GRAPEVINE MEDICAL & SURGICAL CENTER

1501 WEST NORTHWEST HIGHWAY, GRAPEVINE, TEXAS 76051

AUTHORIZATION AND AGREEMENTS FOR TREATMENT

PATIENT: ____ BIRTHDATE: ____________________

The undersigned hereby makes the following acknowledgement and agreements regarding treatment to be provided the patient named above.

1. CONSENT TO TREATMENT: I understand that medical treatment is necessary for the patient and that such medical care, treatment and procedures will be performed by the physicians, their physician assistants, and by employees of the clinic during published times of operation. I hereby grant my authorization and consent to such treatment and procedures, and certify that no guarantee or assurance has been made as to the results which may be obtained.

2. AGREEMENT TO PAY FOR SERVICES: For and in consideration of the care and treatment provided to the patient, I promise to pay **Grapevine Medical and Surgical Center** all charges for services rendered to or in behalf of the patient.

3. RELEASE OF MEDICAL INFORMATION: I hereby authorize the **Grapevine Medical & Surgical Center** to release any Protected Healthcare Information (PHI) and/or Individually Identifiable Health Information (IIHI) in connection with these services for health insurance purposes and to other physicians involved in treating the patient, through mail, electronic mail and facsimile, knowing fully well that no matter how secure, it may be sent inadvertently to the wrong recipient.

   I. Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operations):

   ____

   ____

   II. Please list the family members or significant others, if any, whom we may inform about your medical condition ONLY IN AN EMERGENCY:

   ________________________________ Phone Number ____________________

   ________________________________ Phone Number ____________________

   III. Please print the address where you would like your billing statements and/or correspondence from our office to be sent if other than your home.

   ____

   ____

   IV. Please indicate if you want all correspondence from our office sent in a sealed envelope marked "CONFIDENTIAL":
   [] Yes [] No

   V. Please print the telephone number where you want to receive calls about your appointments, lab and x-ray results, or other health care information if other than your home phone number: ______________________________
   I am fully aware that a cell phone is not a secure and private line.

   VI. Can confidential messages (i.e., appointment reminders) be left in your telephone answering machine or voicemail?
   [] Yes [] No

This consent will expire: __-__-_____ [] 60 days [] 90 days [] 180 days [] one year [] until revoked
The patient may revoke this consent at any time.

I HAVE READ THE ABOVE ACKNOWLEDGEMENTS AND AGREEMENTS AND FULLY UNDERSTAND THE SAME.

PATIENT NAME ____(guardian if under 18 years)

______________________________ ______________________
Patient/Guardian Signature Date

Relationship to patient: ____________________ Witness: ______________________________