Welcome and thank you for selecting InterMed as your health care provider. Choosing a physician is an important decision and we are honored that you have entrusted your care with us. InterMed takes great pride in providing the highest quality health care to patients in all stages of life.

To best serve your needs and enhance your visit, we have enclosed paperwork for you to review and complete prior to your first appointment:

- **Enclosure 1: Authorization to Release Health Care Information**
  This form authorizes your previous primary care provider to transfer your medical records to InterMed. *It’s important to complete and return this form to InterMed as soon as possible.* Send the completed form via:
  - Mail: InterMed, 100 Gannett Drive, South Portland, ME 04106
  - Fax: (207) 523-8581
  - Upload it through the Contact Us page at www.intermed.com

  Please call our Health Information team with question at (207) 523-3963.

- **Enclosures 2-3: Patient Communication Form and Medical History Form**
  Thoroughly complete these forms and bring them to your first appointment.

- **Enclosures 4-6: General Patient Information**
  These enclosures are informational only. No action is necessary.

Please bring your health insurance card and driver’s license or state issued identification to your appointment. Your office co-payment will be due at the time of your visit. Learn more about InterMed and our services by visiting www.intermed.com. We look forward to meeting you!

Sincerely,
InterMed Family Medicine Team

---

**Address**
100 Foden Road, South Portland
East Building, 2nd Floor

**Phone**
Family Practice (207) 874-1489

**Parking**
Free and onsite. Wheelchairs available at entrance.

**Directions**
From I-95, take Exit 45 (Maine Mall Road). After tollbooth, take first exit (To Route 114/Maine Mall Road). Bear right at the light onto Maine Mall Road. Travel 0.6 miles and turn right onto Gorham Road. Travel 0.3 miles then turn left onto Foden Road. You’ll see 100 Foden Road on the right.
AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION
If this form is not filled out in its entirety it will result in a delay in processing.

Patient Name: _______________________________ Previous Name: _________________ DOB: ____________________
Address: __________________________________________ Phone Number: ________________________

I understand that health care information is confidential and will not be released without my authorization
unless permitted by law. I understand that I have the right to refuse authorization to disclose all or some
health care information, but refusal may result in improper diagnosis or treatment, denial of insurance
coverage, or other adverse consequences.

Please tell us where the records are coming from: Please tell us where the records are going to:
Physician/Individual Name: _______________________ Physician/Individual Name: InterMed, P.A.
Address: _____________________________________ Address: 100 Gannett Drive, Suite C
City/State/Zip Code: _____________________________ City/State/Zip Code: South Portland, Maine 04106
Phone Number: _________________________________ Phone Number: 207-523-3745
Fax Number: ___________________________________ Fax Number: 207-523-8581

By law, providers are required to release the minimum amount of information necessary to carry out the
purpose of a release. Please indicate below exactly which records you would like to be released.

☐ Lab results ☐ Physical exams ☐ Office visits ☐ Radiology reports ☐ Radiology Films
☐ Last 5 years of health record ☐ Other (specify): __________________________________________

The information and material above may only be used for the following purpose(s) please check below:

☐ Transfer of Care: Please indicate the reason for transfer below
  ☐ Reason for Transfer:

☐ Insurance changes please indicate new insurance:

☐ Dissatisfaction:

☐ Coordination of Care (NOT Transferring) ☐ Disability/FMLA ☐ Insurance Application
☐ Legal Matter(s) ☐ Self ☐ Workers Compensation Claim

I understand that my specific consent is necessary to disclose information pertaining to treatment and/or diagnosis
of mental health conditions, substance abuse and/or HIV status. I understand that authorizing the release of such
information does not confirm the existence of such history or treatment.

By checking the boxes below, I authorize that specific health information to be released:

☐ AIDS/HIV ☐ Alcohol and/or Drug Abuse Treatment ☐ Mental Health Treatment

This authorization expires (12) months from the date hereof. I have the right to revoke this authorization in writing at any time.
Revocation will not cover information/material released prior to that date, but will prevent further release of information. I
understand that revocation may be the basis for denial of health benefits or other insurance coverage or benefits.

My signature below indicates that I have read this release form and have had all of my questions answered, if any.

• I understand what this form authorizes.
• I consent to the release of information as recorded on this form.
• I authorize the party (ies) listed in section 1 of this form to make subsequent disclosures to the same recipient
  pursuant to this authorization.
• I understand that information released might be further released by the receiving party and that if this occurs,
  InterMed cannot guarantee the protection of this information once disclosed.
• I understand that I have a right to request a copy of the authorization.

X ____________________________________________________________________________
Patient or Representative Signature                                Date
☐ Parent      ☐ Legal Guardian       ☐ Other Legally Authorized Representative: __________________

100 Gannett Drive, Suite C South Portland, ME 04106 Telephone: 207-523-3745 Fax: 207-523-8581
Patient Communication Form

Patient’s Legal Name: ___________________________ Date of Birth: ______________
First      MI      Last

Parent(s)/Legal Guardian(s): ______________________________________________________

Mailing Address: __________________________________________________________________

E-mail Address: _____________________________________________________________________

By providing my email address I understand I will remain/be enrolled in a MyInterMed patient portal account. This service is offered to adult patients 18 years of age and older.

Check this box if you do NOT want to be enrolled in the patient portal. □

Phone Contacts

Circle One          Circle One
☐ Home  ☐ Cell  ☐ Work  Okay to leave message?  Yes/No  **Extended Message?  Yes/No
☐ Home  ☐ Cell  ☐ Work  Okay to leave message?  Yes/No  **Extended Message?  Yes/No

**Extended messages may contain medical and/or prescription information.

I agree to receive follow up surveys by an automated dialing service and/or an artificial or prerecorded voice, and/or text messages to my telephone number or cell phone number provided during my registration process.

Check this box if you do NOT want to receive follow up surveys via cell phone. □

Patient’s Marital Status (Circle One)  Single  Married  Partner  Divorced  Widowed

Patient’s Primary Care Physician: ___________________________

Patient’s Employer: ___________________________ Occupation: _______________________

Patient’s Health Insurance Company: __________________ Policy Number: __________________

Emergency Contact Name: ___________________________ Relationship: __________________

Emergency Telephone: Cell (___) ___________ Home (___) ___________ Work (___) ___________

Select One:

☐ I do not want any information about my healthcare communicated to family members/caregivers.

☐ I give InterMed permission to verbally communicate to family members/caregivers listed below.

Name: ___________________________ Name: ___________________________ Name: ___________________________

Please check the box next to the specific information that may be verbally communicated to the individual(s) listed above:

☐ Prescription Request  ☐ Request/Confirm/Cancel Appointments  ☐ Referral Request

This authorization will be updated every 12 months. I have the right to revoke this authorization in writing at any time. Revocation will not cover information released prior to that date. If I want to grant permission to InterMed to discuss other information, including AIDS/HIV, Alcohol and/or Drug Abuse, or Mental Health with anyone besides myself, I understand that I will need to complete a separate Release of Information form.

Patient/Parent/Legal Guardian Signature ___________________________ Date ___________

Office Use Only
☐ Data entered into eCW  ☐ Insurance card scanned  ☐ Driver’s license/picture ID scanned

Updated: 12.2015

www.InterMed.com - January 2017
Date: __________________________

<table>
<thead>
<tr>
<th>First Name</th>
<th>Middle Name</th>
<th>Last Name</th>
<th>Date of Birth</th>
<th>Physician</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

Date of last physical exam, with whom:

Referring Physician:

Medications: Please list all prescriptions including over-the-counter medications

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose (# mg)</th>
<th>Instructions (ex: 1 daily)</th>
<th>How long have you been on this medication?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

Write in the names of any diseases or conditions you have: __________ I do not have any medical problems

______________________________________________________________________________

Write in the names of any other provider(s) you obtain care from: __________ I do not have additional providers

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Serious illnesses which you have had: (ex: requiring hospitalization) __________ I have never been hospitalized

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Write in the names of any operations which you have had: __________ I have had no prior surgeries

<table>
<thead>
<tr>
<th>Operation</th>
<th>Year</th>
<th>Operation</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Continued on other side…
Name any drugs to which you are allergic, list the symptoms caused:  

<table>
<thead>
<tr>
<th>Medication</th>
<th>Reaction</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Have you ever had any of the following problems? If so, please provide approximate date (month/year):

<table>
<thead>
<tr>
<th>Heart Attack</th>
<th>Stroke:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Seizure:</th>
<th>Blood transfusion:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cancer of, please specify:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sports injuries (including concussions):</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

Do you know of any blood relative who has or had any of the following problems:

_____ I do not know my family history

Please circle and give relationship:

<table>
<thead>
<tr>
<th>Cancer: Breast</th>
<th>Epilepsy</th>
<th>Heart attack</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colon</td>
<td>Suicide</td>
<td>Stomach ulcers</td>
</tr>
<tr>
<td>Melanoma</td>
<td>Migraine</td>
<td>Kidney stones</td>
</tr>
<tr>
<td>Ovary</td>
<td>Asthma</td>
<td>Thyroid problems</td>
</tr>
<tr>
<td>Other</td>
<td>Eczema</td>
<td>Arthritis</td>
</tr>
<tr>
<td>Stroke</td>
<td>Bleeding problems</td>
<td>Leukemia</td>
</tr>
<tr>
<td>High blood pressure</td>
<td>Glaucoma</td>
<td>High cholesterol</td>
</tr>
<tr>
<td>Tuberculosis</td>
<td>Diabetes</td>
<td>Congenital heart disease</td>
</tr>
<tr>
<td>Colon polyps</td>
<td>Mental illness</td>
<td>Mitral valve prolapse</td>
</tr>
<tr>
<td>Colitis</td>
<td>Depression</td>
<td>Heart valve problems</td>
</tr>
<tr>
<td>Osteoporosis</td>
<td>Alcoholism</td>
<td>Aortic aneurysm</td>
</tr>
<tr>
<td>Other:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Family History**

<table>
<thead>
<tr>
<th>Family History</th>
<th>If Living</th>
<th>If Deceased</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Sex</td>
<td>Age</td>
</tr>
<tr>
<td>Father</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brothers / Sisters</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Husband / Wife</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sons / Daughters</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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www.InterMed.com - January 2017
Patient Name: ______________________________

Patient Date of Birth: ________________________

Reason for Visit: ____________________________

New Issues to Discuss: _______________________ ___________________________________________

SOCIAL HISTORY

Smoking:

______ I currently smoke _____ packs/day for ___ yrs

______ I have never smoked

______ I quit smoking. Quit date ______________________

______ I used to smoke _____ packs/day for ___ yrs

Other tobacco: Pipe ___ Cigar ___ Snuff ___ Chew ___

Interested in quitting? __________

Alcohol:

Do you drink alcohol? Never ___ Occ ___ Regularly ____

Average # of drinks/week: Wine ___ Beer ___ Liquor ___

Is alcohol use a concern for you? Yes No

Have other people mentioned your alcohol use? Yes No

Drug use:

Do you use recreational drugs? Yes No

Have you ever used needles? Yes No

Sexuality:

Are you currently sexually active? Yes No

______ In the past, but not currently

Current sexual partner(s) is/are: Male __ Fem __ Both __

Current birth control method: ________________

Contraception/protection: ________________

Have you ever had a sexually transmitted disease (STD)?

______ Yes No

Would you like to be screened? Yes No

Occupation: ________________________________

Marital status:

Single Engaged Married Separated Divorced

Widowed Co-habitate

Spouse/Partners name: ________________________

Number of children: _____ Sons _____ Daughters

Household: Who lives with you? _______________

Exercise:

Do you exercise regularly? Yes No

Number of days per week ____

Education completed:

_____ Grade School _____ High School

_____ College _____ Graduate School

Current School __________________________

Domestic abuse:

Is violence at home a concern for you? Yes No

Do you have a history of physical, emotional or sexual abuse? Yes No

Please explain: ______________________________

FAMILY HISTORY

Any recent changes? Yes No

If yes, please explain: _______________________

PREVENTIVE CARE/SAFETY

Do you have a living will? Yes No

Do you eat a healthy diet? Yes No

Do you drink caffeine? Yes No

# cups per day

Do you do breast/rectal self exams Yes No

Do you get regular eye exams? Yes No

Do you get regular dental exams? Yes No

Do you take extra calcium/vitamin D? Yes No

Have you had a bone density test? Yes No

Have you had a colonoscopy? Yes No

If yes, when? _______________

Do you wear sunscreen? Yes No

Have you had a bone density test? Yes No

Are you currently being treated for depression? Yes No

Are you receiving counseling for depression? Yes No

Are you taking medicine for depression? Yes No

Over the last two weeks, how often have you been bothered by or had little interest in doing things?

______ Not at all

______ Several days

______ More than half the days

______ Nearly every day

Over the last two weeks, how often have you been feeling down, depressed or hopeless?

______ Not at all

______ Several days

______ More than half the days

______ Nearly every day

www.InterMed.com - January 2017
Please CIRCLE if you have any ongoing problems with any of the following:

1. CONSTITUTIONAL
Weight change
Fever
Night Sweats
Weakness
Fatigue

None

2. EYES
Wear glasses/contacts Yes No
Blurred vision
Vision loss/change
Double vision

None

3. EAR/NOSE/THROAT
Date of last dental exam: ______
Hearing loss/difficulty hearing
Dizziness
Ringing in ears
Sinus congestion
Post nasal drip
Loss of smell
Sore throat or mouth
Hoarseness
Dry mouth

None

4. CARDIOVASCULAR
Chest pain/angina
Palpitations
Swelling in feet
Fainting/passing out
Varicose veins
Pain in legs with walking

None

5. RESPIRATORY
Shortness of breath with exertion
Cough
Wheeze
Coughing up blood
Unable to sleep lying flat
Snoring

None

6. GASTROINTESTINAL
Difficulty swallowing
Nausea/vomiting
Constipation
Diarrhea
Abdominal pain
Change in bowel habits
Heartburn
Hemorrhoids

None

7. GENITOURINARY/BREAST
Date of last menses: _____
Urinary incontinence/leakage
Abnormal vaginal bleeding
Abnormal vaginal discharge
Irregular periods
Pain with urination
Blood in urine
Urinary frequency/urgency
Pain with intercourse
Breast lumps
Hot flashes
Kidney stones

None

8. GENITOURINARY (MALE)
Urinary incontinence
Getting up at night to urinate
Decreased force urinary stream
Testicular pain/lumps
Hernias
Difficulty with erections
Pain with ejaculation
Pain with urination
Blood in urine
Urinary frequency/urgency
Kidney stones

None

9. MUSCULOSKELETAL
Joint swelling or pain
Joint stiffness
Back pain
Neck pain
Leg pain/cramps with walking

None

10. SKIN
Changing/new moles
Rashes/hives
Itching
Acne

None

11. NEUROLOGIC
Headache
Seizure
Migraine
Dizziness/Vertigo
Tremors
Weakness
Memory loss
Difficulty walking
Confusion
Tingling/burning in hands or feet
Fainting/blackouts

None

12. PSYCHIATRIC
Depression
Stress
Insomnia
Suicidal thoughts
Eating disorder
Mental or physical abuse
Anxiety
Mood changes
Hallucinations/hearing voices

None

13. ENDOCRINE
Pain in legs with walking
Pain with ejaculation
Excessive thirst/hunger
Excessive sweating
Heat intolerance
Cold intolerance
Hair changes

None

14. HEMATOLOGIC
Tender/enlarged lymph nodes
Easy bruising
Easy bleeding

None

15. ALLERGIC
Seasonal allergies
Facial/tongue swelling
Itchy eyes
Runny nose
Sneezing

None

Continued on other side…

Print Patient Name: __________________________
Patient Date of Birth: _________________________
Patient Signature: ____________________________
Date: ______________________________________
Provider Signature: __________________________
Welcome! The following information explains some of the policies our office uses.

**Answering Service:**
Our phones are answered Monday through Friday from 8:00 am until 5:00 pm. Should you require medical assistance outside normal office hours, an on-call physician may be reached by calling the office, 207-774-5816, and leaving a message with the answering service. If a call is placed after 5:00 pm the answering service will page the physician on call or contact our weekend clinic if applicable. The physician on call will respond to calls in order of priority. If you do not receive a call back within 20 minutes of placing the call to our answering service, please call again and let the answering service know you have not received a call back.

**Cancellations and Missed Appointments:**
Should you need to reschedule or cancel an appointment, we require at least 24 hour notice in order to make the time available for another patient.

The third time an appointment is missed or cancelled without proper notice within an 18 month period, it may be necessary for us to consider discharge from the practice.

New patients who miss or cancel their initial appointment twice without providing proper notification shall be discharged from the practice and not eligible to establish care with another InterMed provider.

**Prescription Refills:**
We ask patients to contact their pharmacies first to fill all ongoing prescriptions. The pharmacy will then fax a request to our office which we will fax back before the end of the current business day. If this is a request for a new medication then we ask you to contact your physician’s office to obtain prescription refills. When requesting a refill, call (207) 774-5816 between the hours of 8:00 am-5:00 pm. Having the following information at the time of the call would be helpful:
- The medication you are in need of with correct dosage, frequency taken, and quantity requesting.
- The name and location of pharmacy.

Please allow us until the end of the business day (5:30 pm) to fulfill all prescription requests. If we have any questions we will call you back, otherwise please assume the pharmacy has your refill.

**Reporting of Test Results:**
We make every attempt to report test results as soon as they are received. Different tests take varying amounts of time for results to be received. Feel free to ask your physician or their clinical assistant the timeframe in which they expect to receive your results. Once the results have been received, you will be notified by the physician or their clinical assistant via mail, phone or online patient portal. Please note that any sensitive test results will not be published to the portal. If for any reason you do not receive communication regarding results on a test after two weeks please contact our office.
Patient Financial Policy

Insurance Verification and Co-payments
The patient is expected to present an insurance card at each visit. All co-payments and past due balances are due and payable at the time of service.

Self-Pay Accounts
Self-pay accounts shall exist if a patient has no insurance coverage, there is no insurance card on file, or if the patient has not met a yearly deductible or coinsurance. Payment is expected at the time of service. Alternatively for large balances, a payment plan may be worked out with authorized personnel in the Billing Office.

Patient Collection Policy
A patient’s claim balance will be considered past due 30 days from the date of the first statement. If a patient is unable to pay the balance in full within the 30 days, the patient should call the InterMed Billing Office (207-828-0361) to setup a payment plan. If a patient’s claim balance becomes 120 days past due, the balance will be transferred to the Thomas Collection Agency. The patient should then contact the Thomas Collection Agency (207-772-4659) for payment options.

Non-participating Insurance Plans
As a service and courtesy to our established patients, non-participating health insurance plans will be billed as a non-assigned claim. Any outstanding balances are the responsibility of the patient.

Appointments
It is patient’s responsibility to call and cancel scheduled appointments within 24 hours of the appointment. If appointments are not cancelled within 24 hours, InterMed shall reserve the right to charge for the no-show.

Accident Cases
Patients shall be financially responsible for medical services related to an accident. InterMed will submit claims to the patient’s health insurance carrier. All outstanding balances will be the responsibility of the patient.

Workers Compensation Cases
Patients are responsible for notifying InterMed that certain treatment is injury related. Furthermore, the patient is responsible for providing InterMed the appropriate billing information (insurer, claim #, date of injury, etc.)

Patient Refunds
In order for a patient refund to be issued, there must be no outstanding insurance or patient balances. InterMed will process a refund request within 4 – 6 weeks.

Returned Check Fees
A patient’s account will be charged a $15 fee for any checks returned from the bank for insufficient funds.

Child Custody Cases
Unless otherwise notified and accepted by InterMed, the custodial parent shall be responsible for all outstanding charges and balances. If parents share custody (joint custody), unless otherwise agreed by the parties, the parent with the first birthday of the year will have responsibility for outstanding charges and balances. InterMed will bill the insurance carrier for both custodial and non-custodial parents.

Specialty Referrals
If your insurance requires you to choose a primary care physician (PCP), you may need prior authorization completed by your PCP prior to seeing an InterMed Specialist (Audiology, Cardiology, Dermatology, ENT, OB/GYN, Physical Therapy, Sports Medicine and certain ancillary services). It is the patient’s responsibility to ensure a prior authorization is obtained. All charges incurred without a required prior authorization will be the responsibility of the patient.

This financial policy is intended to promote a clear understanding with our patients. If you have any questions or need clarification of any of the above issues, please contact the InterMed Business Office at (207) 828-0361.
Nondiscrimination Notice

InterMed, P.A. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. InterMed, P.A. does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

InterMed, P.A.:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you believe that InterMed has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person or by mail, fax, or email.

InterMed, P.A.
Compliance Officer
84 Marginal Way, Suite 900
Portland, Maine 04101
Phone: 207-347-2937 or Fax: 207-523-1428
Email: compliance@intermed.com

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Language Services

At InterMed, interpreters are available at no cost to assist with communication between health care providers and patients whose primary language is not English. Patients should indicate if they need an interpreter when requesting an appointment.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-207-774-5816.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-207-774-5816.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-207-774-5816.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-207-774-5816.

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-207-774-5816.


警告: 日本語を話される場合、無料の言語支援をご利用いただけます。1-207-774-5816 まで、お電話にてご連絡ください。


주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-207-774-5816 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-207-774-5816.


عنوان: إذا كنت تتحدث لغة أخرى، فإن خدمات المساعدة اللغوية متوفرة لك بالمجاني. اتصل برقم 1-207-774-5816.