Welcome to The Orthopedic Center of St. Louis!

Dr. Chris Reeves and his team would like to welcome and thank you for choosing our practice for your orthopedic spine care. We're honored to be a part of your journey toward better health and mobility.

Dr. Reeves, a board-certified orthopedic spine surgeon with more than 20 years of experience. Dr. Reeves is a graduate of Kansas City University of Medicine and Biosciences, completed his orthopedic surgery residency at Michigan State University, and pursued an advanced spine fellowship at the renowned Beverly Hills Spine Group. During his fellowship, he trained extensively in minimally invasive spine surgery and motion-preserving techniques, including disc arthroplasty. His approach focuses on reducing recovery time and maximizing outcomes by using muscle-sparing, state-of-the-art surgical methods, when necessary, alongside comprehensive non-operative care options.

Our team is here to support you every step of the way:

- Dr. Chris R. Reeves, DO
- Cassidy Harris, PA-C
- Karla Waldt, A.A., CCMA, Clinical and Workers' Compensation Coordinator
- Emma Schnuriger, Clinical Medical Assistant
- Merilee Shelton, Billing Specialist

We understand that seeking care for spine-related issues can be stressful. That's why our team is committed to providing you with compassionate, flexible care tailored to your individual needs. Whether surgical or non-surgical treatment is appropriate, our goal is always to return you to your daily activities as safely and efficiently as possible.

Dr. Reeves is proud to receive most of his referrals from former patients, which is a testament to the quality of care and trust we've built over the years. We're grateful for the opportunity to serve you and hope to earn your trust as well.

We look forward to meeting you and helping you move toward a healthier, more active life!

Sincerely, Dr. Reeves and Team

Practice Information:

- Our office is open Monday through Friday, from 8:00 a.m. to 5:00 p.m.
- If you have any questions before your appointment, please don't hesitate to contact us at (314) 336-2555.
- Our address is: 14825 N. Outer 40 Rd., Suite 200, Chesterfield, MO 63017
- Other location: 201 S. Mount Auburn Rd., Suite B, Cape Girardeau, MO 63703
- Dr. Reeves sees patients in clinic on Tuesday, Wednesday, and Friday mornings. We travel to Cape Girardeau every other Wednesday for clinic.
- Dr. Reeves does surgery on Mondays and Thursdays at the following facilities:
    - St. Louis Spine and Orthopedic Surgery Center (Town and Country)
    - St. Lukes Chesterfield Hospital

After Hours and Emergency Care:

- If you experience a life-threatening medical condition after hours, please call 911 or immediately go to the nearest Emergency Department, even if you are out of town.
- If you have an urgent medical concern that cannot wait until the office reopens, you may call the exchange at 314-622-9522.
- Reminder: the doctors will not authorize refills of pain medication or maintenance medications after hours.

Appointments:

- Each patient is required to present a valid insurance card and photo ID at each visit, even if you have an active workers compensation claim or litigation claim.
- We strive to minimize waiting times and spend as much time as needed to address your medical concern. Please note that Dr. Reeves only addresses 1 body part at a time. If you need to address 2 body parts at a time, please notify us while scheduling so we can find an appropriate time slot for your appointment.
- If you are running late to your appointment, please call the office at 314-336-2555 and notify us to ensure you will still be able to be seen.
- If you are 20 minutes late for your arrival time, you will be asked to reschedule if Dr. Reeves is unable to work you onto the remaining schedule. We strive to see everyone, but we are an orthopedic office that sees emergencies which may cause unforeseen delays and may not allow us to work someone in.

Narcotic Policy:

- Dr. Reeves has a very strict policy regarding narcotics. It is his policy that patients will receive prescription narcotics only for immediate post operative period or if you have an acute traumatic injury. You should only require these for a short time. Every effort will be made to switch you over to a non-narcotic pain medication as soon as your pain level permits. If you require long term narcotic use or narcotic use for chronic, non-traumatic conditions, you will be referred to your primary care provider or a pain management physician for pain management.
    - Please allow 48-72 hours for our staff to process your refill request.
    - Dr. Reeves will only authorize prescriptions for narcotic medications during office hours Monday-Thursday. Please note that medication refills will not be sent out on Fridays.
    - Dr. Reeves' staff may ask you to schedule an office visit before authorizing your refill request.
    - If you are prescribed narcotic pain medication you must:
        1. Only use one pharmacy for these prescriptions.
        2. Only receive your narcotic pain medicine from one physician.
        3. It is your responsibility to call for refill requests in a timely manner. Refill requests again will not be filled on Fridays.
        4. We ask you to inform us of your present medications. Please inform us of any new medications that you have received from other physicians at each appointment.
        5. You must use your medications as directed. Early refills will not be honored for any reason.
- Any violation above may be addressed by referring you to a pain management specialist or discontinuing your narcotic medicine.

XRAY/Imaging:

- Dr. Reeves requires x-rays to be obtained on all of his new patients. Please bring all previously taken x-rays/MRI/CT films to your appointment on a disc along with the written report.
- If an MRI or CT is required to diagnose your condition, our office schedules these at Imaging Partners of Missouri, MRI Partners, CT Partners, Rayus (Chesterfield or St. Peters), and Midwest Imaging Specialists in Cape Girardeau. These imaging centers are known for their high-resolution diagnostic scans which is crucial to ensure you are getting the best quality so that Dr. Reeves can provide best treatment plan.

Medical Records / Disability Paperwork:

- Each physician reserves the right to determine the type of medical-related forms they will complete and sign.
- FMLA and STD forms will only be completed for surgery and will only be completed when a surgical date is scheduled. Please fax the forms to 833-365-7948. Please allow 10 business days from the date we receive it.
- There will be a charge for completion of the paperwork. Insurance companies do not cover this service.

Billing:

We are happy to bill your medical insurance for you. Please understand that our billing service is offered as a courtesy to you. It does not obligate us to wait indefinitely for payment by your carrier.

- Co-payments and any prior balance, including co-insurance and/or deductible are required to be paid before every visit and we reserve the right to reschedule your appointment if you are not prepared to pay your account balance.
- Prior to elective surgery, we will check with your insurance company to determine if authorization is required. It is your responsibility to also contact your insurance company to determine your coverage, check any pre-existing condition clauses, and your financial responsibility. You will be required to pay your portion of your financial responsibility prior to your elective surgery.
- Dr. Reeves reserves the right to cancel surgery if your financial obligation has not been met. If you have any billing questions, please contact Merilee, billing specialist, at 314-336-2638.

Workers' Compensation Patients:

Dr. Reeves is very experienced in workman's compensation injuries and laws pertaining to work comp. He will help you to get you back to your activities and to work as quickly as possible.

- After your examination, Dr. Reeves will advise you of your work restrictions due to your injury or condition. Our office is aware that the restrictions may not necessarily be an option at your place of employment. Nevertheless, we still must list the restrictions on your work status statement, and your employer will advise as to whether they can accommodate you or not.
- Please keep in mind that worker's comp patients are not allowed to change or reschedule their own appointments without authorization from the case manager/adjuster. Therefore, all changes must go through their worker's compensation case manager/adjuster.

DR. CHRIS R. REEVES

PATIENT REGISTRATION

FIRST NAME	MIDDLE NAME/INITIAL	LAST NAME

Preferred Name	Date of Birth	Social Security Number	Gender: Male ☐ Female ☐

Primary Care Doctor	Name	Address	Phone	Fax
Referring Provider	Name	Address	Phone	Fax

DEMOGRAPHIC INFORMATION

Home Address							Zip code
Home Phone	Area code	Number		Work Phone	Area code	Number	Extension
Cell Phone	Area code	Number		Preferred Phone	☐ Home	☐ Work	☐ Cellular
Email Address				Preferred communication	☐ Phone	☐ Mail	☐ Email

Mailing Address *(if different from home address)*-	Zip code

Whom shall we contact in an emergency?	Relationship to patient?	Phone number

Race	Ethnicity: ☐ Hispanic/Latino ☐ Non Hispanic/Latino ☐ Unreported/Refused

Preferred Language ☐ English ☐ Spanish ☐ Other	Do you need an interpreter? ☐ Yes ☐ No What type of interpreter?

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Domestic Partner

Employment ☐ Full-Time ☐ Part Time ☐ Not Employed ☐ Student	Employer

PRIMARY INSURANCE

Insurance Plan Name		Effective Date	
Subscriber ID		Group Number	
Insured's Name		Date of Birth	
Relationship to Patient ☐ Self ☐ Spouse ☐ Parent ☐ Partner		Social Security #	

SECONDARY INSURANCE

Insurance Plan Name		Effective Date	
Subscriber ID		Group Number	
Insured's Name		Date of Birth	
Relationship to Patient ☐ Self ☐ Spouse ☐ Parent ☐ Partner		Social Security #	

ASSIGNMENT OF BENEFITS

- I understand I am financially responsible for all charges and services provided to me, including the balance remaining after payment of potential insurance benefits. I authorize payment of medical insurance benefits to The Orthopedic Center of St. louis for professional services rendered.
- I authorize the release of any information necessary to process this claim.
- I certify that all the above information is true and correct to the best of my knowledge. I give my permission to the Provider and/or medical staff to administer and perform such procedures deemed necessary in the diagnosis and/or treatment of my medical condition(s).

Signature of Patient / Legal Guardian/Representative	Relationship	Date

Complete this section if you are here for a work comp injury, if not proceed to the next page:

Your answers to these questions are very important. Please take the time to be as accurate and as specific as possible.

Work History:

What is your current occupation? _____

What company do you currently work for? _____

When did you first start working for this company? _____

If you are no longer working for this company, when did you last work for this company? _____

Are you currently working at your regular job? ☐Yes ☐No If so, are you light duty? ☐Yes ☐No

If you are on light duty, what are your restrictions?

_____

What was your occupation when you developed the problem you are being seen for?

_____

What company were you working for when you developed this problem? _____

How many hours a day do you (or did you) work? _____

How many hours a week do you (or did you) work? _____

Have you had prior injuries or treatment under work comp? ☐Yes ☐No

If so, please list prior work comp injuries:

_____

Describe your job in detail (the job you were working when you developed the problem):

- What percentage of your day is standing? _____
- What percentage of your day is sitting? _____
- How much walking is required? _____
- Do you climb, work on ladders, or work at heights? _____
- How much do you lift? _____ How frequently? _____

Additional comments: _____

Do you have a second job? ☐Yes ☐No

If yes, please describe what you do and list how many hours per day and week you work there:

_____

Signature: _____ Date: _____

AUTHORIZATION FOR MEDICAL TREATMENT and RELEASE OF INFORMATION

I authorize my physician and his/her employees, to provide the medical care, tests, procedures, medications, services and supplies considered advisable by my physician. These services may include pathology, radiology, emergency and other special services. In consenting to treatment, I have not relied on any statements as to results. In the event that any personnel assisting in the provision of care and treatment suffer inadvertent exposure to any of my blood and/or other bodily substance that are capable of transmitting disease and I am unable to consult timely with my physician prior to testing, I consent to limited testing to determine the presence, if any of antibodies to hepatitis A, B, and C and HIV.

STORAGE AND RELEASE OF INFORMATION

I consent to the electronic storage and transmission of patient health information. I hereby authorize my treating physician, to release by electronic means or otherwise any medical and/or billing information concerning my care, including copies of my medical records to:

a. Any governmental or other entity as required by law for purposes of reporting or for purposes of determining the eligibility in government sponsored benefit programs.
b. The supplier of any blood or blood products which may be administered to me for the purposes of quality control and recipient monitoring.
c. Any continuing care, residential or long-term care facility, or home health agency for the purposes of providing services for my care.
d. Another health care provider that prescribes medication electronically to provide continuity of care and quality of care issues regarding prescriptions.
e. I also authorize my physician to obtain information from other providers regarding my care and treatment including obtaining my electronic medication and prescription history from whatever source for the purpose of my continuing care and treatment.

Signature of Patient/Legal Guardian/Representative	Relationship	Date

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient Name _____
Last First MI Maiden

Date of Birth _____ Social Security Number _____

I Authorize and Request: _____

_____

_____

_____ _____
Office Phone Office Fax

To Release to: Dr. Chris R. Reeves
14825 N Outer 40 Road, Suite 200
Chesterfield, MO 63017
Office Phone: 314-336-2555
Office Fax: 833-365-7948

Medical Records covering the periods of health care from _____ to _____
Date Date

Please check, and initial, the types of records you do not want released.

☐ HIV Testing/Treatment Records ☐ Substance Use/Abuse History ☐ Psychiatric Evaluation

☐ Other (please specify) _____

The Medical Information is neededfor: _____

ATTENTION: Once this information has been released pursuant to the Authorization, it may no longer be protected by Federal, and/or State law/regulations and may no longer be deemed "confidential."

I understand that neither Dr. Chris R. Reeves or any of its affiliated healthcare providers can make me sign this Authorization as a condition to getting treatment, making payments on any bills, or gaining enrollment or eligibility in any health insurance plan, unless the Federal Privacy Regulations allow it. I agree that I have received a signed copy of this Authorization, if so requested.

I understand that I may revoke the Authorization at any time except to the extent that prior action has been taken in reliance on this Authorization. This Authorization will expire one (1) year from the date it is signed if I do not cancel it in writing prior to the expiration date. I understand that if I want to cancel/revoke this Authorization, I must mail, fax, or bring a letter in person stating that I want to cancel this Authorization. I understand that I need to mail, fax or bring the letter to the address or fax number at the top of the page.

If you are signing on behalf of a patient for whom you are the legal guardian or personal representative, you must attach a certified copy of your appointment as legal guardian or personal representative. If you are signing on behalf of a patient who is deceased, you must attach a certified copy of the patient's Death Certificate.

_____ _____ _____
Signature of Patient (if the patient is incompetent, of his guardian or other) *Relationship* *Date*

_____
Printed name of person authorized under State Law to act in the patient's behalf, if the patient is deceased, or his personal representative or if none, of his child, parent, or sibling.

THE ORTHOPEDIC CENTER OF ST. LOUIS
COMMUNICATION AUTHORIZATION

Patient Name _____
Last First MI Maiden

Date of Birth _____ Social Security Number-Last 4Digits _____

I authorize the providers and staff of The Orthopedic Center of St. Louis to discuss and disclose my Protected Health Information (PHI) to the person(s) named below.

Name	Relationship	Phone Number

I authorize the providers and staff of The Orthopedic Center of St. Louis to leave messages:

☐ On my home answering machine / voice mail.

☐ On my cell phone voice mail.

HIPAA: NOTICE OF PRIVACY PRACTICES

I have received, and/or been provided the opportunity to receive, a copy of the "Notice of Privacy Practices" that explains when, where and why my confidential health information may be used or shared.

I acknowledge that The Orthopedic Center of St. Louis physicians, medical assistants and other staff may use and share my confidential health information with others in order to 1) treat me, 2) to arrange for payment of my bill, and 3) for issues that concern The Orthopedic Center of St. Louis operations and responsibilities.

This authorization remains in force until revoked in writing. The purpose of this disclosure/use is for continued medical care.

_____ _____ _____
Signature of Patient, Guardian, Personal Representative Relationship Date

_____
Print name of person authorized under state law to act in the patient's behalf, if the patient is deceased, or his personal representative, or if none, of his child, parent or sibling.

THE ORTHOPEDIC CENTER OF ST. LOUIS

NEW PATIENT HEALTH HISTORY

Dr. Chris Reeves

Date of Visit _____

Name _____ DOB _____ Gender ☐ M ☐ F

Who referred you to Dr. Reeves? _____ Phone Number _____

Patient Phone Number: _____ Height _____ Weight _____

Hand Preference ☐ Right ☐ Left Are you pregnant? ☐ No ☐ Yes ☐ Unknown

Primary Care Provider _____ Phone _____

Preferred Pharmacy _____ Phone _____

Work Compensation Information Claim Number: _____ Date of Injury: _____

Employer: _____

Claims Adjuster: _____ Phone Number: _____ Fax: _____

Case Manager: _____ Phone Number: _____ Fax: _____

CHIEF COMPLAINT

Please describe your current injury/complaint. _____

How long have you experienced this condition? _____

What makes your symptoms better (ie, rest, medication)? _____

What makes your symptoms worse (ie, walking, bending)? _____

Which of your symptoms caused you the most concern? _____

Date of onset/injury _____ Were you in an auto accident? _____

Is this a work-related injury? ☐ YES ☐ NO Who is your case manager/case adjuster? _____

Have you had any x-rays or test performed for this condition?

☐ **YES (PLEASE BRING IMAGES ON DISC)** ☐ **NO**

Type of test/scan _____

Date _____ Where was it done? _____

Type of test/scan _____

Date _____ Where was it done? _____

Type of test/scan _____

Date _____ Where was it done? _____

Have you had any prior treatment for this condition? ☐ **YES** ☐ **NO**

Describe _____

PAST MEDICAL HISTORY: *Please check if you have now, or have had in the past, any of these medical conditions.*

☐ **NO PAST MEDICAL PROBLEMS**	☐ Arrhythmia	☐ Asthma
☐ Heart Attack	☐ Anemia	☐ Pneumonia
☐ Angina or Chest Pain	☐ Bleeding Ulcer	☐ Chronic Bronchitis
☐ Congestive Heart Failure/Heart Disease	☐ Headache/Migraines	☐ Blood Clot in Lung
☐ Mitral Valve Prolapse	☐ Sleep Apnea	☐ Tuberculosis
☐ High Blood Pressure	☐ Lung Disease	☐ Liver Problems
☐ High Cholesterol/Triglycerides	☐ Emphysema (COPD)	☐ Diabetes- ☐ Insulin ☐ Non-Insulin

☐ Psychiatric history	☐ Diverticulitis	☐ Thyroid Problems
☐ Anxiety	☐ Osteoarthritis	☐ Kidney Stones / Disease
☐ Depression	☐ Ulcerative Colitis	☐ Urologic Problems
☐ Schizophrenia	☐ Hiatal Hernia	☐ Stress Incontinence
☐ Blood Clot/DVT	☐ Reflux	☐ Enlarged Prostate
☐ Legs ☐ Lungs ☐ Other	☐ Stomach or Intestinal Ulcer	☐ Frequent Urinary Inf (UTI)
☐ Peripheral Vascular Disease	☐ Crohn's Disease	☐ Problems with Anesthesia
☐ Peripheral Neuropathy	☐ Irritable Bowel	☐ Seizure Disorder
☐ Cancer _____	☐ Peptic Ulcer Disease	☐ Other _____
☐ Fracture(s) _____	☐ Crohn's Disease	☐ Other _____
☐ Hepatitis __	☐ Intestinal Bleeding	☐ Other _____
☐ HiV+	☐ Fibromyalgia	☐ Comments _____

SURGICAL HISTORY: *Please check if you have had any of these surgeries.*

☐ **NO PREVIOUS SURGERY**	☐ Breast Surgery	☐ Prostate Surgery
☐ Abdominal Surgery	Type _____	☐ Other (explain)
Type: _____	☐ Carotid Surgery	_____
☐ Aneurysm	☐ Colon Surgery	_____
☐ Angioplasty/Stents	☐ Coronary Bypass (CABG)	_____
☐ Artery Bypass of Arm or Leg	☐ Heart Valve Replacement	_____
☐ Bone/Joint Surgery	☐ Hysterectomy	_____
Type _____	☐ Pacemaker/Defibrillator	_____

☐ Back/Neck Surgery

☐ Cervical (neck)	Level(s) _____	When?	
☐ Thoracic	Level(s) _____	When?	_____
☐ Lumbar (low back)	Level(s) _____	When?	_____

☐ Implanted Devices *(If YES, check all that apply.)*

☐ Spinal Cord Stimulator	☐ Pacemaker	☐ IUD	☐ Venous Access
☐ Aneurysm Clip(s)	☐ AICD	☐ Breast Implant	☐ Screws, Pins, Plates
☐ Intrathecal Pump	☐ Insulin Pump		Where? _____

MEDICATION ALLERGIES (PLEASE REVIEW/FILL OUT ATTACHED MEDICATION LIST)

☐ **NO KNOWN MEDICATION ALLERGIES**			
Are you allergic to Contrast Dye?	☐ NO	☐ YES	Reaction:
Are you allergic to Latex?	☐ NO	☐ YES	Reaction:
Are you allergic to Tape?	☐ NO	☐ YES	Type of tape or adhesive / reaction:
Are you allergic to any Food Items?	☐ NO	☐ YES	Type of food / reaction:
Medication Allergy:			Reaction:
Medication Allergy:			Reaction:
Medication Allergy:			Reaction:
Medication Allergy:			Reaction:
Medication Allergy:			Reaction:

FAMILY HISTORY:

*Please check below if any immediate relatives have had any of these conditions: **F**–father, **M**–mother, **S**-sibling.*

☐ Adopted

☐	**NO FAMILY HISTORY TO REPORT**	☐	Cancer	☐	Stroke
☐	Heart Disease	☐	Liver Disease		Diabetes
☐	Lung Disease	☐	Arthritis		Psychiatric Disease
☐	Osteoporosis	☐	High Blood Pressure	☐	Other (Explain)
☐	Anesthesia Difficulties	☐	Kidney Disease		_____
☐	Bleeding Disorders	☐	Rheumatoid Arthritis		_____
☐	Other Inherited Disease (type)				

Patient Name _____ DOB _____ Date of Visit _____

SOCIAL HISTORY:

Occupation									
Work Demands	☐	Sedentary		Moderately Active		Heavy Labor			
Work Status	☐	Working	☐	Retired	☐	Disabled	☐	Other	
Education Level	☐	Grade School	☐	High School	☐	Technical School	☐	Associated Degree	
	☐	Bachelor's Degree	☐	Master's Degree	☐	Doctorate			
Marital Status	☐	Single	☐	Married	☐	Partner	☐	Divorced	☐ Widow/Widower
Smoking	☐	Never Smoked			☐	Former Smoker	☐	Quit Date: _____	
Are you a current smoker?	☐	No	☐	Yes How many packs per day? _____					
Do you dip or chew tobacco?	☐	No	☐	Yes How much per day? _____					
Do you drink alcoholic beverages?	☐	No	☐	Yes How many drinks per week? _____					
Do you use recreational drugs?	☐	No	☐	Yes What and how often? _____					
Have you injected illegal drugs?	☐	No	☐	Yes What and how often? _____					
Do exercise regularly?	☐	No	☐	Yes Describe _____					
What sports/activities do you participate in?									

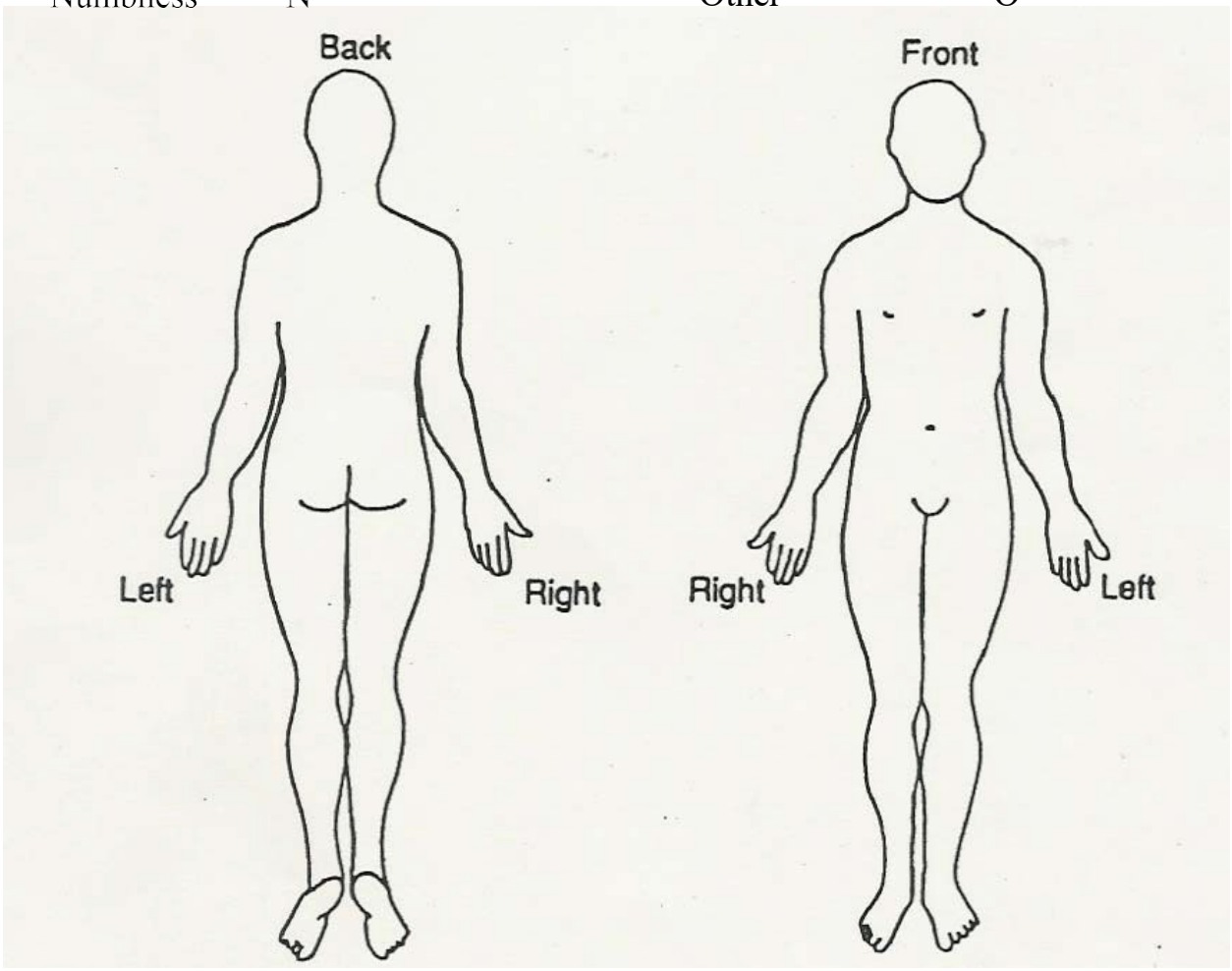
REVIEW OF SYSTEMS: *Please check if you have now, or recently experienced any of these medical conditions.*

☐	**Good General Health**	☐	Wheezing	☐	Dry Skin / Itching
☐	Recent Weight Gain / Loss	☐	Spitting up Blood	☐	Chronic Skin Ulcers
☐	Fever/Chills/Night Sweats	☐	Change in Bowel Habits	☐	Varicose Veins
☐	Fatigue	☐	Loss of Appetite	☐	Numbness / Tingling
☐	Eye Disease/Injury	☐	Nausea / Vomiting	☐	Blackouts
☐	Wear Glasses / Contacts	☐	Diarrhea	☐	Tremors
☐	Blurred / Double Vision	☐	Constipation	☐	Paralysis
☐	Hearing Loss / Ringing	☐	Indigestion	☐	Depression
☐	Chronic Sinus Problem	☐	Burning / Painful Urination	☐	Memory Loss or Confusion
☐	Nosebleed	☐	Frequent Urination	☐	Nervousness
☐	Difficulty Swallowing	☐	Blood in Urine	☐	Insomnia
☐	Shortness of Breath	☐	Joint Pain	☐	Slow Healing after Cuts
☐	Chest Pain	☐	Back Pain	☐	Bruising Tendency
☐	Palpitations	☐	Difficulty Walking	☐	Transfusions
☐	Faintness	☐	Muscle Weakness	☐	Excessive Thirst
☐	Breathing Problems	☐	Leg Cramps	☐	Excessive Sweating
☐	Chronic / Frequent Coughs	☐	Rashes	☐	Other _____

PAIN DIAGRAM

Please use the symbols below to show the area, upon the body outlines, in which you are experiencing pain.

Ache-	A	Pins and Needles	P
Burning-	B	Stabbing	S
Numbness-	N	Other-	O



The line below represents the intensity of the pain you are experiencing. Please make an "X" at the position on the scale which indicates how much pain you are feeling ***at this time***.

Date _____

1 **10**

NO PAIN **WORST PAIN IMAGINABLE**

Patient Medication List

Please list ALL medications (including prescription, over the counter, vitamins, dietary or nutritional supplements) which you may be taking routinely and/or on an as needed basis.

MEDICATION	DOSAGE	FREQUENCY	HOW TAKEN

I understand the need to inform Dr. Reeves of any changes in my medical condition. To the best of my knowledge, the information provided on this form is correct and accurate.

Signature of Patient / Legal Guardian

Date