COMPREHENSIVE SPINE CENTER OF DALLAS

NEW PATIENT REGISTRATION FORM

Legal Name: ______________________ ______________ __________ ________________
Last First Middle Preferred

Home Address: ____________________________ _______ ____________________________
Street Apt# City/ST/Zip

Phone(s): Home:______________________Cell:____________________Work: ________________

Email:_____________________________DOB:______________Age:_______Gender:_____M or _____F

Marital Status:_______Single_______Married_______Divorced______Widow SS#_______________________

How did you hear about us? ____

Primary Care Doctor:_________________________________Doctor Phone#: ___________________

PRIMARY INSURANCE INFORMATION:

Name of Primary Policy Holder:____________________________Relationship to Patient: ______________
As It Appears On Card

DOB:___________SS#: ___________________ Employer_________________________________

Insurance Company:________________Policy ID#:______________________Group#:____________

SECONDARY INSURANCE INFORMATION:

Name of Primary Policy Holder:__________________________Policy ID/Group#:____________________
As It Appears On Card

RESPONSIBLE PARTY INFORMATION: (____*CHECK IF SAME AS ABOVE*)

Name:________________________________Address: ____________________________________

DOB:__________SS#:______________Phone#:_____________Relationship to Patient: ______________

EMERGENCY CONTACT/LEGAL GUARDIAN:

Name:_________________________Phone#:______________Relationship to Patient: _______________

RELEASE OF INFORMATION AND ASSIGNMENTS OF BENEFITS: I hereby authorize the above-named agency to release my treatment information requested by attorneys, physicians, insurance companies, employers, healthcare providers or any other entity which may be concerned with the payment of charges incurred for the treatment of services of Comprehensive Spine Center of Dallas, and hereby authorize Medicare and other insurance payment directly to Comprehensive Spine Center of Dallas for services rendered to me by any healthcare providers associated with that group. I accept responsibility for payment of any charges not paid for or accepted by my insurance. This authorization remains valid and effective from the date of signing until revoked in writing.

____ ______________________
Signature of Patient or Legal Guardian **Date**

_______**FINANCIAL RESPONSIBILITY AGREEMENT:**
Initials
I agree to assign insurance benefits to Comprehensive Spine Center of Dallas. We bill all primary insurance companies that we are contracted with as "network" providers as a courtesy to our patients.

I acknowledge full financial responsibility for services rendered by Comprehensive Spine Center of Dallas, and authorize transfer of all unpaid amounts to me, which includes, but is not limited to, Co-pays, Deductibles, Co- Insurance, and/or termination of coverage. I further authorize and request all insurance payments be made directly to Comprehensive Spine Center of Dallas.

_______**CONSENT OF TREATMENT:**
Initials
I, the undersigned, do hereby request and consent to an evaluation and treatment by Comprehensive Spine Center of Dallas, Physicians and its staff. I wish to rely on the Practice to exercise judgment for my best interest during the course of treatment. The duration of this consent is indefinite and continues until revoked in writing**. I UNDERSTAND THAT BY NOT SIGNING THIS CONSENT, THE PATIENT WILL NOT BE PROVIDED MEDICAL CARE EXCEPT IN A CASE OF EMERGENCY**.

_______**DISCLOSURE OF FINANCIAL INTEREST:**
Initials
Pursuant to certain disclosure requirements under Federal and State Law, Dr Scott A. Farley, the owner of Comprehensive Spine center of Dallas, PLLC, is required to notify all patients of certain financial arrangements with entities he will receive a remuneration from. As such, please not that Dr Scott A. Farley has financial arrangements with the following entities (a) Metroplex DME, LLC; and (b) Spinal Hardware Solutions, LLC. Should you have any questions regarding this notice, or any services provided by these entities, please discuss them with Dr Farley directly. My initials above verify that I have read and understand the above statement and information.

_______**MEDICARE AND MEDICARE ELIGIBLE PATIENTS ONLY:**
Initials
I understand that Dr Scott Farley and Dr Arash Bidgoli have opted out of Medicare and is no longer a participating provider. As such, I understand that Dr Farley, Dr Bidgoli and Comprehensive Spine will not submit nor allow anyone else to submit a claim for services provided to a Medicare Beneficiary. I am aware that I have the right to seek treatment by a physician or practitioner who has not opted out of Medicare. By signing this agreement, I or my legal representative accept full responsibility for the physician's charges by entering into this private contract.

_______**ELECTRONIC RECORDING:**
Initials
To ensure confidentiality and privacy, the use of any type of recording device by a patient while in any of our offices is strictly prohibited. This includes the use of cameras, audio recording devices and camera phones. Using these devices breaches the confidentiality rights of patients and infringes on the privacy rights of our employees. Patients are welcome to take notes during their office visits. Additionally, all conversations between the medical provider and patient are documented in the patient's medical chart. To review this information, a patient may request a copy of their medical records.

_______**ADDITIONAL CONSENTS:**
Initials
Unless I request to the contrary in writing:

I will accept appointment reminders on my home/cell phone, answering system and/or appointment reminder cards sent by mail, text message or email, whichever is the policy of this practice.

I consent to have data regarding my treatment experience from questionnaires, surveys, interviews, testimonials, and other Similar feedback tools obtained by Comprehensive Spine Center of Dallas, PLLC and its staff. I understand that such Data will be recorded to document and assist with the Patients care and to assist the Practice health care operations and may be used on Practice's website, Social Media and email marketing in which I have agreed to participate as a patient of the Practice. I further understand that my participation is optional and my refusal to provide or consent to Survey Data will in no way affect the medical care provided to me by Practice.

____ _______________________
Signature of Patient or Legal Guardian **Date**

Authorization to Obtain Health Information

Patient Name: ____

DOB: _______________ Date of Injury: ________________ Date of Request: _________________

As required by HIPAA privacy regulations, protected health information may not be used or disclosed to any third party Without patient authorization.

I hereby authorize Comprehensive Spine Center and its employees to obtain my protected health information from any Medical facility that is pertinent to my care.

Patient Health Information to be requested: ____

____

For the specific use or purpose of (described in detail): ____

____

Effective dates for this authorization: ____/_____/______ through _____/_____/______. This authorization will expire at the end of the above designated period.

I understand I have the right to:

1. Revoke this authorization by sending written notice to this office at any time, but not retroactively.
2. Be informed of any remuneration involved due to any marketing activity as allowed by this authorization,
3. and as a result of this authorization.
4. Inspect a copy of the patient health information being used under federal law.
5. Refuse to sign this authorization.
6. Restrict what is obtained with this authorization.
7.

I also understand that if I do not sign this document, it will not affect my treatment, payment, and enrollment in a health plan, or eligibility for benefits whether or not I provide authorization to obtain protected patient health information.

____ _________________

Signature of Patient or Patient's Authorized Representative Date

COMPREHENSIVE SPINE CENTER
OF DALLAS

PATIENT HIPAA & PRIVACY PRACTICES AUTHORIZATION FORM

(Required by Health Insurance Portability & Accountability Act)

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("**HIPAA**"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have been provided access to either review and/or receive a copy of the *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

______________ *(initials)* I acknowledge that my medical information/records will be released to The Practice. I further acknowledge that my medical information/records will be released from The Practice to my primary care provider, referring/consulting providers, and to my insurance company to process insurance claims.

I also allow release of my medical condition or billing information to the following individuals (i.e. family, caregivers, etc.):

Name:	**Relationship:**	**Phone Number:**	**Billing**	**Medical Condition**
______________________	______________________	______________________	☐	☐
______________________	______________________	______________________	☐	☐
______________________	______________________	______________________	☐	☐
______________________	______________________	______________________	☐	☐

I understand that a request for my health or billing information from persons not specified above or otherwise approved in the *Notice of Privacy Practices* will require my specific, written authorization prior to the disclosure of the information.

I acknowledge and agree that The Practice, its employees, officers, and physician are released from any legal responsibility of liability for or resulting from the authorized disclosure of my health or billing information.

____ ____
Printed Patient Name **Signature of Patient/Personal Representative**

____ ____
Relationship to Patient **Date**

____ ____
Practice Representative Name **Signature of Practice Representative/Witness**

AUTHORIZATION TO TREAT AND ASSIGNMENT OF BENEFITS AND AUTHORIZATION FOR DIRECT INSURANCE PAYMENTS TO Dr Scott Farley DO, Comprehensive Spine Center

Purpose. The purpose of this Assignment is to assist the Office in collecting from various Payers who may be responsible for paying on my Charges. Accordingly, I agree to the following and direct all Payers as follows:

Definitions. In this Assignment, the following terms shall have the following meaning: "Office" and "Clinic" shall refer to Dr. Scott Farley DO, Comprehensive Spine Center; "Payer" shall refer to without limit any insurance carrier, health benefit plan, administrator and fiduciary, health maintenance organization, preferred and independent provider organization, attorney, at-fault party, individual, and any other entity, which may elect or be obligated to payer disburse Proceeds, either now or in the future; "Proceeds" shall include without limit the proceeds from any settlement, judgment, or verdict, the proceeds from any promise to payer reimburse, and the proceeds relating to the following benefits, plans, or cover ages: individual and group health benefits, Medicare, Medicaid, workers' compensation, disability, liability, uninsured and underinsured motorist, no-fault, medical payments benefits, personal injury protection, lost wages, lost services, property damage, and malpractice; "Changes" shall include without limit the full fees for the Office's services (including without limit treatment, medical equipment, supplies, supplements, narrative reports, photocopies, depositions, and testimony), any Collection Costs incurred by the Office, interest, and delinquency penalties to the extent permitted by law, and any other charges incurred by me at the Office; "Collection Costs" shall include without limit any pre- and post-judgment court costs, filing fees, service of process charges, attorney fees, and any other costs of collection incurred by the Office in any effort or action to collect my Charges either from me or from any Payer.

Assignment of Benefits. I hereby assign and transfer to Comprehensive Spine Center the cause of action that exists or may exist in my favor up to but not exceeding the amount of my medical bills, generated in my treatment, against such company/ies and/or party/ies, entity/ies or individual/s (the name(s) of which is/are believed to be correctly set forth herein) that I or Comprehensive Spine Center believe to be the responsible company/ies and/or party/ies, entity/ies or individual/s. I further authorize Comprehensive Spine Center to prosecute said action/s up to but not exceeding the amount of my medical bills either in my name or as Comprehensive Spine Center as Comprehensive Spine Center shall see fit. I also authorize Comprehensive Spine Center to compromise, settle, or otherwise resolve said claim/s, for medical bills generated in my treatment, as Comprehensive Spine Center shall see fit. However, it is understood that until all reasonable efforts have been made to collect the sums due from the insurance company/ies and/or other responsible party/ies, entity/ies and/or individual/s, Comprehensive Spine Center will refrain from attempts and efforts to collect the amounts owed directly from me. I understand that whatever amount Comprehensive Spine Center does not collect from the insurance proceeds and/or other responsible party/ies, entity/ies and/or individual/s (whether it be all or part of what is due), I personally owe Comprehensive Spine Center, up to but not to exceed the total amount of medical bills generated in my treatment and I agree to pay in a current manner. Consistent with these terms, I hereby direct any and all entities that pay any monies to make said payments directly to, immediately to, and exclusively in the name of Dr. Scott Farley DO, Comprehensive Spine Center to the extent of said charges or amount agreed to by Comprehensive Spine Center. Consistent with these terms, I hereby direct any and all Payers, to pay the Proceeds directly to, immediately to, and exclusively in the name of Dr. Scott Farley DO, Comprehensive Spine Center to the extent of my Charges.

Specific Direction to Any Attorney I Retain, Such as in Accident Cases. In the event that I retain one or more attorneys to assist me in collecting any Proceeds, I hereby direct (and the Office hereby requests) each attorney to provide immediate notice to the Office regarding any Proceeds received by the attorney, to promptly pay the Office in-full out of such Proceeds, and to provide full accounting of such Proceeds to the Office. I agree that the purpose of any Proceeds received by the attorney shall be to pay my Charges. I also request the attorney to give full disclosure to the Office regarding my case.

Other Disclosure Authorization. I hereby direct all Payers to release to the Office any pertinent information regarding any coverage I may have including without limit the amount of the coverage, the amount paid thus far, and the amount of any outstanding claims. I authorize and direct the Office to release any information regarding my treatment or pertinent to my case(s) to all Payers, including without limit a copy of my Charges and a copy of this Assignment.

Miscellaneous. Except as provided in this paragraph, this Assignment shall not be modified or revoked without expressed, written consent of the Office. I hereby revoke, with the Office's consent, the terms of any previously signed documents, but only to the extent those terms conflict with the terms of this Assignment. I agree that each and every provision of this Assignment is reasonably necessary for the protection of the rights and interests of the Office and myself. However, should any provision of this Assignment be found to be invalid, illegal, or unenforceable, or for any reason cease to be binding on any party hereto, all other portions and provisions of this Assignment shall, nevertheless, remain in full force and effect. This Assignment shall be governed under the laws of the state where the Office is located, and is performable in the county where the Office is located. In any action based upon this Assignment, I hereby consent to personal jurisdiction and venue of any court in said county and waive all objections based on improper jurisdiction, venue, or forum inconvenience. I further waive any statute of limitations which may apply in any action based upon this Assignment.

Authorization of Cause of Action. I hereby assign and transfer to Comprehensive Spine Center the cause of action that exists or may exist in my favor up to but not exceeding the amount of my medical bills, generated in my treatment, against such company/ies and/or party/ies, entity/ies or individual/s (the name(s) of which is/are believed to be correctly set forth herein) that I or Comprehensive Spine Center believe to be the responsible company/ies and/or party/ies, entity/ies or individual/s. This assignment and transfer shall include but is not limited to any rights or claims I might possess from and against all sources, persons, or entities, including but not limited to health insurance coverage, liability insurance coverage, Personal Injury Protection (PIP), Medical Payments Coverage, Uninsured Motorist Coverage, and Underinsured Motorist Coverage. **I** further authorize Comprehensive Spine Center to prosecute and/or initiate an action/s for recovery up to but not exceeding the amount of my medical bills which may be prosecuted either in my name or as Comprehensive Spine Center in the manner Comprehensive Spine Center shall see fit. **I** also authorize Comprehensive Spine Center to compromise, settle, or otherwise resolve said claim/s, for medical bills generated in my treatment, as Comprehensive Spine Center shall see fit. However, it is understood that until all reasonable efforts have been made to collect the sums due from the insurance company/ies and/or other responsible party/ies, entity/ies and/or individual/s, Comprehensive Spine Center will refrain from attempts and efforts to collect the amounts owed directly from me. **I** understand that whatever amount Comprehensive Spine Center does not collect from the insurance proceeds and/or other responsible party/ies, entity/ies and/or individual/s (whether it be all or part of what is due), **I** personally owe Comprehensive Spine Center, up to but not to exceed the total amount of medical bills generated in my treatment and I agree to pay in a current manner.

Patient Initials:_________

I have read, understood and agree to the terms of this Assignment.

Patient Name (Print) ______________________________

Patient Signature ______________________________ Date ______________

Name of Custodial Parent or Legal Guardian, on Behalf of the Patient

Print ______________________________

Signature ____________________________

Antes de firmar este documento se me fue traducido en mi lengua materna que es el español.

Before signing this document, it was translated, if necessary, to me in my native language of Spanish.

Patient Signature: ____________________________________

Translator: ____________________________________

Date: ____________________________________

AUTHORIZATION TO TREAT AND ASSIGNMENT OF BENEFITS AND AUTHORIZATION FOR DIRECT INSURANCE PAYMENTS TO METROPLEX DME

Purpose. The purpose of this Assignment is to assist the Office in collecting from various Payers who may be responsible for paying on my Charges. Accordingly, I agree to the following and direct all Payers as follows:

Definitions. In this Assignment, the following terms shall have the following meaning: "Office" and "Clinic" shall refer to METROPLEX DME; "Payer" shall refer to without limit any insurance carrier, health benefit plan, administrator and fiduciary, health maintenance organization, preferred and independent provider organization, attorney, at-fault party, individual, and any other entity, which may elect or be obligated to payer disburse Proceeds, either now or in the future; "Proceeds" shall include without limit the proceeds from any settlement, judgment, or verdict, the proceeds from any promise to payer reimburse, and the proceeds relating to the following benefits, plans, or cover ages: individual and group health benefits, Medicare, Medicaid, workers' compensation, disability, liability, uninsured and underinsured motorist, no-fault, medical payments benefits, personal injury protection, lost wages, lost services, property damage, and malpractice; "Changes" shall include without limit the full fees for the Office's services (including without limit treatment, medical equipment, supplies, supplements, narrative reports, photocopies, depositions, and testimony), any Collection Costs incurred by the Office, interest, and delinquency penalties to the extent permitted by law, and any other charges incurred by me at the Office; "Collection Costs" shall include without limit any pre- and post-judgment court costs, filing fees, service of process charges, attorney fees, and any other costs of collection incurred by the Office in any effort or action to collect my Charges either from me or from any Payer.

Assignment of Benefits. I hereby assign and transfer to METROPLEX DME the cause of action that exists or may exist in my favor up to but not exceeding the amount of my medical bills, generated in my treatment, against such company/ies and/or party/ies, entity/ies or individual/s (the name(s) of which is/are believed to be correctly set forth herein) that I or METROPLEX DME believe to be the responsible company/ies and/or party/ies, entity/ies or individual/s. I further authorize METROPLEX DME to prosecute said action/s up to but not exceeding the amount of my medical bills either in my name or as METROPLEX DME as METROPLEX DME shall see fit. I also authorize METROPLEX DME to compromise, settle, or otherwise resolve said claim/s, for medical bills generated in my treatment, as METROPLEX DME shall see fit. However, it is understood that until all reasonable efforts have been made to collect the sums due from the insurance company/ies and/or other responsible party/ies, entity/ies and/or individual/s, METROPLEX DME will refrain from attempts and efforts to collect the amounts owed directly from me. I understand that whatever amount METROPLEX DME does not collect from the insurance proceeds and/or other responsible party/ies, entity/ies and/or individual/s (whether it be all or part of what is due), I personally owe METROPLEX DME, up to but not to exceed the total amount of medical bills generated in my treatment and I agree to pay in a current manner. Consistent with these terms, I hereby direct any and all entities that pay any monies to make said payments directly to, immediately to, and exclusively in the name of METROPLEX DME to the extent of said charges or amount agreed to by METROPLEX DME. Consistent with these terms, I hereby direct any and all Payers, to pay the Proceeds directly to, immediately to, and exclusively in the name of METROPLEX DME to the extent of my Charges.

Specific Direction to Any Attorney I Retain, Such as in Accident Cases. In the event that I retain one or more attorneys to assist me in collecting any Proceeds, I hereby direct (and the Office hereby requests) each attorney to provide immediate notice to the Office regarding any Proceeds received by the attorney, to promptly pay the Office in-full out of such Proceeds, and to provide full accounting of such Proceeds to the Office. I agree that the purpose of any Proceeds received by the attorney shall be to pay my Charges. I also request the attorney to give full disclosure to the Office regarding my case.

Other Disclosure Authorization. I hereby direct all Payers to release to the Office any pertinent information regarding any coverage I may have including without limit the amount of the coverage, the amount paid thus far, and the amount of any outstanding claims. I authorize and direct the Office to release any information regarding my treatment or pertinent to my case(s) to all Payers, including without limit a copy of my Charges and a copy of this Assignment.

Miscellaneous. Except as provided in this paragraph, this Assignment shall not be modified or revoked without expressed, written consent of the Office. I hereby revoke, with the Office's consent, the terms of any previously signed documents, but only to the extent those terms conflict with the terms of this Assignment. I agree that each and every provision of this Assignment is reasonably necessary for the protection of the rights and interests of the Office and myself. However, should any provision of this Assignment be found to be invalid, illegal, or unenforceable, or for any reason cease to be binding on any party hereto, all other portions and provisions of this Assignment shall, nevertheless, remain in full force and effect. This Assignment shall be governed under the laws of the state where the Office is located, and is performable in the county where the Office is located. In any action based upon this Assignment, I hereby consent to personal jurisdiction and venue of any court in said county and waive all objections based on improper jurisdiction, venue, or forum inconvenience. I further waive any statute of limitations which may apply in any action based upon this Assignment.

Authorization of Cause of Action. I hereby assign and transfer to Metroplex DME the cause of action that exists or may exist in my favor up to but not exceeding the amount of my medical bills, generated in my treatment, against such company/ies and/or party/ies, entity/ies or individual/s (the name(s) of which is/are believed to be correctly set forth herein) that I or Metroplex DME believe to be the responsible company/ies and/or party/ies, entity/ies or individual/s. This assignment and transfer shall include but is not limited to any rights or claims I might possess from and against all sources, persons, or entities, including but not limited to health insurance coverage, liability insurance coverage, Personal Injury Protection (PIP), Medical Payments Coverage, Uninsured Motorist Coverage, and Underinsured Motorist Coverage. **I** further authorize Metroplex DME to prosecute and/or initiate an action/s for recovery up to but not exceeding the amount of my medical bills which may be prosecuted either in my name or as Metroplex DME in the manner Metroplex DME shall see fit. **I** also authorize Metroplex DME to compromise, settle, or otherwise resolve said claim/s, for medical bills generated in my treatment, as Metroplex DME shall see fit. However, it is understood that until all reasonable efforts have been made to collect the sums due from the insurance company/ies and/or other responsible party/ies, entity/ies and/or individual/s, Metroplex DME will refrain from attempts and efforts to collect the amounts owed directly from me. **I** understand that whatever amount Metroplex DME does not collect from the insurance proceeds and/or other responsible party/ies, entity/ies and/or individual/s (whether it be all or part of what is due), **I** personally owe Metroplex DME, up to but not to exceed the total amount of medical bills generated in my treatment and I agree to pay in a current manner.

Patient Initials:_________

I have read, understood and agree to the terms of this Assignment.

Patient Name (Print) ______________________________

Patient Signature ______________________________ Date ______________

Name of Custodial Parent or Legal Guardian, on Behalf of the Patient

Print ______________________________

Signature ____________________________

Antes de firmar este documento se me fue traducido en mi lengua materna que es el español.

Before signing this document, it was translated, if necessary, to me in my native language of Spanish.

Patient Signature: ____________________________________

Translator: ____________________________________

Date: ____________________________________

Telemedicine Consent Form

I. **Introduction.** Telemedicine involves the real-time evaluation, diagnosis, consultation on, and treatment of a health condition using advanced telecommunications technology, which may include the use of interactive audio, video, or other electronic media. As such, telemedicine allows the provider to see and communicate with the patient in real-time.

II. **Consent for Treatment.** I voluntarily request Comprehensive Spine Center of Dallas physician(s) and such Doctors, Physician Assistants, Nurse Practitioners, technical assistants and other health care providers as they may deem necessary ("Comprehensive Spine Center of Dallas Telemedicine Providers") to participate in my medical care through the use of telemedicine. I understand that Comprehensive Spine Center Telemedicine Providers (i) may practice in a different location than where I present for medical care, (ii) may not have the opportunity to perform an in-person physical examination, and (iii) rely on information provided by me. I acknowledge that Comprehensive Spine Center Telemedicine Providers' advice, recommendations, and/or decision may be based on factors not within their control, such as incomplete or inaccurate data provided by me or distortions of diagnostic images that may result from electronic transmissions. I acknowledge that it is my responsibility to provide information about my medical history, condition and care that is complete and accurate to the best of my ability. I understand that the practice of medicine is not an exact science and that no warranties or guarantees are made to me as to result or cure. If Comprehensive Spine Center Telemedicine Providers determine that the telemedicine services do not adequately address my medical needs, they may require an in-person medical evaluation. In the event the telemedicine session is interrupted due to a technological problem or equipment failure, alternative means of communication may be implemented or an in-person medical evaluation may be necessary. If I experience an urgent matter, such as a bad reaction to any treatment after a telemedicine session, I should alert my treating physician and, in the case of emergencies dial 911, or go to the nearest hospital emergency department.

III. **Release of Information.** To facilitate the provision of care and/or treatment through telemedicine, I voluntarily request and authorize the disclosure of all and any part of my medical record (including oral information) to Comprehensive Spine Center of Dallas Telemedicine Providers. I understand and agree that the information I am authorizing to be released may include: 1) AIDS/HIV test results, diagnosis, treatment, and related information: 2) drug screen results and information about drug and alcohol use and treatment; 3) mental health information; and 4) genetic information. I understand that the disclosure of my medical information to Comprehensive Spine Center Telemedicine Providers, including the audio and/or video, will be by electronic transmission. Although precautions are taken to protect the confidentiality of this information by preventing unauthorized review, I understand that electronic transmission of data, video images, and audio is new and developing technology and that confidentiality may be compromised by failures of security safeguards or illegal and improper tampering. I certify that this form has been fully explained to me, that I have read it or have had it read to me, and that I understand its contents.

____ ________________________

Printed Patient Name **Signature of Patient/Personal Representative**

______________________________ ___________________

Relationship to Patient **Date**