Cotton D. Feray, M.D.
Lance M. Feray, D.O.
720 Lawrence Street, Tomball, Texas 77375

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

I consent to the use or disclosure of my protected health information by Cotton Feray, M.D., P.A. for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct the practice's health care operations. I have been given the opportunity to review this office's Notice of Privacy Practices which explains how my medical information will be used and disclosed prior to signing this document. I u8nderstand that I am entitled to receive a copy of this document.

I hereby give my authorization to release my protected health information including results of my laboratory tests, x-ray and/or other test results to the following designated representatives:

Patient Initials

_____ My Spouse (Name)_____

_____ My Child (Name) _____

Patient Initials

_____ Other (Name) _____

_____ **May not be given to other than myself**

_____ _____ _____
Signature of Patient or Representative Printed Name Date

NOTICE OF PHYSICIAN'S FINANCIAL INTEREST

In order to assist our patients in obtaining quality diagnostic procedures and/or laboratory testing in our area, **our practice has partnered with Elite Diagnostics (444 Holderreith Blvd, Tomball, Texas 77375)**.

Ethically, under the Texas Medical Care Act, a physician must notify a patient that the physician has a direct/ indirect financial interest in a separate diagnostic or treatment facility to which a patient has been referred.

This is to inform you that we have a direct financial interest in this/these facilities. Further, we hereby notify you that the treatments prescribed (blood work, x-rays, CAT Scans, MRI and ultrasound, outpatient surgery) are available at other facilities on a competitive basis and we will be glad to refer you elsewhere if you desire.

ACKNOWLEDGMENT: In compliance with Section 102.006 of Texas Occupations Code, my referring physician has disclosed to me at the time of referral: (A) his, her, or its affiliation with Elite Diagnostics, and (B) that he, she, or it will receive, directly or indirectly, remuneration for referring me. I certify that I was informed of effective alternative resources at the time of my decision-making and that it is my option to use one of the alternative resources. I was further informed that if I selected to use an alternative resource, neither my physician nor his or her staff would treat me differently if I choose an alternative provider or entity. I understand the referring physician does not have control of whether or not the provider is in or out of network or of the fees the provider charges. I understand that a copy of this ACKNOWLEDGMENT will be kept in my patient file and that I can request a copy for my records.

Dated this _____ Day of _____, 20_____.

_____
Signature of Patient or Guardian