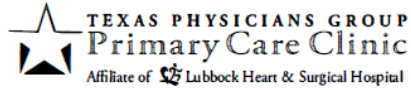


Physician
M. Yates

Originating Clinic
TPG-Slide



General Consent for Treatment

Chart #

Date

Welcome to our clinic!

You have the right, as a patient, to be informed about your condition and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether or not to undergo the suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services. You have the right to discuss the treatment plan with your physician about the purpose, potential risks, and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designers as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at the practice. I understand that if additional testing, invasive or intervention procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of Patient or Personal Representative

Date

Printed Name of Patient or Personal Representative

Relationship to Patient

Signature of Witness

Date

Physician
M. Yates
Originating Clinic
TPG-Slide

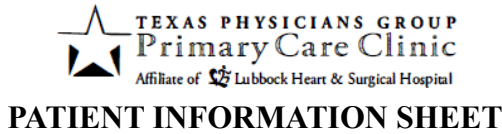


Chart #

Date

Name: _____ Gender: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Mobile Phone: _____

Social Security #: _____ - _____ - _____ Email: _____

Date of Birth: _____ Age: _____ Marital Status: _____

Employer: _____ Emp. Phone: _____

Referring Physician: _____ Ref. Phys. Phone: _____

Primary Physician: _____ Primary Phys Phone: _____

Spouse or Parent Information

Name: _____ Relation: _____

Employer: _____

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

Emergency Notification Outside of Home

Name: _____ Relation: _____

Employer: _____

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

Insurance Information

Primary – Insurance Company: _____

Insured's Name: _____ **DOB:** _____

Secondary – Insurance Company: _____

Insured's Name: _____ **DOB:** _____

NOTICE

Patient Billing
for
Texas Physicians Group
(Affiliate of Lubbock Heart and Surgical Hospital)

Lubbock Heart and Surgical Hospital is the owner of the Ancillary Service Center at Texas Physicians Group

This means that patients may potentially receive notice of *two separate filings* of insurance claims for services rendered by the primary care physicians and the hospital.

1. One claim will represent physician fees; and
2. An additional claim will be for hospital outpatient EKGs, lab tests and/or radiology exams.

Depending on your insurance coverage, patients may experience:

1. One co-insurance and deductible for **physician** services; and
 2. An additional co-insurance and deductible for **hospital** ancillary services.
- Our office makes every effort to send patients' labs to their respective insurance's "preferred" lab.
 - The "preferred" status changes from time to time.
 - Patients are encouraged to inform us if there have been any insurance changes since the last visit to our office at TPG-Slide (Dr. Yates).

Physician
M. Yates

Originating Clinic
TPG-Slide

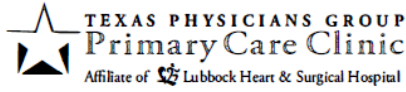


Chart #

Date

**Acknowledgment of Receipt of Notice
of Privacy Practices**

I, _____, acknowledge that I have received a copy of TPG/LHH Notice of Privacy Practices.

Patient Signature

Date

Patient Legal Representative (if applicable)

Date

Print Name of Legal Representative

Relationship to Patient

TPG ONLY

TPG/LHH made the following good faith efforts to obtain the above-referenced individual's written acknowledgment of receipt of the Notice of Privacy Practices:

(Identify the efforts that were made to obtain the individual's written acknowledgment, including the reasons (if known) why the written acknowledgment was not obtained.)

TPG Representative

Date

Physician
M. Yates

Originating Clinic
TPG-Slide

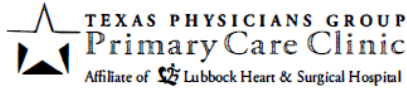


Chart #

Date

**Authorization for Payment and/or Release of
Information to Private or Supplemental Group
Insurance**

Patient Name

Address

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the undersigned physician or physicians for services as described below, but not to exceed the reasonable and customary charge for those services.

Signed (insured person, parent, or legal guardian)

Date

AUTHORIZATION TO RELEASE INFORMATION: I hereby also authorize the undersigned physician to release any information acquired in the course of my examination or treatment.

Signed (insured person, parent, or legal guardian)

Date

MEDICARE

I request that payment of authorized Medicare benefits be made either to me or on my behalf to **Texas Physicians Group/Lubbock Heart Hospital**, for any services furnished to me by that Professional Association. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents information needed to determine benefits or the benefits payable for the related services.

Signed (only if you have Medicare)

Date

Physician
M. Yates

Originating Clinic
TPG-Slide

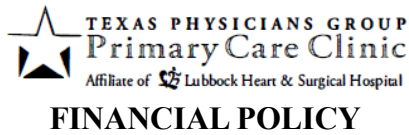


Chart #

Date

We want to thank you for choosing Texas Physicians Group for your medical care. We have developed this financial policy to clarify our billing practices and to avoid any confusion in the future.

For your convenience, we accept payment by cash, check, VISA, MasterCard, Discover, or debit card.

We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit.

All co-payments and deductibles must be paid at the time of service. This arrangement is part of our contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud.

Medicare Patients: All of our physicians, physician's assistants, and nurse practitioners are Medicare providers, and we will submit your bill to Medicare for you. However, you are responsible for payment of your Medicare deductible each year. If you have secondary insurance, we will submit your claim to your secondary insurance as a courtesy to you if you provide us with accurate information. If we do not receive payment from your secondary payor within 60 days after the Medicare payment has been received, it will be your responsibility to make payment at that time. For patients without secondary insurance, you will be required to pay 100% of your co-insurance at the time the service is rendered.

Patients with Managed Care/PPO Plans: You will be asked to pay any deductible or co-pay due per your plan prior to the service being rendered. It will not be waived as long as the physician has rendered the service.

Patients with No Insurance: You will be asked to pay for each visit at the time of service.

Broken appointments: Broken appointments represent not only a cost to us, but also an inability to provide services to others who could have been seen in the time set aside for you. We would appreciate a 24-hour notice of cancellation when possible.

Form Completion: All forms requiring medical review and physician signature, including, but not limited to, FMLA, disability, etc. are subject to an administrative fee of \$25.00. These charges are not covered by insurance and must be paid before completion of the form.

Lastly, it is the patients' responsibility to notify the front desk of any changes in insurance coverage before the service is rendered. Any charges denied because of termination of coverage when we have not been informed, or because of a per-existing condition, will be billed directly to the patient upon receipt of denial from the insurance company.

Nonpayments: If your account is over 60 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency, and you may be discharged from this practice. If this is to occur, you will be notified by certified mail that you have 30 days to find alternative medical care. During that 30-day period, your physician will treat you on an emergency basis only.

I have read and understand the payment policy and agree to abide by its guidelines.

Signature of patient or responsible party

Date

Physician
M. Yates

Originating Clinic
TPG-Slide

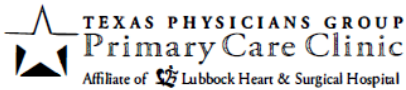


Chart #

Date

Health Insurance Portability and Accountability Act (HIPAA)
Consent for Special Disclosure of Protected Health Information

Please check Yes or No for the following:

I, _____, consent to TPG/LHH employees identifying themselves and leaving messages on my answering machine (if I have one), for the purposes of appointment confirmation, follow-up after a procedure, or to inform me that I need to call TPG/LHH.

Yes

No

I consent to TPG/LHH employees identifying themselves and leaving a message with those who answer my home phone for the purposes of appointment confirmation, follow-up after a procedure, or to inform me that I need to contact TPG/LHH.

Yes

No

I consent to TPG/LHH employees contacting me at work, if applicable, for the purposes of appointment confirmation, follow-up after a procedure, or to inform me that I need to call TPG/LHH.

Yes

No

If using the Virtual Waiting Room, per the agreement concerning its use at the time of registration, I consent to be contacted via phone by TPG/LHH employees identifying themselves and leaving a message with those who answer my phone for the purposes of appointment confirmation; then by text regarding waiting room times, arrival times, and appointment reminders.

Yes

No

I consent to TPG/LHH employees disclosing my private health information such as test results and billing information with a designated family member or personal representative.

Yes

No

If yes, please designate the person(s) to whom such information may be disclosed:

Name: _____

Address: _____

Phone#(s): _____

Relation: _____

Name: _____

Name: _____

Address: _____

Address: _____

Phone #(s) _____

Phone #(s) _____

Relation: _____

Relation: _____

***Patient Signature:** _____

Date: _____

***Witness Signature:** _____

Date: _____

Physician **Marissa Yates, M.D.**

Patient Type

First Names MI Last Name Primary Phone

Reason for Visit

MEDICATION ALLERGIES

Are there any changes to your medication allergies? Y N

If yes, please detail your allergies and reaction below i.e. Rash, Hives, Anaphylaxis

Medication Allergy 1	<input type="text"/>	Medication Reaction 1	<input type="text"/>
Medication Allergy 2	<input type="text"/>	Medication Reaction 2	<input type="text"/>
Medication Allergy 3	<input type="text"/>	Medication Reaction 3	<input type="text"/>
Medication Allergy 4	<input type="text"/>	Medication Reaction 4	<input type="text"/>

Do you Drink	Y <input type="checkbox"/> N <input type="checkbox"/>	If yes, how much?	<input type="text"/>	How Often?	<input type="text"/>
Do you Smoke?	Y <input type="checkbox"/> N <input type="checkbox"/>	If yes, how much?	<input type="text"/>	How Often?	<input type="text"/>

MEDICAL HISTORY

Are there any changes to your medical history? Y N Have you ever had, or do you now have, any of the following conditions? Please check YES or NO. If yes, indicate the age when the condition occurred.

Condition	N	Y	Age	Condition	N	Y	Age	Condition	N	Y	Age
Broken Bones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	Dislocated Joints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	Painful/Stiff Joints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Knee Conditions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	Foot Trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	Head/Spinal Injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Hives/Eczema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	Asthma/Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	Pneumonia/Pleurisy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	Excess Phlem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	Dizziness/Fainting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	Allergy/Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	Cancer/Tumor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	Liver Conditions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	Kidney/Bladder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	Nervous/Mental	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Sinus Trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Industrial Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	Eye Conditions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Genital Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Hernia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	Back Trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Lung Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	Meningitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	Mononucleosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	Tobacco Addiction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Alcohol Addiction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	Drug Addiction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>				

CURRENT MEDICATIONS

Preferred Pharmacy

Are there any changes to your medications since you've seen Dr. Yates? Y N

Names	Dosage	Frequency
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

HOSPITAL ADMISSIONS

Have there been any changes to your hospital admissions? Y N

Condition	Hospital	Year
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

FAMILY MEDICAL HISTORY

Are there any changes to family medical history? Y N

	Mother	Father	Maternal Family	Paternal Family
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer (if so, what type?) <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease (Men <55) (Women <65)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PHYSICIAN INFORMATION

Are there any changes to physician information? Y N

Who is your regular physician?

Last time you saw her/him?

Have you seen any specialists in the last 5 years?

If yes please detail below:

Specialist 1	<input type="text"/>	Condition	<input type="text"/>
Specialist 2	<input type="text"/>	Condition	<input type="text"/>
Specialist 3	<input type="text"/>	Condition	<input type="text"/>

Are you currently under a physician's restrictions?

If yes, please explain

Are you interested in hearing more about medical our weight loss program?