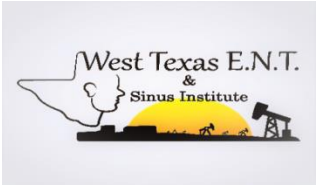

Acknowledgment of Receipt of Notice of Privacy Practices

I have been presented with a copy of the West Texas ENT and sinus Institute notice of privacy practices, detailing how my health information may be used and disclosed as permitted under federal and state law and outlining my rights regarding my health information.

_____ _____

Signature of patient or patient's representative Date

_____

Relationship to patient

For office use only

If patient/patient representative refuses to sign acknowledgment, please document it in time the notice was presented to patient and sign below.

[ ] Presented in person – date and time_____

[ ] Date mailed _____

By (name and title) _____

Patient's Name_____

DOB _____

File in patient's medical record – must be retained for six years

Authorization/release

1. I hereby consent, authorize and direct the physician(s) of West Texas ENT and sinus Institute provides such services for me as they deem reasonable and necessary.
2. I authorize release of any medical information necessary to process my claims in a copy of this authorization to be used as an original.
3. I authorize direct payment of my medical benefits to West Texas ear, nose, throat (ENT) and sinus Institute.
4. I understand I'm responsible for any services not covered by my insurance company, and payment is due at the time of service.
5. If your account is pleased with an attorney outside agency for collection, you will be responsible for all collection fees.
6. I authorize West Texas ENT and sinus Institute physician(s) and employee(s) to take my photograph for proper identification of my medical record and authorize all other photographs for monitoring my condition in the medical record.
7. This authorization release shall be valid until the end of the calendar year in which it is signed.

_____ _____

Signature Date

Consent to wireless telephone calls/text messages /email

I consent to receive telephone calls, text messages, emails and other communications on my cellular phone, other phone(s), and other communication devices, including autodialed calls and prerecorded messages from West Texas ENT and sinus Institute, its successors, assigns, affiliates, agents, independent contractors, services and collection agents. I understand this calls may regard my visit to West Texas ENT and sinus Institute clinic or financial obligations related to my visit.

_____ _____

Signature Date