CONSENT FOR TREATMENT

By signing this consent I am authorizing my physician(s), known as United Regional Physician Group (URPG) to perform and/or order another person to perform all exams, tests, procedures and any other care deemed necessary or advisable for the diagnosis and treatment of my medical condition. This consent is valid for each visit/telephone call made to URPG unless revoked by me orally or in writing.

> Please be informed Texas law allows patient to be tested for possible exposure to the Human Immunodeficiency Virus (HIV), the virus associated with AIDS, in the following situations: 1) to screen blood, blood products, organs or tissues to determine suitability for donation; 2) if another individual is accidentally exposed to a patient's blood or bodily fluids, such as through a needle stick (any such test shall be conducted pursuant to Ambulatory Services infectious disease protocol): or 3) if a medical or surgical procedure is to be performed which could expose healthcare workers to the patient's blood or bodily fluids. This disclosure is to inform you that you may be tested if any of these situations occur during your treatment period.

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize URPG to furnish medical information pertinent to my medical condition including, but not limited to the diagnosis, treatment and care offered or rendered to me while a patient under his/her care. I understand this information may be furnished 1) to my insurer(s) to which my medical bills have been assigned for payment; 2) as required by law, 3) for the diagnosis and/or treatment as deemed necessary by URPG and/or 4) upon my written authorization on a form acceptable to URPG .By signing this Consent to Release Medical Information, I agree not to hold URPG, its agents and/or employees, liable for any unfavorable outcomes as the result of releasing this information. I realize that release of my medical information may be necessary before my insurer(s) will cover the cost of my medical treatment, and that by failing to authorize the release of this information, I may be required to pay the entire bill.

ACKNOWLEDGMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES / PATIENT RIGHTS AND RESPONSIBLITIES

I have reviewed the URPG Notice of Privacy Practices/ Patient Rights and Responsibilities, which explains how my medical information may be used and disclosed. I understand that I am entitled to receive a copy of this document at my request.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize the physician to release any information acquired in the course of my examination and/or treatment to my insurance carrier; and I hereby assign to the physician all payments for medical services rendered to myself. I understand that I am responsible for the payment of services. Insurance will be filed as a courtesy; however, after 60 days, if not response is received, I understand that I will be responsible for any charges. I understand that I am responsible for payment of any amount that is not covered by insurance.

ASSIGNMENT OF INSURANCE BENEFITS

The undersigned hereby authorizes the insurance carrier represented as contractually responsible for payment in whole or in part of the patient's healthcare bill, to pay directly to the physician rendering services for my care, any benefits payable for said care and/or treatment.

I agree that, should the amount paid by the insurance carrier be insufficient to cover the physician's charge, I will be responsible for payment of the difference, and that if the nature of the illness and/or injury be such that it is not covered by the policy, I will be responsible to the physician for payment of the entire bill, unless contractual agreements have been made between the physician and the insurance company which negates responsibility.

____ _______________

Signature of patient/responsible party Date

____ _______________

Witness Date