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With this consent, the Family Care Center may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that the Family Care Center restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to the Family Care Center's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, the Family Care Center may decline to provide treatment to me.

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGMENT FORM. MY SIGNATURE BELOW STATES I HAVE RECEIVED A COPY OF THE FCC NOTICE OF PRIVACY PRACTICES.

____

Signature of Patient of Legal Guardian   Date

____

Print Name of Patient or Legal Guardian

Thomas A Kelly DO
Khristina Coker FNP-C
1500 S Main St
Eaton Rapids MI 48827
517-663-2705

The PCMH Brochure has been offered to me, ______________________________,
(please print your name)

todays date:____. I acknowledge that I have read

and understand this brochure and it's entirety and agree to my role and patient

responsibilities in part with Patient Centered Medical Home (PCMH).

Patient's Signature: ____

Witness signature: ____

The brochure was taken   Y   N

The brochure was refused   Y   N

THOMAS A KELLY, DO: FACEP & KHRISTINA COKER FNP-C

1500 S Main St
EATON RAPIDS MI 48827
Phone: 517-663-2705
Fax: 517-663-9470

PATIENT-CENTERED MEDICAL HOME (PCMH)

Our mission is to provide Personalized High quality care with special attention to Preventative Care

WELCOME TO OUR PRACTICE

As we build your Medical Home, you will notice some changes in the way we provide care, but many things will stay the same.

As part of our Patient-Centered Medical Home (PCMH) orientation, we will ask you to acknowledge your agreement to the enclosed and we will acknowledge our agreement to you. Our goal has been to provide excellent care for you.

WE DESIRE TO GET BETTER AND BETTER

We appreciate the opportunity to provide you with medical services. The information that follows is designed to answer the questions most frequently asked by our patients. We want you to know our policies and methods of practice. If you have any questions, please ask us.

PRACTICE HOURS:

Monday, Tuesday, Wednesday and Thursday: 8:30 am to 4:30 pm, Friday 8:30am-11:30am Closed daily for lunch from 12:00 noon until 1:00pm

URGENT CARE:

If the doctor's office is closed and you require urgent care, please consider Eaton Rapids Medical Center urgent care. Eaton Rapids Medical Center is conveniently located next to our office.

INSURANCE PARTICIPATION:

We participate in many health plans. Some health plans are better for preventative care than others; some health plans offer more choices. We review health plans with your interests in mind.

LAB TEST RESULTS:

Please try to use Eaton Rapids Medical Center laboratory to ensure better communication. We will review normal results with you at your next appointment and with any abnormal results you will be contacted by phone. Call 663-2705 for all test results

WHAT ARE YOUR OPTIONS?

Helping you make the right choices.

A Patient-Centered Medical Home (PCMH) is a trusting partnership between a doctor-led health care team and an informed patient. It includes an agreement between the doctor and the patient that acknowledges the role of each in a total health care program.

OVER THE NEXT SEVERAL MONTHS YOU MAY NOTICE THAT:

□ We may ask what your goal is, or what you want to do to improve your health.

□ You can help us plan your care.

□ Written copies of care plans may be given in more complex illnesses.

□ Dr. Kelly and his staff encourage a healthy lifestyle.

□ We can help by reminding you when tests are due so that you can receive the best quality care.

□ We may ask you to have blood tests done before your visit so that the doctor has the results at your visit.

□ *Learn how to prevent diseases by maintaining ideal body weight, regular exercise, Good night sleep, healthy eating and tobacco cessation.*

WE TRUST YOU, OUR PATIENT, TO:

□ Tell us what you know about your health and illnesses.

□ Tell us about your needs and concerns.

□ Take part in planning your care.

□ Follow the care plan that is agreed upon-or let us know why you cannot.

□ Tell us what medications you are taking and ask for a refill at your office visit when you need one.

□ Let us know when you see other doctors and what medications they put you on or change.

□ Ask other doctors to send us a report about your care when you see them.

□ When possible, seek our advice before you see other physicians.

□ Learn about wellness and how to prevent disease.

□ Learn about your insurance so you know what it covers.

□ Respect us as individuals and partners in your care.

□ Keep your appointments as scheduled, or call and let us know when you cannot at least 24 hours before your appt.

□ Pay your share of the visit fee when you are seen in the office.

□ Give us feedback so we can improve our services. (We may survey you in the future to understand this better.)

PATIENT-CENTERED MEDICAL HOME

WE WILL CONTINUE TO:

□ Provide you with a care team who will know you and your family.

□ Respect you as an individual-we will not make judgments based on race, religion, sex, age, disability, etc.

□ Respect your privacy-your medical information will not be shared with anyone unless you give us permission or it is required by law.

□ Provide care given by a team of people led by your physician.

□ Give care that meets your needs and fits with your goals and values.

□ Give care that is based on quality and safety.

□ Have a doctor on call 24 hours a day and 7 days a week.

□ Tell you about your health and ill-nesses in a way you can understand.

□ To improve your care, we are using technology-like our --E-prescribing, and as always we will strive to continuously improve.

□ Community Resources may be accessed by dialing 211 on your phone

□ When being treated at an urgent care /ER please make a follow up appt.

Thomas A Kelly, DO; FACEP
Khristina Coker FNP-C

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