Caprock Cardiovascular Center, LLP

4316 23rd Street
Lubbock, TX 79410
Phone: (806) 701-5858
Fax: (806) 701-5799

CAPROCK
CARDIOVASCULAR CENTER, LLP

Thank you for choosing Caprock Cardiovascular Center, LLP for your personal cardiac needs. Please completely fill out the enclosed forms and bring them with you to your appointment.

To ensure you have an excellent experience in our office, here are a few reminders for your first visit.

- **Please arrive 15 minutes early to your first appointment to allow for processing of your initial paperwork.**
- **Please bring ALL of your Medications/Supplements in their original bottles.**
- **Please bring ALL of your insurance cards and a photo I.D.**
- **Payment of co-pays, co-insurance and/or deductibles are expected at the time of service.**

If you have any questions, please call us at (806) 701-5858 or Toll Free at (844) 340-4812.

Sincerely,

The physicians and staff at Caprock Cardiovascular Center, LLP

Caprock Cardiovascular Center, LLP

PATIENT INFORMATION

A.

PATIENT: _____ SSN: _____
LAST FIRST MIDDLE

DRIVER'S LICENSE NUMBER: _____ STATE: _____ BIRTH DATE: ____/____/____

GENDER: ☐ M ☐ F MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ SEPARATED ☐ DIVORCED

ETHNICITY: ☐ HISPANIC OR LATINO OR SPANISH ORIGIN ☐ NOT HISPANIC OR LATINO OR SPANISH ORIGIN

RACE: ☐ ASIAN ☐ BLACK/AFRICAN-AMERICAN ☐ CAUCASIAN/WHITE ☐ HISPANIC ☐ NATIVE AMERICAN/ALASKAN NATIVE
☐ NATIVE HAWAIIAN/PACIFIC ISLAND ☐ OTHER ☐ REFUSE

MAILING ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME TELEPHONE: (_____)_____ CELL: (_____)_____

EMPLOYMENT STATUS: ☐ EMPLOYED ☐ STUDENT ☐ RETIRED ☐ OTHER

EMPLOYER: _____ PATIENT'S WORK NUMBER: _____

PATIENT'S ADDITIONAL PHONE: (_____)_____ E-MAIL: _____

EMERGENCY CONTACT NAME: _____ TELEPHONE: (_____)_____

EMERGENCY CONTACT RELATIONSHIP: _____

WOULD YOU LIKE TO RECEIVE APPOINTMENT REMINDERS: ☐ YES ☐ NO

PRIMARY CARE PHYSICIAN: _____ OB/GYN IF APPLICABLE: _____

PREFERRED LANGUAGE: ☐ ENGLISH ☐ SPANISH ☐ SIGN LANGUAGE ☐ OTHER _____

B. GUARANTOR INFORMATION (IF PATIENT IS UNDER 18)

GUARANTOR NAME: _____ RELATIONSHIP OF PATIENT TO GUARANTOR: ☐ CHILD ☐ OTHER

DRIVER'S LICENSE NUMBER: _____ STATE: _____

GUARANTOR MAILING ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

GUARANTOR HOME TELEPHONE: (___)_____ GUARANTOR SSN: _____ GUARANTOR DOB: _____

GUARANTOR EMPLOYER: _____ GUARANTOR WORK TELEPHONE: _____

C. PRIMARY INSURANCE INFORMATION
(IF PROVIDING CURRENT INSURANCE CARD, SKIP C & D)

NAME OF COMPANY: _____

MEMBER NUMBER / CERTIFICATE NUMBER: _____ GROUP / PLAN: _____

POLICY EFFECTIVE DATE: _____

RELATIONSHIP OF PATIENT TO SUBSCRIBER / INSURED: ☐ CHILD* ☐ OTHER* ☐ SELF ☐ SPOUSE*
(*IF PATIENT IS NOT THE SUBSCRIBER, PLEASE COMPLETE THE INFORMATION BELOW)

NAME OF SUBSCRIBER: _____ BIRTH DATE: ____/____/____

SUBSCRIBER'S EMPLOYER: _____

D. SECONDARY INSURANCE INFORMATION

NAME OF COMPANY: _____

MEMBER NUMBER / CERTIFICATE NUMBER: _____ GROUP / PLAN: _____

POLICY EFFECTIVE DATE: _____

RELATIONSHIP OF PATIENT TO SUBSCRIBER / INSURED: ☐ CHILD* ☐ OTHER* ☐ SELF ☐ SPOUSE*
(*IF PATIENT IS NOT THE SUBSCRIBER, PLEASE COMPLETE THE INFORMATION BELOW)

NAME OF SUBSCRIBER: _____ BIRTH DATE: ____/____/____

SUBSCRIBER'S EMPLOYER: _____

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PATIENT FINANCIAL RESPONSIBILITY

We are committed to providing you with the best possible Cardiac and medical care: if you have special needs, we are here to work with you. The following information is provided to avoid any misunderstanding or disagreement concerning payment for professional services.

1. The total patient balance due is required to be paid at the time services are provided. For your convenience, we accept cash, checks, Visa, MasterCard, Discover and American Express
2. Our office participates with a variety of insurance plans. It is your responsibility to:
    a. Bring ALL of your insurance cards at EVERY visit
    b. Be prepared to pay your co-payment, co-insurance and/or deducible at each visit. Payment can be made by cash, check or credit card.
    c. For medical care not covered, deemed medically unnecessary or deemed cosmetic by your insurance company, payment in full is due at the time of your visit.
3. If you have insurance that we do not participate in, our office is happy to file the claim upon request; however, payment in full is required at the time of service. A deposit will be required for all surgeries.
4. If the total patient balance due cannot be paid in full, arrangements must be made PRIOR to services being rendered. Failure to make arrangements with Caprock Cardiovascular Center, LLP will result in the immediate collection turnover or payment in full.
5. Referrals: It is your responsibility to bring any required referrals for treatment at, or prior to the visit. If you do not have the referral, your visit may be rescheduled or you will be financially responsible for all services rendered.
6. If the patient is a minor (18 years or younger), the parent or guardian must sign below. The parent, guardian or unaccompanied minor is responsible for any payment due at the time of service, bringing the necessary referrals and insurance card(s).
7. If you have questions about your insurance, we are happy to help you. Specific coverage issues; however, should be directed to your insurance company's member services department.
8. If you fail to make payment in full for the services that are rendered to you, your outstanding balance will be sent to a collection agency. If you consistently refuse to pay for services rendered, Caprock Cardiovascular Center, LLP may choose to cease providing services to you.

Our practice firmly believes that a good physician/patient relationship is based upon understanding and good communication. Questions about financial arrangements should be asked prior to services being provided.

Patient Signature: _____ Date: _____

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CONSENT TO TREATEMENT:
I (the patient/parent/guardian/legal representative of the patient acting on the patient's behalf) give permission for medical treatment, including radiology and laboratory procedures, to be performed by the physicians and staff of Caprock Cardiovascular Center, LLP. **(Center)**. This consent is valid from this date forward.

FINANCIAL AGREEMENT:
The person signing below agrees, whether he/she signs as patient or representative of the patient, that in consideration of the services rendered to the patient, he/she hereby individually obligates himself/herself to pay the account of the Center at the Regular rates and terms of the Center. Should the account be referred to an attorney or collection agency for collection, the person signing below shall pay reasonable attorney's fees and collection expenses.

"I assign payment for the unpaid charges for certain medical treatment furnished by the physicians and staff of Caprock Cardiovascular Center, LLP and by attending physicians for whom the Center is authorized to bill. I understand that I am responsible for any health insurance deductible and coinsurance **at the time services are rendered."**

AGREEMENT AS TO GOVERNING LAW AND FORUM:
The patient or patient's representative and health care provider, including employees and agents of the healthcare provider, rendering or providing medical care, health care, or safety, professional or administrative services directly related to the health care of the patient agree: (1) that all health care rendered shall be governed exclusively and only by Texas Law and in no event shall the law of any other state apply to any health care rendered to patient; and (2) in the event of a dispute, any lawsuit, action, or cause of which in any way relates to health care provided to the patient shall only be brought in a Texas Court in the county/district where all or substantially all of the health care was provided or rendered and in no event will any lawsuit, action or cause of action ever be brought in any other state. The choice of law and forum selection provisions of this paragraph are mandatory and are not permissive.

ASSIGNMENT OF BENEFITS:
In consideration of services rendered, I hereby assign to Caprock Cardiovascular Center, LLP, and/or any physician who has treated me, all rights, title and interest in any payment due me for services described herein as provided in the policy or policies of insurance. I agree to pay the charges of the Center and/or attending physician which is greater than the amount paid by the insurance company or companies.

ADVANCE DIRECTIVE/LIVING WILL:
Do you have an Advance Directive/Living Will? ____ Yes ____No
If you answered No, would you like more information on Advance Directives? ____Yes ____No

Patient Name: _____

Patient Signature: _____ Date: _____

CAPROCK
CARDIOVASCULAR CENTER, LLP

Jason T. Bradley, MD, FACC
Juan Kurdi, MD

ASSESSMENT SUMMARY SHEET

Date of visit: _____ PCP: _____

Name: _____ Referring Physician: _____

Date of Birth: _____ Age: _____ Sex: _____ Marital Status: ☐ M ☐ S ☐ W ☐ D

Chief Complaint: _____

_____

History (please do not write in this area): _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

1. Cardiovascular Review of Systems (Please mark yes or no to all questions)

	Yes	No	Date	Place of Treatment
1. Myocardial Infarction (heart attack)				
2. Heart Catherization				
3. Coronary Angioplasty				
4. Coronary Artery Bypass				
5. Stress Test				
6. Echocardiogram				
7. Holter Monitor				
8. EBT				
9. Carotid Doppler				
10. Lower Extremity Doppler				
11. Bypass/Angioplasty/Stent in Other Locations				

- Are you entitled to Black Lung Medical Benefits? ☐Yes ☐ No
- Was this service for treatment of a work-related injury or illness? ☐Yes ☐ No
    - If YES, provide the name and address of the Worker's Compensation Agency, the Worker's Compensation Carrier and your employer.

      _____
      _____
      _____
      _____
- Was this service for the treatment of an illness or injury which resulted from an automobile or other accident? ☐Yes ☐No
    - If YES, provide the name, address, and policy number of the automobile or non-automobile liability or no-fault insurer:

      _____
      _____
      _____
      _____
      Policy Number: _____
- Do you have a veterans Administration fee service card? ☐Yes ☐No
- Are the services to be paid by a government program such as a research grant? ☐Yes ☐No

Patient's Signature_____

Date_____

ONE TIME MEDICARE FILING AUTHORIZATION

I authorize any holder of medical information concerning me to be released to the Health Care Financing Administration and its agents, any information needed to determine these benefits or the benefits payable for related services.

Patient's Signature _____ Date _____

(if unable to sign) _____
Signature of person signing for patient and relationship

_____
Reason for inability of patient to sign

2. Chest Discomfort

A. Date of Onset _____

B. What part of your chest hurts? _____

C. What kind of pain (dull, ache, stabbing, etc.): _____

D. What causes it to hurt? (exercise, etc.): _____

E. How long does the pain last? _____

F. Accompanied by _____

G. What stops the pain? _____

H. How often do you have the pain? _____

I. Progression of pain _____

3. Rheumatic Fever / Heart Disease:	Age: _____	☐ Yes	☐ No
4. Congenital Heart Disease:	Age: _____	☐ Yes	☐ No
5. Heart Murmur	First noted: _____	☐ Yes	☐ No
6. Enlarged Heart		☐ Yes	☐ No
7. Palpitations (heart racing, skipping, pounding, fluttering)		☐ Yes	☐ No
8. Light-headedness/dizziness		☐ Yes	☐ No
9. Syncope (passing out, fainting)		☐ Yes	☐ No
10. Claudication (leg cramps with exercise)		☐ Yes	☐ No
11. Previous Leg Vein Stripping Operation / Phlebitis		☐ Yes	☐ No
12. Ventricular Dysfunction Symptoms		☐ Yes	☐ No
A. Number of pillows to sleep _____			
B. Waking up because of shortness of breath		☐ Yes	☐ No
C. Tiredness/fatique		☐ Yes	☐ No
D. Pedal Edema (swelling of feet and/or legs)		☐ Yes	☐ No
E. Orthopnea (difficulty breathing lying down)		☐ Yes	☐ No

B. Cardiovascular Risk Factors:

1. A Current or past smoker: ☐ No ☐ Yes # or packs _____ How many years _____ Stopped smoking when _____

2. Hypertension (high blood pressure): ☐ Yes ☐ No

When were you diagnosed: _____ Treatment: _____

3. High Cholesterol/Triglycerides _____ ☐ Yes ☐ No

What were your levels, if known: Cholesterol _____ Triglycerides _____

4. Diabetes: (self) _____ ☐ Yes ☐ No

5. Do you exercise regularly? _____ ☐ Yes ☐ No

C. **Present Medications:** (Name of medication, dosage, how often you take medication)

D. **Allergies:**

Drugs: _____

Foods: _____

E. Past Medical/Surgical History:

Reason for hospitalization	Name of Hospital	Dates of Hospitalizations

Other Medical Problems: _____

_____

F. Social/Personal History:

Place of Birth: _____ Place of Residence(city/state): _____

Occupation: _____

Do you drink caffeine: _____ How much / how often: _____

Do you drink alcohol: _____ How much / how often: _____

Do you use recreational drugs: _____ What kind/how much/how often: _____

Do you have any religious restrictions: _____

Have you had any recent stresses: _____

_____

G. Family History (illness your family members have had):

Relation	Living	Deceased	Age	Cause of Death	Did he/she have: Heart attack, Stroke, Diabetes, High Blood Pressure
Mother					
Father					
Brothers					
(living or deceased)					
Sisters					
(living or deceased)					
Children					
(living or deceased)					

Vital Signs Right Arm Left Arm

BP: Supine _____ _____ HR: _____ HT: _____

Sitting _____ _____ Resp: _____ WT: _____

HEENT: Pupils: _____ Sclerae: _____ Arcus: _____

FUNDI: _____Normal _____AV Nicking _____Narrowing _____Hemorrhages

NECK: _____Normal _____JVD _____Carotid Bruits _____Thyromegaly

LUNGS: _____Clear _____Rhonchi _____Rales

HEART: _____PMI _____Lift _____Heart Sounds _____Rub _____Click

_____Systolic Murmur _____Diastolic Murmer

PULSES:

	FEM.	P. TIB.	D.P.
RIGHT			
LEFT			

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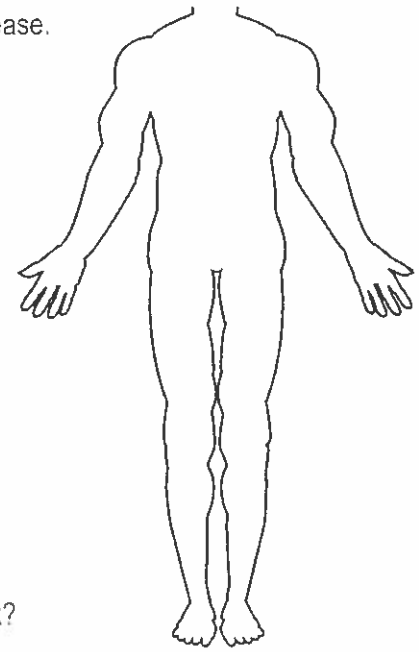
Jason T. Bradley, MD, FACC
Juan Kurdi, MD

Are you at risk for Peripheral Arterial Disease?

Name: _____ D.O.B: _____ Date: _____

Peripheral Arterial Disease (PAD) is a common circulation problem in which the blood vessels, which carry blood to the legs or arms, become narrow or clogged.

Please fill out this questionnaire to see if you have symptoms of Peripheral Arterial Disease. Please mark Yes or No to the following questions.



1. Do you have diabetes? ☐ Yes ☐ No

2. Have you experienced TEMPORARY:
   - Loss of vision in one eye? ☐ Yes ☐ No
   - Slurred speech? ☐ Yes ☐ No
   - Weakness or numbness of an arm or leg on one side of your body? ☐ Yes ☐ No

3. Have you had blockages in your coronary arteries? ☐ Yes ☐ No

4. Do you have any ulcers or slow healing wounds on your legs, feet or toes? ☐ Yes ☐ No

5. Do you get any discomfort, cramping, aching, or fatigue in your leg(s) when you walk? ☐ Yes ☐ No

If yes, circle the area of the body on the diagram to the right where you feel pain.

6. How much walking do you do on a typical day? _____
What is the farthest and/or fastest you have walked in the past 6 months? _____
Does anything limit your walking ability? _____
Do you ever use assistance to walk (i.e. cane, walker, motorized cart, someone's arm)? _____
Do you ever need to stop and rest when you are walking? ☐ Yes ☐ No
Why? _____

7. Does the discomfort disappear at rest? ☐ Yes ☐ No

Physician Use Only

Risk Factors Assessment
- ☐ Smoking History/Date Quit ___
- ☐ Diabetes
- ☐ Coronary Artery Disease
- ☐ High Cholesterol/Heart Attack
- ☐ Previous Stroke/TIA
- ☐ Hypertension
- ☐ Family History of Heart Attack/Stroke

Diagnostic Test Ordered
- ☐ ABI
- ☐ ABI with Exercise
- ☐ Arterial Doppler
- ☐ Carotid Doppler
- ☐ AAA
- ☐ Venous Ultrasound

Dear Medicare Patient:

In order to properly file your charges with Medicare, we have been instructed to ask you the following questions. Please answer all of the questions in full. If your status changes at any time in the future, you must let us know at the time of your next visit so that we can update your account.
(Please check the appropriate answer, or fill in the blank[s])

Name: _____ **Medicare Number:** _____

Age: _____ **Date of Birth:** _____ **Sex:** ☐ **Male** ☐ **Female**

Basis for Medicare eligibility: ☐Age ☐Disability ☐End Stage Renal Disease

- Are you or your spouse currently working full or part-time? ☐Yes ☐No
    - If NO, please provide the following:
      Retirement Date of Patient_____
      Retirement Date of Spouse_____
- If you and/or your spouse work(s), how many employees does your employer or your spouse's employer have?
  ☐Less than 20 ☐More than 20
- Are you covered under an employer Group Health Plan based on the current employment of you or your spouse? ☐Yes ☐No
    - If YES, please provide the following:
        - Name of insured and relationship to patient (self, spouse)

          _____;
        - Name and Address of Employer

          _____
          _____
          _____;
        - Name and Address of Insurance Company

          _____
          _____
          _____;
        - Group Identification Number

          _____;
        - Policy Identification Number

          _____;

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2. Our office participates with a variety of insurance plans. It is your responsibility to:
    a. Bring ALL of your insurance cards at EVERY visit
    b. Be prepared to pay your co-payment, co-insurance and/or deducible at each visit. Payment can be made by cash, check or credit card.
    c. For medical care not covered, deemed medically unnecessary or deemed cosmetic by your insurance company, payment in full is due at the time of your visit.
3. If you have insurance that we do not participate in, our office is happy to file the claim upon request; however, payment in full is required at the time of service. A deposit will be required for all surgeries.
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6. If the patient is a minor (18 years or younger), the parent or guardian must sign below. The parent, guardian or unaccompanied minor is responsible for any payment due at the time of service, bringing the necessary referrals and insurance card(s).
7. If you have questions about your insurance, we are happy to help you. Specific coverage issues; however, should be directed to your insurance company's member services department.
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Patient Signature: _____ Date: _____

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Jason T. Bradley, MD, FACC
Juan Kurdi, MD

ASSESSMENT SUMMARY SHEET

Date of visit: _____ PCP: _____

Name: _____ Referring Physician: _____

Date of Birth: _____ Age: _____ Sex: _____ Marital Status: ☐ M ☐ S ☐ W ☐ D

Chief Complaint: _____

History (please do not write in this area): _____

1. Cardiovascular Review of Systems (Please mark yes or no to all questions)

	Yes	No	Date	Place of Treatment
1. Myocardial Infarction (heart attack)				
2. Heart Catherization				
3. Coronary Angioplasty				
4. Coronary Artery Bypass				
5. Stress Test				
6. Echocardiogram				
7. Holter Monitor				
8. EBT				
9. Carotid Doppler				
10. Lower Extremity Doppler				
11. Bypass/Angioplasty/Stent in Other Locations				

2. Chest Discomfort

A. Date of Onset _____

B. What part of your chest hurts? _____

C. What kind of pain (dull, ache, stabbing, etc.): _____

D. What causes it to hurt? (exercise, etc.): _____

E. How long does the pain last? _____

F. Accompanied by _____

G. What stops the pain? _____

H. How often do you have the pain? _____

I. Progression of pain _____

3. Rheumatic Fever / Heart Disease:	Age: _____	☐ Yes	☐ No
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5. Heart Murmur	First noted: _____	☐ Yes	☐ No
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7. Palpitations (heart racing, skipping, pounding, fluttering)		☐ Yes	☐ No
8. Light-headedness/dizziness		☐ Yes	☐ No
9. Syncope (passing out, fainting)		☐ Yes	☐ No
10. Claudication (leg cramps with exercise)		☐ Yes	☐ No
11. Previous Leg Vein Stripping Operation / Phlebitis		☐ Yes	☐ No
12. Ventricular Dysfunction Symptoms		☐ Yes	☐ No
A. Number of pillows to sleep _____			
B. Waking up because of shortness of breath		☐ Yes	☐ No
C. Tiredness/fatique		☐ Yes	☐ No
D. Pedal Edema (swelling of feet and/or legs)		☐ Yes	☐ No
E. Orthopnea (difficulty breathing lying down)		☐ Yes	☐ No

B. Cardiovascular Risk Factors:

1. A Current or past smoker: ☐ No ☐ Yes # or packs _____ How many years _____ Stopped smoking when _____

2. Hypertension (high blood pressure): ☐ Yes ☐ No

When were you diagnosed: _____ Treatment: _____

3. High Cholesterol/Triglycerides _____ ☐ Yes ☐ No

What were your levels, if known: Cholesterol _____ Triglycerides _____

4. Diabetes: (self) _____ ☐ Yes ☐ No

5. Do you exercise regularly? _____ ☐ Yes ☐ No

C. Present Medications: (Name of medication, dosage, how often you take medication)

D. Allergies:

Drugs: _____

Foods: _____

E. Past Medical/Surgical History:

Reason for hospitalization	Name of Hospital	Dates of Hospitalizations

Other Medical Problems: _____

F. Social/Personal History:

Place of Birth: _____ Place of Residence(city/state): _____

Occupation: _____

Do you drink caffeine: _____ How much / how often: _____

Do you drink alcohol: _____ How much / how often: _____

Do you use recreational drugs: _____ What kind/how much/how often: _____

Do you have any religious restrictions: _____

Have you had any recent stresses: _____

G. Family History (illness your family members have had):

Relation	Living	Deceased	Age	Cause of Death	Did he/she have: Heart attack, Stroke, Diabetes, High Blood Pressure
Mother					
Father					
Brothers					
(living or deceased)					
Sisters					
(living or deceased)					
Children					
(living or deceased)					

Vital Signs Right Arm Left Arm

BP: Supine _____ _____ HR: _____ HT: _____

Sitting _____ _____ Resp: _____ WT: _____

HEENT: Pupils: _____ Sclerae: _____ Arcus: _____

FUNDI: _____Normal _____AV Nicking _____Narrowing _____Hemorrhages

NECK: _____Normal _____JVD _____Carotid Bruits _____Thyromegaly

LUNGS: _____Clear _____Rhonchi _____Rales

HEART: _____PMI _____Lift _____Heart Sounds _____Rub _____Click

_____Systolic Murmur _____Diastolic Murmer

PULSES:

	FEM.	P. TIB.	D.P.
RIGHT			
LEFT			

CAPROCK CARDIOVASCULAR CENTER, LLP
PATIENT PORTAL CONSENT

Due to a Federal Government mandate, we are now required to send you an e-mail offering you the opportunity to communicate with us via an online patient portal.

Please note: you will only receive one e-mail from us inviting you to join this portal. Once you get this email, you can either elect to join or decline the offer.

Thank you in advance for helping us comply with this federal mandate by supplying us with your email address.

Name: _____

Email: _____

Caprock Cardiovascular Center, L.L.P.

Consent For Use And Disclosure Of Protected Health Information For Treatment, Payment, Or Healthcare Operations

I understand that as part of my healthcare, the Physician originates and maintains medical records describing my health history, symptoms, examination and test results, diagnosis, treatment, financial and demographic information, and any plans for future care or treatment. The Physician also originates and maintains billing records. I understand and consent to this information being used or disclosed for the following purposes:

- Planning my care and treatment;
- Communications between my Physician and healthcare professionals that act under the direction of my Physician and participating in my diagnosis, evaluation, or treatment;
- Collection of fees for medical services;
- Determining liability for payment and obtaining reimbursement;
- Conducting healthcare operations, including the evaluation of healthcare services, appropriateness and quality of healthcare treatment, and the qualifications of healthcare practitioners.

I have been provided with a copy of the Physician's *Notice of Privacy Practices* that provides information about how the Physician uses and discloses Protected Health Information about me. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent; and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations. The Physician is not required to agree to the requested restrictions, but is bound to any restrictions agreed to.

I understand that as provided in the *Notice of Privacy Practices*, the terms of the *Notice* may change. If they do, I may obtain a revised copy from the privacy officer by calling (806) 701-5858.

I understand that I may revoke this consent in writing, except to the extent that the Physician has already taken action in reliance thereon. I also understand that by refusing to sign or revoking this consent, the Physician may refuse to treat me. I wish to restrict the use or disclosure of my health information as follows:

_____

_____

I understand that my confidential information may be released to the following individuals:

_____

_____

_____ _____

Signature of Patient or Representative | Date

_____ _____

Patient Name | Patient Identification Number (SSN)

_____ _____

Name of Representative (if applicable) | Relationship

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MEDICARE AND/OR MEDICAID CERTIFICATION:

The person signing below certifies that he/she has read this document and is the patient, or is duly authorized by the patient as the patient's representative, to execute the above and accept its terms.

"I certify that the information given by me in applying for payment under Title XVII and/or Title XIX of the Social Security Administration is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries/carriers any information for this or related Medicare claim. I request that payment of authorized benefits be made on my behalf."

Patient Name: _____

Patient Signature: _____ Date: _____