Dear Sir/Madam,

Thank you for choosing Texas Institute of Dermatology, Laser and Cosmetic Surgery. We strive to provide you with state of the art skin care.

Quality patient care and satisfaction is very important to us. You'll find our staff to be responsive and anxious to answer your questions or address your needs from insurance billing to meeting your scheduling requirements. Your feedback is very important to us, please send your comments and feedback to: survey@txid.org or www.drstars.com/ghohestani . I personally review all comments. I encourage you to fill-out our survey online by visiting our website at www.txid.org. Your feedback allows us to immediately identify a defect and also to improve our service.

Please complete the enclosed forms and bring them with you when you come in for your appointment. If you need further assistance do not hesitate to give us a call at 210-698-6777 or email to frontoffice@txid.org.

If you must change or cancel your appointment, please try and give at least 48 hours notice. Your consideration is greatly appreciated.

Our goal is to build a lasting relationship with you. We will look forward to meeting with you and discussing your specific needs.

Sincerely,

Reza Fredrick Ghohestani, M.D., Ph.D.
Director,
Texas Institute of Dermatology, Laser and Cosmetics

TEXAS INSTITUTE OF DERMATOLOGY™

Reviewed by …

Name ____Maiden Name: _______________ Sex _____Today's Date___/___/__________________

Last First MI

Mailing Address ____

Street Apt # City State Zip

SS# _________________ Date of Birth ___/___/_____ Marital Status ___________Email: ____

Cell Phone (_____)_________________Work Phone (_____)__________ Home Phone (____)_________Prefered Method of Sending Reminders___________________________________

Occupation ____________________________________ Employer _______________________________ Employer Phone Number (___)____________________________________

(If Minor or if in College, Name of School)

How did you hear about us? Google Yahoo Bing Yellow Pages Magazine Sign Billboard Radio TV Yelp Family________ Friend_______ Doctor ________ _ Other ________________

Responsible Party for Payment (if different from patient) Name _________________________________ Date of Birth ___/___/_____ SSN:____________________________________

Address____

Street Apt # City State Zip

Occupation ______________ Employer ________________ Employer Phone Number (___)_________ Address ____

How much is your specialist copay? ___________Do you have health saving account (HSA)? Y N How much is your deductible? ____________Have you met your deductible? Y N

Primary Insurance Company Name ____

Subscriber's Name ____

Subscriber's SSN ________________ DOB: ________________________________

Policy/ID Number: ____

Group Number: ____

Patient Relationship to Insured: ____

Referred by a Physician? Y N Name: ___________________Specialty: _______________

Pharmacy of Choice:_______________________________ Pharmacy Street Number: _________

In case of Emergency Notify:_________________________Relation: _______________

Secondary Insurance Company Name ____

Subscriber's Name ____

Subscriber's SSN ___________________________DOB:____________________

Policy/ID Number: ____

Group Number: ____

Patient Relationship to Insured: _______________________________________

Phone: (____)______________Primary Care Physician(PCP): _________________

Pharmacy Phone: (____)____

Phone: (____)____

PAYMENT POLICY I hereby confirm under penalty by law that all information on this page is true, correct and accurate. I authorize the release of medical information for the use of my primary care/ referring physician, consultants to process insurance claims, billing, insurance applications, & prescriptions. I understand that payment is required for all services at the time of visit. It is my responsibility to ensure my insurance covers my visits, I am responsible to obtain any referral that is needed for this specialist visit if I have a HMO. I authorize payment of medical benefits from insurance companies to Texas Institute of Dermatology (TXID) and/or the physician. Applicable copayments and deductibles will be collected when services are rendered or there will be a $11.00 charge to offset administrative and mailing expenses if there is an outstanding balance after processing the insurance payment (this fee is waived if I authorize credit card payment for my balance). I understand that I am obligated to pay my balance within 30 days of service and authorize TXID to save my credit card information and automatically charge my credit card in file to pay any remaining balance. If any balance is unpaid after 30 days, I am subject to a 18% interest fee (minimum $20) for any outstanding balance after 30 days of service and additional $11 administrative fee for sending me the statement. It is my responsibility to inform TXID of any change in address, health insurance company. In the event my account is turned over to collections, I understand that an additional collection fee (up to an additional 50%) will be added to my account. I agree to pay an additional $50 fee for returned checks. I understand that for appointments which are missed or cancelled less than 48 hours prior to the scheduled appointment for any reason, will incur a $45.00 missed appointment fee, which will be added to my account and I agree to pay it. I authorize Texas Institute of Dermatology (TXID) and his assignee to keep my signature and credit card info on file and to charge my card any outstanding balance and charges not paid by insurance or by myself after 30 days from the date of service. I understand that this form is valid for 36 months from today unless I cancel the authorization through a written notice to TXID. I understand that I have option to opt out the credit card authorization, in that case I agree with paying late fees and interest charge if I fail to pay the balance after 30 days of sending a statement. My signature below signifies my understanding and willingness to comply with this policy. I understand that Texas Institute of Dermatology, Laser and Cosmetic Surgery does not currently accept Medicaid or Medicare and I cannot send the invoice to Medicaid or Medicare. All medical, cosmetic services, skincare and cosmetic products are non-refundable.

PRINT YOUR NAME:_________________________________ SIGNATURE: ______________________________

NAME OF LEGAL GAURDIAN OR PERSON WHO IS FINANCIAL RESPONSIBLE _____________________ SIGNATURE: _______________________________

TEXAS INSTITUTE OF DERMATOLOGY™

Reviewed by …

HEALTH HISTORY

Name :____Date:____________ DRUG ALLERGY: N Y ____________________________

WHAT IS THE REASON FOR TODAY'S VISIT? ____

WHAT ARE THE AREAS THAT YOU WOULD LIKE US TO TREAT? ____

HAVE YOU SEEN A DERMATOLOGIST BEFORE? Y N Name:______________HAVE YOU EVER BEEN ON ACCUTANE (Isotretinoin, CLARAVIS) ? Y N When? _________

DO YOU HAVE ANY HEALTH PROBLEMS? Y N Explain:____

WHAT ORAL OR TOPICA L MEDICATIONS DO Y OU TAKE? ____

HAVE YOU EVER HAD A SKIN ALLERGY? Y N Explain: ____________________DOES YOUR SKIN APPEAR FRAGILE/ BURN EASILY? Y N Explain: ________________

HAVE YOU EVER HAD SKIN CANCER? Y N Explain: ____________HAVE ANYONE IN YOUR FAMILY, EVER HAD SKIN CANCER? Y N Explain: ______________________

DO YOU FORM A THICK OR RAISED SCAR FROM A CUT OR BURN? Y N Explain: _________DO YOU TAKE VITAMINS? Y N DO YOU EVER GET COLD SORES? Y N

DO YOU SMOKE? Y N HOW MUCH? _____ DO YOU CONSUME ALCOHOL? Y N HOW MUCH? ____DO YOU EAT HEALTH Y? Y N DO YOU EXERCISE? Y N

ACNE: DO YOU HAVE FREQUENT BREAKOUTS? Y N SKIN CONDITION: DRY_____OILY_____FLAKY_____UNREMARKABLE_____

WHAT PERCENTAGE OF THE TIME DO YOU SPEND IN THE SUN? SUMMER__________ WINTER__________ DO YOU USE SUNBLOCK OUTDOORS? Y N

For Women Only: ARE YOU PREGNANT OR BREAST-FEEDING? Y N DO YOU HAVE REGULAR PERIODS? Y N ARE YOU CURRENTLY GOING THROUGH MENOPAUSE? Y N

DURING PREGNANCY OR NOW HAVE YOU EVER HAD ANY PROBLEM WITH DARKENING OF YOUR SKIN? Y N

PLEASE ANSWER ALL THAT APPLY. IF ANY OF YOUR ANSWERS ARE YES, PLEASE BRIEFLY EXPLAIN ON THE LINE PROVIDED BELOW EACH SECTION.

RECENT WEIGHT CHANGES……………………	NO YES	KELOID/SCAR…………………………	NO YES	PIGMENTED SPOTS………….……NO YES WHERE……........	
RASH………………………………………....	NO YES	ACNE………………………………...	NO YES	EXPLAIN:..	
GOOD APPETITE……………………………….	NO YES	SKIN LESIONS…………………………	NO YES	EXPLAIN:..	
FEVER………………………………………...	NO YES	CHANGE IN SIZE/SHAPE OF MOLES	NO YES	WHERE IS THE MOLE? …...	
HEPATITIS…………………… …………...........	NO YES	SKIN CYST …………………………..	NO YES	EXPLAIN:..	
WEAKNESS…………………………………….	NO YES	ORAL LESIONS………………………..	NO YES	EXPLAIN:..	
BREAST LUMPS…………………………………..	NO YES	HAIR LOSS/CHANGES………………..	NO YES	EXPLAIN:..	
HIV……………………………………………….	NO YES	NAIL LESIONS/CHANGES……………	NO YES	EXPLAIN:..	

EXPLANATION (IF ANSWERED YES):

____

SHORTNESS OF BREATH..……………………	NO YES	LIGHT HEADED OR DIZZY……………...	NO YES	JOINT PAIN…………………………………….....	NO YES
NOSE BLEEDS..…………………………………..	NO YES	HEADACHES………………………………	NO YES	MUSCLE PAIN OR CRAMPS…………...….…...	NO YES
MOUTH SORES…………………………….....	NO YES	CONFUSION…………………………….	NO YES	BLEEDING OR BRUISING TENDENCY..	NO YES
BLEEDING GUMS..……………………………..	NO YES	NUMBNESS/TINGLING SENSATION..... .	NO YES	SLOW TO HEAL AFTER CUTS…………	NO YES
SORE THROAT…………………………………..	NO YES	WEAKNESS………………………………...	NO YES	PAST TRANSFUSION……………………	NO YES
SWELLING OF FEET/ANKLES/HANDS….......	NO YES	DEPRESSION…………………………….	NO YES	ENLARGED GLANDS………………….....	NO YES
CHRONIC OR FREQUENT COUGHS……........	NO YES	INSOMNIA…..…………………………...	NO YES	BACK PAIN…………….………..……………….	NO YES
SPITTING UP FOOD……..…………………..	NO YES	HOT FLASHES……………………..........	NO YES		

EXPLANATION ____ ____________________________________

HISTORY OF SKIN OR OTHER ADVERSE REACTION TO:		PENICILLIN OR OTHER ANTIBIOTIC…	NO YES	LIDOCAINE OR OTHER ANESTHETICS.	NO YES
IODINE, METHIOLATE-OTHER ANTISEPTICS.	NO YES	ASPIRIN OR OTHER PAIN MEDICINE…	NO YES	OTHER DRUGS/MEDICATIONS.	NO YES
LATEX………………………………........	NO YES				

EXPLANATION (IF ANSWERED YES): ____

HAVE YOU BEEN PREVIOUSLY DIAGNOSED WITH:

CANCER…………………………………………..	NO YES	HEART DISEASE…………………………	NO YES	ALLERGIES……………………………...	NO YES
RESPIRATORY DISEASE……………………….	NO YES	THYROID OR DIABETES………………..	NO YES	PSYCHIATRIC DISORDER……………...…….	NO YES
INFLAMMATORY BOWEL DISEASE………….	NO YES	BLOOD DISORDER………………………	NO YES	LUPUS OR OTHER AUTOIMMUNE DISEASE	NO YES
CROHN'S DISEASE……………….……………...	NO YES	KIDNEY DISEASE……………………......	NO YES		

EXPLANATION:____

LIST PREVIOUS SURGERIES:____ Signature: ____________________________________

Are you interested in any Cosmetic Dermatology Procedure? If Yes, please answer the following questions. If no, skip the following questions, go to office policy section.

WHAT PRODUCTS DO YOU USE ON YOUR FACE? ____ DO YOU WAX OR USE DEPILATORIES ON YOUR FACE? Y N

HAVE YOU EVER HAD A LASER OR COSMETIC PROCEDURE BEFORE? Y N EXPLAIN: ____

WHAT AREA ARE YOU INTERESTED IN IMPROVING? HAIR ___ FACE _____ NECK ____CHEST____-BACK____ HANDS ______ LEGS ___ ABDOMEN _______NAIL_____ FEET______

ARE YOU INTERESTED IN ANY OF THE FOLLOWING COSMETIC PROCEDURES?

ABDOMINAL CIRCUMFERENTIAL REDUCTION	Y N	BODY CONTOURING	Y N	CELLULITE TREATMENT	Y N
BOTOX, DYSPORT OR XEOMIN FOR WRINKLES	Y N	ANY BOTOX INJECTIONS IN THE PAST?	Y N	WHO INJECTED BOTOX?	____________
CHEMICAL PEEL	Y N	FILLERS FOR FACE (JUVEDERM)	Y N	HAND OR NECK REJUVENATION	Y N
LASER FOR ACNE	Y N	LASER FOR AGED SPOTS	Y N	LASER FOR DARK/PIGMENTED SPOTS	Y N
LASER RESURFACING/SKIN REJUVENATION	Y N	ANY PRIOR LASER ON YOUR FACE ?	Y N	LASER TATTOO REMOVAL	Y N
LIP AUGMENTATION/ENHANCEMENT	Y N	MICRODERM	Y N	MELASMA TREATMENT	Y N
NOSE RESHAPING	Y N	NAIL FUNGUS LASER TREATMENT	Y N	VEIN TREATMENT	Y N
LASER FOR ACNE SCAR	Y N	LASER HAIR REMOVAL	Y N	ANY PRIOR LASER HAIR REMOVAL?	Y N

How much is your budget for any of above mentioned cosmetic procedures? TODAY ______________________________ THIS YEAR ______________________________________

OFFICE POLICY

Thank you for choosing the Texas Institute of Dermatology (TXID) for your medical and cosmetic needs. Office staff is available at (210) 698-6777 Monday through Friday, 8:00 am to 5:00 pm. We would like to hear your feedback Survey@txid.org. All surveys are read by our director. Please report all address, insurance, and/or telephone number changes immediately. You are financially responsible for any payment rejection by your insurance due to lack of your current information or any other reasons.

Telephone / Email: We encourage you to contact our office with any questions you may have concerning your medical and cosmetic needs. We will do our best to ensure that your concerns are addressed promptly. If your call concerns an emergency, the doctor will be contacted at once. Otherwise, your call will be answered at the earliest opportunity by either our doctor or the staff. Our office will email or call you to remind you about upcoming appointments, important lab results, newsletters, and/or promotions. Please let us know by sending an email to info@txid.org and mention "unsubscribe", if you do not wish us to email or call you. If you unsubscribe, you are then responsible for paying attention to your appointment time and date since our system will not send you a reminder.

Prescriptions: For any refill, you must contact your pharmacy who will contact us for authorization. If appropriate to refill the prescription, we will provide this authorization within 72 hours. All prescription refills should be requested during regular weekday office hours, when your medical record is available to the doctors. We submit your prescription electronically to your pharmacy, please have the phone and street number available when you place the request. All prescriptions are sent electronically or by phone. Some prescriptions however, will not be given without a recent examination by the physician.

Lab Fees and Results: There may be times when you receive laboratory services. In these cases, you may receive a bill from LabCorp, Global Pathology or Quest Diagnostics Laboratories, as we do not perform the analysis of these tests in our office. We do supply these companies with your biling information from our files, but again it is your responsibility to follow up with these companies to provide financial reimbursement. Most lab results generally take one business week to get back. O ur office will contact you immediately upon receiving them. If you do not hear from us about your lab within 10 business days, you should call our office to follow up. You are responsible for payment of all lab and pathology fees.

Emergency Care: Should you have a medical emergency, we will do our best to respond to your problem promptly. In the event of a serious emergency, you should go immediately to the hospital emergency room.. In a less serious situation, call the office and you will be contacted at our earliest convenience. Please call the office if no one responds to your call within one hour.

Fees & Insurance: Payment for services, including any co-payment, is due at the time of the office visit. Please remember that you are fully responsible for the payment of all medical bills. A photocopy of your ID and insurance card is needed by our insurance department to assist you in filing your claim.

We must have current information concerning your insurance carrier in order to file your claim successfully. If we do not have the correct information, payment of your claim will be delayed. If we do not receive the correct information within time limits imposed by some insurance carriers, your claim may be denied by the carrier and the obligation for paying the bill would be yours. It is your responsibility to present a current insurance card complete with the address and phone number of your carrier to our receptionist at each visit. Our office does not assume any responsibility for denial of any or all parts of your claim by any insurance company if the information provided by you is not correct. If you are a member of a managed care plan (a plan which limits your providers, such as an HMO or PPO), please check your most recent provider directory to determine whether our physicians are members of your plan. If you see a doctor who is not listed on your plan, you may have to pay higher co-pays and/or deductibles. In some cases, insurance carriers will not pay at all when a patient sees a doctor outside of the plan. In this case, you are responsible for paying our service in full.

Referrals: If your managed care plan required a referral from a primary care doctor (usually an HMO), please bring the referral with you on the day of your appointment. Without a proper referral, payment may be refused by your insurance carrier and it would be your responsibility to pay the entire cost of the visit. Patients may be asked to reschedule if a proper referral is not provided. It is your responsibility to provide any referral, if needed. You are responsible to pay for all medical service fees if a referral is not provided at the time of visit. If we are an out-of-network provider, our office will gladly file with your insurance company upon your request. You are responsible for any portion of the bill not covered by insurance. Our office will bill your insurance for the services you receive. Please understand that your medical insurance is a contract between you and your insurance company. Our office will do its best to ensure that your claim is paid, but if your insurance company has not paid your account in full within 30 business days, it will then become your responsibility to pay the balance. You are ultimately responsible for all fees relating to your care. The responsibility for children's accounts rests with the individual that accompanies the child and/or the legal guardian. It is your responsibility to fill-out all paperwork accurately and determine what type of coverage you have when you visit our office and you will be required to pay for the difference if we are not an in-network provider.

*Co-payments, deductibles and fees:*All co-payments, insurance deductibles and fees for services not covered by your insurance policy are due at the time service is rendered. The co-pay cannot be waived, as it is a requirement placed on you by your insurance company. Payment is due at the time of service for all patients. A 18% interest rate will be applied to billed charges not paid 30 days after the date of service. I understand that I have to pay an additional $11 statement fee on any account that has an unpaid balance when the Institute has to mail me a statement to pay. We accept cash, personal checks, and credit cards . A $50.00 charge will be added to my account for each returned check, in addition to any other charges applied by my bank.

Private Pay Patients: All patients are responsible for payment at the time of service. Payment arrangements are available upon request for all patients and are subject to approval by the office Manager. Typically, a payment arrangement for an uninsured patient entails that 50% of the balance is paid at the time of the office visit and the remaining 50% will be due within 30 days of the initial appointment.

Keeping a credit card on file: Please sign our Patient Pay Easy Consent form in order to keep a credit card number on file (the same process you would go through for hotels, rental cars, etc.) to be used for any unpaid balances. I authorize the Institute to charge my card for any outstanding balances.

Cosmetic Packages: All cosmetic packages are non-refundable once they are purchased. Under exceptional circumstances, with the doctor's approval, part of the package can be refunded, based on individual price per session not the discounted package price minus a 15% admin fee. There is a $200 no show fee for all cosmetic packages.

No-Show Policy / Missed appointments: A missed appointment leaves an empty slot that could have been used by another patient. Therefore, we request that patients who are unable to keep their scheduled

appointments notify our office at least 48 hours in advance, so that the time might be made available to someone else. A missed appointment without 48 hours advance notice will result in a no-show fee of $45.00, which is not covered by your insurance. I agree to pay the no-show fee. Multiple no shows will lead to termination of service.

Prior Account Balances: At the time of appointment, patients are responsible for any prior balance that is owed to the office. Accounts balances should be current before any new procedures or treatment is done. I may be rescheduled until I pay the balance in-full. I understand that all outstanding balances and fees should be paid prior to seeing any physician and I may be required to pay upfront at the time of visit for all future appointments.

Collection: I understand that if an account is not paid within 30 days of receiving the first bill, the Institute may turn my account over to a collection agency. TXID may charge a 18% interest fee to any unpaid balance after 30 days. If my account has been turned over to a collection agency, I agree to pay the account balance in full plus an additional administrative/collection fee (up to an additional 50%).

Additional Information and Fees: There is a $50 fee for returned checks. Completing disability insurance forms and employer forms is not a medical service and is not paid by insurance. There is a $45.00 prepaid fee for completing these forms. Please allow at least one week for completion. Please provide a pre-addressed envelope for mailing or a fax number if requested.There is a $25 fee for copying first 10 pages of medical records with the exception of continuation of care, and $1 per page after the first 10 pages. A legal release is required. Please allow at least one week for records to be released. I,

I have read the Texas Institute of Dermatology, Laser and Cosmetic Surgery Financial Policy in full, and I understand and agree to this policy. I acknowledge full financial responsibility for services rendered by Dr. Ghohestani and his staff. I understand that I am responsible for prompt payment of any portion of the charges not covered by insurance, including deductibles and co-payments. I understand that payment of co-payments is expected at the time of service, as well as any prior balance that I owe and I agree to the late payment and collection fees. I understand the policy regarding missed appointments. I also consent that the payment of authorized insurance benefits be made on my behalf directly to Texas Institute of Dermatology, Laser and Cosmetic Surgery for any medical or surgical or cosmetic services furnished.

Photos and Case Information: I understand and accept that I may be recognized from my likeness or case history. Nevertheless, I authorize my Physician to use my photographs, videotapes and case information in educational and scientific settings including lectures and multi-media presentations for an audience of media professionals, at which members of the press may be present, and medical, surgical and scientific journal articles. I authorize the use of my photographs, videotapes and case information in the following commercial/educational settings: my physician's office patient education materials; my physician's file of pre- and postoperative patient photographs available to prospective patients for viewing in the office; newspaper and magazine articles in which my surgeon participates; television programs in which my dermatologist participates; my physician's personal web site or web page; lectures and multi-media presentations given by my physician for the general public. I also authorize my physician's professional associations to use my photographs and case information in fulfilling its mission of public education, in any of the following settings: educational video tapes available for purchase; lectures and slide presentations.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. This form is a "friendly" version. A more complete text is posted in the office, please ask our staff to review it. What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. A copy of the full Notice of Privacy Practices is available to you. If you have any questions regarding the information set forth in the form, please do not hesitate to ask the staff. If you need further assistance, please contact the Office Administrator or the Front office at (210) 698-6777. Additional information is also available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other health care providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff . You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information. The data can also be stored in computer or electronically in a third party server, the data is sent electronically through internet.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice. We may send you other communications informing you of changes to office policy, new promotions, newsletters, and new technology that you might find valuable or informative. You may inform us if you do not wish to receive any promotional information from us.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA. In the event a bill is overdue we may need to give Health Information to a collection agency as necessary to help collect the bill or may disclose an outstanding debt to credit reporting agencies.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, will be to someone who may be able to help prevent the threat.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services except as those agreed.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward. I consent to the release of any medical information necessary to process any claims. I also authorize the release of medical records to my referring physicians.

I agree with all details specified in office policy, financial statement and notice of privacy practices.

______________________________ ______________________________ DATE____________

PATIENT/GUARDIAN SIGNATURE WITNESS SIGNATURE