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INTERNAL MEDICINE

# New Patient Registration Form

Today's Date_____ DOB_____/_____/_____

Last Name_____ First Name_____

Nickname_____ ☐Male ☐Female

Home Address _____

City_____State _____Zip Code_____Email_____

Medical Power of Attorney (if applicable)_____DOB_____/_____/_____

Address_____City_____State_____ZIP_____

Home#_____Cell#_____Work#_____

Employer_____

**Primary Insurance Company :** _____

ID number _____ Group Number_____

Insurance phone number _____

Subscriber's name_____

Subscriber's DOB_____

Subscriber's relationship to patient _____

Secondary Insurance Company: _____

ID number _____ Group Number _____

Insurance phone number _____

Subscriber's name_____

Subscriber's DOB_____

Subscriber's relationship to patient _____

**Please place your initials next to the statements below indicating you have read & understand them:**

_____I authorize the insurance listed above to pay directly to **Continuum Internal Medicine & Pediatrics** (which is a Division of Texas Digestive Disease Consultants) all benefits due me, as provided for in the above policy contract with the aforementioned company(ies). I will pay for all such charges that may be denied by the insurance company(ies) above mentioned.

_____I hereby consent to treatment rendered by **Continuum Internal Medicine & Pediatrics**, which could include in office procedures and injections.

Preferred Pharmacy_____

Pharmacy phone number_____

_____ _____

Patient's Signature Date

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Dr. Mai Sharaf, MD ☐
Dr. Kelly Felps, MD ☐
Phone: 817-617-8650

# New Patient Health & History Form

**Today's Date:**_____

_____ **Last Name** _____ **First Name** _____/_____/_____ **DOB**

| **Medication Name/ Strength** | **How many times a day?** |
|---|---|
| | |
| | |
| | |
| | |
| | |

**OR** ☐ None

## Past Medical History

| | | | |
|---|---|---|---|
| ☐ High Blood pressure | ☐ Diabetes | ☐ Stroke | ☐ Anxiety |
| ☐ High Cholesterol | ☐ Colon Disease | ☐ COPD/Emphysema | ☐ Depression |
| ☐ Hypothyroid | ☐ Peptic Disease/GERD | ☐ Asthma | ☐ Cancer/Type_____ |
| ☐ Anemia | ☐ Heart Disease | ☐ Allergies | ☐ Skin Disease |
| ☐ Hepatitis | ☐ Seizure Disorder | ☐ Arthritis | ☐ Kidney Disease/Stones |

☐ Other _____

| **Allergies to medications** | **Reaction** |
|---|---|
| | |
| | |
| **Latex Allergy? ☐ Yes ☐ No | |

**-OR-** ☐ **None**

| **Past Surgeries/Procedures** | **Date** |
|---|---|
| | |
| | |
| | |
| | |

**-OR-** ☐ **None**

| **Hospitalizations** | **Date** |
|---|---|
| | |
| | |
| | |

**-OR-** ☐ **None**

| **Family History** | | **Significant Diseases** |
|---|---|---|
| Father | Alive? ☐ Yes ☐ No/ Age of death_____ | |
| Mother | Alive? ☐ Yes ☐ No/ Age of death_____ | |
| Siblings | ☐ Yes ☐ No #___Brothers #___Sisters | |
| Children | ☐ Yes ☐ No #___Sons #____Daughters | |

**Examples of significant diseases:** diabetes, high cholesterol, high blood pressure, cancers, heart diseases, osteoporosis, auto immune disorders

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Dr. Mai Sharaf, MD
Dr. Kelly Felps, MD
Phone: 817-617-8650

## Social History

| | |
|---|---|
| Tobacco Use: Are you a... | ☐ Current Smoker/ #_____cigarettes per day/ week/ month (**please circle one**)<br>☐ Former smoker ☐ Nonsmoker ☐ E-Cigerette ☐ Chewing Tobacco<br>☐ Other (please specify) _____ |
| Alcohol Use | ☐ I do not drink ☐ Socially<br>☐ Everyday/ I drink #_____beer/ wine/ liquor (**please circle one**) |
| What is your occupation? | |

## Do you currently have any of the following symptoms today? -OR- ☐ NONE

General/ Constitutional
☐ Change in appetite ☐ Fever ☐ Night Sweats ☐ Weight gain

Ophthalmologic
☐ Blurred vision ☐ Eye Pain ☐ Itching and redness

ENT
☐ Decreased hearing ☐ Nosebleed ☐ Snoring ☐ Swollen glands

Endocrine
☐ Cold intolerance ☐ Excessive thirst ☐ Heat intolerance ☐ Weight loss

Respiratory
☐ Cough ☐ Shortness of breath ☐ Wheezing

Cardiovascular
☐ Chest pain ☐ Fluid accumulation in the legs ☐ Irregular heartbeat ☐ Palpitations

Gastrointestinal
☐ Abdominal pain ☐ Blood in stool ☐ Constipation ☐ Diarrhea ☐ Nausea ☐ Vomiting

Genitourinary
☐ Blood in urine ☐ Difficulty urinating ☐ Frequent urination ☐ Painful urination

Musculoskeletal
☐ Back/Neck problems ☐ Painful joints ☐ Weakness

Skin
☐ Dry skin ☐ Itching ☐ Rash

Neurologic
☐ Dizziness ☐ Headache ☐ Memory loss ☐ Tingling/ Numbness

Psychological
☐ Anxiety ☐ Depressed mood

## Preventive Medicine

| ✦Females | Date/ Name of doctor | ✦Males | Date/ Name of doctor |
|---|---|---|---|
| Last menstrual period? | | Last colonoscopy? | |
| Last Mammogram? | | Last PSA? | |
| Last Pap Smear? | | | |
| Last Bone density test? | | | |
| Last colonoscopy? | | | |

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## Contact Information:

Cell Phone: _____

May we leave a message? YES / NO (circle one)

Home Phone: _____

May we leave a message? YES / NO (circle one)

Work Phone: _____

May we leave a message? YES / NO (circle one)

Other #'s: _____

May we leave a message? YES / NO (circle one)

**I give Dr. Mai Sharaf/Dr. Kelly Felps and the staff, my permission to discuss my condition, treatment, and diagnosis with the following individuals.**

Name:_____Phone:_____Relationship:_____

Name:_____Phone:_____Relationship:_____

Name:_____Phone:_____Relationship:_____

Patient's Name (PRINT) _____

Patient's Signature/Date _____

Continuum Internal Medicine & Pediatrics
A Division of Texas Digestive Disease Consultants
9509 North Beach Street, Suite 102, Fort Worth, Texas 76244
P: 817-617-8650
F: 877-906-1852

# Financial Policies

Please initial each section after reviewing

_____ No Show Policy:

We ask you to be considerate of the medical needs of others and call our office promptly at least 24 hours prior to your appointment if you are unable to make it. This allows us to make your appointment available to another patient who needs medical attention.

If you do not arrive for your appointment, fail to reschedule or cancel **prior to 24 hours** before your appointment time, there will be a **$25.00** no show fee applied to your account that will need to be paid in full by the next scheduled appointment time. **This fee also applies to same day cancel or reschedule of your appointment**. This fee cannot be billed to your insurance company.

You may be reminded of your upcoming appointment by portal reminder, text, or phone call. Please understand that these reminders regarding your appointment are a COURTESY only, any disputes regarding no shows because of a courtesy call or text "not received" will NOT be waived. You are ultimately responsible.

The doctors make every effort to be respectful of our patients' time and to see our patients on time. Please be aware that if you arrive 10 minutes after your scheduled appointment time, you may be asked to reschedule.

_____ After Hours Calls:

Our office hours are Monday through Friday 8:00am to 5:00pm. We make every effort to return patient calls promptly, usually by end of the business day. After hour calls are defined as calls received after 5:00pm Monday-Friday and all weekends or holidays. These calls will accrue a **$35.00** after hours call fee applied to your account. This fee cannot be billed to your insurance company.

_____ Letters/Completion of Forms:

All patient letter requests and form completion will accrue a letter/form fee. This fee will be applied to your account. This fee cannot be billed to your insurance company. Please contact the office administrator for the specific fee for a letter or form completion requested. Please allow 48hrs for the physician to complete your form or compose your requested letter.

_____ Payment at Time of Service:

Your insurance company may require a co-pay at every visit. If you have scheduled a well visit but require additional evaluation or tests you may be billed for both a well and "sick" visit. Please check with your insurance carrier for any questions.

_____ Medicaid Waiver:

**Continuum Internal Medicine & Pediatrics does NOT ACCEPT Medicaid of Texas as primary or secondary insurance.**
This waiver is valid for all dates of service. All patients must initial this section even if you have no intention of using Medicaid as a form of payment.

I _____ (patient's name) have read, understand, and agree to the above policy by Continuum Internal Medicine & Pediatrics. I will be responsible for any non-covered services not covered by my health insurance plan(s).

_____ _____

Patient's Name (PRINT) Patient Signature & Date

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# ImmTrac Frequently Asked Questions

Question: **What is ImmTrac?**
Answer: The official Texas immunization registry from the Texas Department of State Health Services (DSHS). It is a secure, confidential registry that stores immunization records electronically in one centralized system at no cost.

Question: **What are the benefits?**
Answer: You can safely store your immunization records in ImmTrac at no cost to you. Your records will be kept secure and confidential. Even if, you got one vaccine at your doctor's office and another at your local pharmacy, you can electronically store all your immunization records in ImmTrac. Then, you will have one immunization history. You can request a copy of your immunization history when you need it for college entrance requirements, military enlistment, travel, employment in health and safety fields, and other instances.

Your ImmTrac authorized health-care provider can access your immunization history and make sure you are not over or under vaccinated. This way, you will be fully protected against vaccine-preventable diseases and save money by not paying for vaccines you do not need.
ImmTrac offers many benefits:

- A NO COST SERVICE
- SECURE
- CONFIDENTIAL
- ELECTRONIC
- CENTRALIZED
- ACCESSIBLE TO AUTHORIZED HEALTH- CARE PROVIDERS

Question: **Who can be a part of ImmTrac?**
Answer: Anyone in Texas who would like to keep his or her immunization records in a secure and confidential electronic system can register.

Question: **What if I'm already registered in ImmTrac as a child?**
Answer: If your immunization records were in ImmTrac as a child, you can keep them in ImmTrac as an adult. You must sign an *ImmTrac Adult Consent Form* between your 18th and 19th birthday to continue to keep your record in ImmTrac. If you do not sign this form by your 19th birthday, your record will be deleted.

Question: **If an ImmTrac client's records were entered into ImmTrac by the client's parent as a child (age 17 and younger), will the client's immunization history be in ImmTrac for a lifetime?**
Answer: No, when an ImmTrac client turns 18 years old, the client is legally an adult. The client must sign an ImmTrac Adult Consent form in the time between the client's 18th and 19th birthday to keep the immunization records in ImmTrac that were entered in as a child in ImmTrac for a lifetime. If an ImmTrac client does not sign an ImmTrac Adult Consent

Form by the client's 19th birthday, the client's ImmTrac ID, including immunization records, will be deleted and cannot be recovered in ImmTrac.

Question: **If I've never registered in ImmTrac, how can I register?**
Answer: If you have never registered with ImmTrac, either as a child or as an adult, you can:

1. **Download** and complete the ImmTrac Adult Consent Form (F11-13366) from ImmTracForEveryone.com.
2. **Gather and make copies** of all your official immunization records.
3. **Send in** your completed ImmTrac Adult Consent Form and copies of your official immunization records to your authorized health-care provider, local health department (LHD), DSHS health service region (HSR) office **or** the Department of State Health Services ImmTrac office.

Question: **Do I have to be up to date on my vaccines to register?**
Answer: No. You do not have to be up to date with all your vaccines to register with ImmTrac. You may want to review the *Recommended Adult Immunization Schedule* with a health-care provider to determine which vaccines you still need. Even though you are a young adult, there are more recommended adult vaccines now then when you were a child. Go to www.Vaccinesforeveryone.com or www.ImmTrac4everyone.com to download the *Recommended Adult Immunization Schedule.*

Question: **How do I find out if I am already signed up for ImmTrac?**
Answer: Fill out and submit an Authorization to Release ImmTrac History form. ImmTrac will look in the registry and inform you if your records are part of the registry.

Question: **Who can access ImmTrac?**
Answer: An ImmTrac client can access ImmTrac by requesting a paper copy of your immunization record from an authorized health-care provider, local health department, health service region, or the Texas Department of State Health Services ImmTrac office. An ImmTrac client does not have direct access to the ImmTrac registry. Just like you cannot view your medical records online, you cannot view your ImmTrac records online either. This is to ensure the confidentiality and security of the immunization records.

Question: **Are all health-care providers part of the ImmTrac registry?**
Answer: No. Only health-care providers who are registered with ImmTrac are part of ImmTrac as an authorized provider. It is optional for all health- care providers to be a part of ImmTrac.

Question: **How do ImmTrac clients contact ImmTrac?**
Answer: The ImmTrac group can be contacted by:
Phone: 800- 252- 9152
Fax: 512-458- 7790
Email: ImmTrac@dshs.state.tx.us

TEXAS Health and Human Services | Texas Department of State Health Services

# *IMMUNIZATION REGISTRY (ImmTrac2)*
# ADULT CONSENT FORM

(Please print clearly)

**Last Name**

**First Name** **Middle Name**

**Date of Birth** **Gender:** ☐ **Male** ☐ **Female**

**Address** **Apartment #** **Telephone**

**City** **State** **Zip Code** **County**

**Mother's First Name** **Mother's Maiden Name**

ImmTrac2, the Texas immunization registry, is a free service of the Texas Department of State Health Services (DSHS). The immunization registry is a secure and confidential service that consolidates immunization records for public health purposes (e.g., giving all doctors treating a patient a central place to see that patient's immunization records). With your consent, your immunization information will be included in ImmTrac2. *For a family member younger than 18 years of age, a parent, legal guardian, or managing conservator may grant consent for participation for that minor by completing the ImmTrac2 Minor Consent Form (# C-7). The ImmTrac2 Minor Consent Form (# C-7) can be downloaded by visiting www.ImmTrac.com.*

**The Texas Department of State Health Services encourages your voluntary participation in the Texas immunization registry.**

## Consent for Registration and Release of Immunization Records to Authorized Persons / Entities

I understand that, by granting the consent below, I am authorizing release of my immunization information to DSHS and I further understand that DSHS will include this information in the state's central immunization registry, ImmTrac2. Once in ImmTrac2, my immunization information may by law be accessed by:

- a Texas physician, or other health care provider legally authorized to administer vaccines, for treatment of the individual as a patient;
- a Texas school in which the individual is enrolled;
- a Texas public health district or local health department, for public health purposes within their areas of jurisdiction;
- a state agency having legal custody of the individual;
- a payor, currently authorized by the Texas Department of Insurance to operate in Texas for immunization records relating to the specific individual covered under the payor's policy.

**I understand that I may withdraw this consent at any time.**

**By my signature below, I <u>GRANT</u> consent for registration. I wish to <u>INCLUDE</u> my information in the Texas immunization registry.**

**Individual (or individual's legally authorized representative):**

Printed Name

Date

Signature

**Privacy Notification:** With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See *http://www.dshs.texas.gov* for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003, and 559.004)

**Upon completion, please fax or mail form to the DSHS ImmTrac2 Group or a registered Health-care provider.**

**Questions?** (800) 252-9152 • (512) 776-7284 • Fax: (866) 624-0180 • www.ImmTrac.com

**Texas Department of State Health Services • ImmTrac2 Group – MC 1946 • P. O. Box 149347 • Austin, TX 78714-9347**

**<u>PROVIDERS REGISTERED WITH ImmTrac2</u>**: Please enter client information in ImmTrac2 and **affirm** that consent has been granted. **DO NOT fax to ImmTrac2. Retain this form in your client's record.**

**Limited Patient Authorization for Disclosure of Protected Health Information** **Form 7.31**

Please print all information. Form must be signed and dated each year.

**Patient Name**: _____

**SSN** (last four digits):_____ **Date of Birth:** _____

**Entity Requested to Release Information:**

**Continuum Internal Medicine & Pediatrics**

**Purpose of request (who will be authorized to receive information)** - I authorize the entity identified above to disclose or provide protected health information, about me to the individual(s) listed below.

**Who will be authorized to receive information** (list the individual/entity who is to receive your PHI):

Individual/Entity Name:_____Relationship:_____

Address:_____

Phone: _____

Individual/Entity Name:_____Relationship:_____

Address: _____

Phone: _____

**Description of information to be disclosed** - I authorize the practice to disclose the following protected health information about me to the entity, person, or persons identified above:

- ☐ Entire patient record; or, check only those items of the record to be disclosed:
  - ☐ Office notes
  - ☐ Nursing home, home health, hospice, and other physician records
  - ☐ Lab results. pathology reports
  - ☐ Record of HIV and communicable disease testing
  - ☐ X-rays
  - ☐ Record of mental health or substance abuse treatment
  - ☐ Financial history report (previous 3 years only).
- ☐ Only send the following: _____

**Purpose of disclosure** (please record the purpose of the disclosure or check patient request):

O Patient Request O Other (please specify): _____

-This authorization will expire at the end of the calendar year of your last signature below, unless you specify an earlier termination. You must renew or submit a new authorization after the expiration date to continue the authorization. Please list the date of expiration if earlier than the end of the calendar year: _____

-You have the right to terminate this authorization at any time by submitting a written request to our Privacy Manager. Termination of this authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization.

-The practice places no condition to sign this authorization on the delivery of healthcare or treatment.

-We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization may no longer be protected by the requirements of the Privacy Rule, and will no longer be the responsibility of the practice.

Patient or representative signature_____date_____

You have the right to receive a copy of signed authorization upon request.

**Continuum Internal Medicine & Pediatrics**
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## Continuum Internal Medicine and Pediatrics

**This notice describes how medical information about you may be used and disclosed, and how you can gain access to this information. Please review it carefully.**

Protected health information (PHI), about you, is maintained as a written and/or electronic record of your contacts or visits for healthcare services with our practice. Specifically, PHI is information about you, including demographic information (i.e., name, address, phone, etc.), that may identify you and relates to your past, present or future physical or mental health condition and related healthcare services.

Our practice is required to follow specific rules on maintaining the confidentiality of your PHI, using your information, and disclosing or sharing this information with other healthcare professionals involved in your care and treatment. This Notice describes your rights to access and control your PHI. It also describes how we follow applicable rules and use and disclose your PHI to provide your treatment, obtain payment for services you receive, manage our healthcare operations and for other purposes that are permitted or required by law.

### Your Rights Under The Privacy Rule

Following is a statement of your rights, under the Privacy Rule, in reference to your PHI. Please feel free to discuss any questions with our staff.

**You have the right to receive, and we are required to provide you with, a copy of this Notice of Privacy Practices** - We are required to follow the terms of this notice. We reserve the right to change the terms of our notice, at any time. Upon your request, we will provide you with a revised Notice of Privacy Practices if you call our office and request that a revised copy be sent to you in the mail or ask for one at the time of your next appointment. The Notice will also be posted in a conspicuous location within the practice, and if such is maintained by the practice, on it's web site.

**You have the right to authorize other use and disclosure** - This means you have the right to authorize any use or disclosure of PHI that is not specified within this notice. For example, we would need your written authorization to use or disclose your PHI for marketing purposes, for most uses or disclosures of psychotherapy notes, or if we intended to sell your PHI. You may revoke an authorization, at any time, in writing, except to the extent that your healthcare provider, or our practice has taken an action in reliance on the use or disclosure indicated in the authorization.

**You have the right to request an alternative means of confidential communication** – This means you have the right to ask us to contact you about medical matters using an alternative method (i.e., email, telephone), and to a destination (i.e., cell phone number, alternative address, etc.) designated by you. You must inform us in writing, using a form provided by our practice, how you wish to be contacted if other than the address/phone number that we have on file. We will follow all reasonable requests.

**You have the right to inspect and copy your PHI** - This means you may inspect, and obtain a copy of your complete health record. If your health record is maintained electronically, you will also have the right to request a copy in electronic format. We have the right to charge a reasonable fee for paper or electronic copies as established by professional, state, or federal guidelines.

**You have the right to request a restriction of your PHI** - This means you may ask us, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. If we agree to the requested restriction, we will abide by it, except in emergency circumstances when the information is needed for your treatment. In certain cases, we may deny your request for a restriction. You will have the right to request, in writing, that we restrict communication to your health plan regarding a specific treatment or service that you, or someone on your behalf, has paid for in full, out-of-pocket. We are not permitted to deny this specific type of requested restriction.

**You may have the right to request an amendment to your protected health information** - This means you may request an amendment of your PHI for as long as we maintain this information. In certain cases, we may deny your request.

**You have the right to request a disclosure accountability** - This means that you may request a listing of disclosures that we have made, of your PHI, to entities or persons outside of our office.

**You have the right to receive a privacy breach notice** - You have the right to receive written notification if the practice discovers a breach of your unsecured PHI, and determines through a risk assessment that notification is required.

If you have questions regarding your privacy rights, please feel free to contact our Privacy Manager. Contact information is provided on the following page under Privacy Complaints.

## How We May Use or Disclose Protected Health Information

Following are examples of uses and disclosures of your protected health information that we are permitted to make. These examples are not meant to be exhaustive, but to describe possible types of uses and disclosures.

**Treatment** - We may use and disclose your PHI to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party that is involved in your care and treatment. For example, we would disclose your PHI, as necessary, to a pharmacy that would fill your prescriptions. We will also disclose PHI to other Healthcare Providers who may be involved in your care and treatment.

**Special Notices** - We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We may contact you by phone or other means to provide results from exams or tests and to provide information that describes or recommends treatment alternatives regarding your care. Also, we may contact you to provide information about health-related benefits and services offered by our office, for fund-raising activities, or with respect to a group health plan, to disclose information to the health plan sponsor. You will have the right to opt out of such special notices, and each such notice will include instructions for opting out.

**Payment** - Your PHI will be used, as needed, to obtain payment for your healthcare services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the healthcare services we recommend for you such as, making a determination of eligibility or coverage for insurance benefits.

**Healthcare Operations** - We may use or disclose, as needed, your PHI in order to support the business activities of our practice. This includes, but is not limited to business planning and development, quality assessment and improvement, medical review, legal services, auditing functions and patient safety activities.

**Health Information Organization** - The practice may elect to use a health information organization, or other such organization to facilitate the electronic exchange of information for the purposes of treatment, payment, or healthcare operations.

**To Others Involved in Your Healthcare -** Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person, that you identify, your PHI that directly relates to that person's involvement in your healthcare. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, of your general condition or death. If you are not present or able to agree or object to the use or disclosure of the PHI, then your healthcare provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is necessary will be disclosed.

**Other Permitted and Required Uses and Disclosures** - We are also permitted to use or disclose your PHI without your written authorization for the following purposes: as required by law; for public health activities; health oversight activities; in cases of abuse or neglect; to comply with Food and Drug Administration requirements; research purposes; legal proceedings; law enforcement purposes; coroners; funeral directors; organ donation; criminal activity; military activity; national security; worker's compensation; when an inmate in a correctional facility; and if requested by the Department of Health and Human Services in order to investigate or determine our compliance with the requirements of the Privacy Rule.

## Privacy Complaints

You have the right to complain to us, or directly to the Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying the Privacy Manager at:

(469) 930-3064

We will not retaliate against you for filing a complaint.

Effective Date 9/23/2013 Publication Date 9/23/2013

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INTERNAL MEDICINE

## Thank you for coming! How did you hear about us?

☐Former patient of Dr. Sharaf

☐Former patient of Dr. Felps

☐Facebook post

☐Internet search

☐Heard about from a friend

☐Postcard mailed to your home

☐Another doctor referred you

☐Attended a community event

☐Other

_____