FACIAL PLASTIC SURGERY ASSOCIATES

GENERAL PATIENT INFORMATION

LAST NAME | FIRST NAME, MIDDLE INITIAL | PREFERRED NAME

May we send information by mail to your home? YES ☐ NO ☐

MAILING ADDRESS [CITY/STATE/ZIP]

EMAIL

May we send information, such as appointment reminders and current offers and discounts to the above email address? YES ☐ NO ☐

CELL PHONE | HOME PHONE

Preferred number? CELL ☐ OTHER ☐

AGE | BIRTHDAY

LAST 4 OF SOCIAL SECURITY NUMBER | GENDER

ETHNICITY | DRIVERS LICENSE NUMBER

MARITAL STATUS | SPOUSE NAME | SPOUSE OCCUPATION & EMPLOYER

PATIENT EMPLOYER | OCCUPATION

WORK ADDRESS

Is it ok to call you at work? YES ☐ NO ☐

WORK PHONE | EXTENSION

MOTHER'S NAME (IF MINOR) | FATHER'S NAME (IF MINOR)

EMERGENCY CONTACT | RELATIONSHIP

HOME PHONE | CELL PHONE | OTHER

REFERRING PHYSICIAN | PHONE NUMBER | MAILING ADDRESS [CITY/STATE/ZIP]

REFERRAL SOURCE | PHONE NUMBER | MAILING ADDRESS [CITY/STATE/ZIP]

May we thank the person for referring you? YES ☐ NO ☐

NAME | DATE

Thank You for Choosing FPSA

How did you hear about us?

- ☐ INTERNET SEARCH
- ☐ TODAYSFACE.COM
- ☐ TV
- ☐ SALON OR SPA
- ☐ OTHER

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FACIAL PLASTIC SURGERY ASSOCIATES

GENERAL PATIENT HISTORY

1. Please specifically give the reason for your visit:

2. Please list all drug-related allergies or intolerances (or indicate none).

3. Primary Care Physician

NAME OF PHYSICIAN | PHONE

ADDRESS [CITY/STATE/ZIP]

4. Date of last complete physical examination?

5. List all medications you are currently taking, along with the dosage and frequency:
(including over the counter medicines, aspirin or medicines containing aspirin, birth control pills, diet pills, Vitamin E, or herbal preparations)

6. List all previous operations or major illnesses and all hospitalizations you have had, along with dates.

7. Have you had a Botox Injection? YES ☐ NO ☐

WHEN | WHERE

8. Have you ever had COVID-19? YES ☐ NO ☐ (If you were ever hospitalized with COVID-19, please list under #6.)

WHEN

9. Have you been vaccinated for COVID-19? YES ☐ NO ☐

If yes, which vaccine did you receive?

PFIZER ☐ MODERNA ☐ JOHNSON & JOHNSON ☐ DATE OF LAST INJECTION

How many shots did you receive? 1 SHOT ☐ 2 SHOTS ☐

10. Additional Details

HEIGHT | WEIGHT

FAMILY HISTORY

Allergies	YES ☐ NO ☐	High Blood Pressure	YES ☐ NO ☐	Diabetes	YES ☐ NO ☐
Heart Attacks	YES ☐ NO ☐	Nervous Breakdown	YES ☐ NO ☐	Strokes	YES ☐ NO ☐
Bleeding Tendencies	YES ☐ NO ☐	Congenital Defects	YES ☐ NO ☐	Cancer	YES ☐ NO ☐

This information is correct and complete to the best of my knowledge, and I give my permission for you to contact and communicate with my physicians and insurance company.

Patient Signature_____Date_____

NAME | DATE

Thank You for Choosing FPSA

MEDICAL HISTORY

Do you have (or have you had) any of the following? If yes, please provide details.

YES	NO		ADDITIONAL INFORMATION:
☐	☐	Nasal Allergy	
☐	☐	Post-Nasal Discharge	
☐	☐	Sinus Infections	
☐	☐	Nose Bleeds	
☐	☐	Headaches	
☐	☐	Hepatitis	
☐	☐	Sleep Apnea	
☐	☐	CPAP Use?	
☐	☐	Heart Trouble	
☐	☐	Diabetes	
☐	☐	Anemia	
☐	☐	Asthma	
☐	☐	Lung Trouble	
☐	☐	High Blood Pressure	
☐	☐	+HIV/AIDS	
☐	☐	Blood Disorders	
☐	☐	Other Health Problems (describe):	

Have you ever smoked? YES ☐ NO ☐

Do you currently use tobacco? YES ☐ NO ☐

How many packs a day?

How long?

Do you drink alcohol? YES ☐ NO ☐

How many drinks per day?

Drug use? If yes, explain. YES ☐ NO ☐

Indicate if drugs or alcohol posed a dependency problem for you: DRUGS ☐ ALCOHOL ☐

Have you had exposure to HIV through prior sexual history, surgery, transfusions or IV drug use? YES ☐ NO ☐

Have you had a reaction to anesthetics? YES ☐ NO ☐

Do you have a history of increased bleeding or clotting? YES ☐ NO ☐

Have you ever been under the care of a psychiatrist? YES ☐ NO ☐

Have you ever had a nervous breakdown? YES ☐ NO ☐

Do you wear glasses? YES ☐ NO ☐

Do you wear contacts? YES ☐ NO ☐

Do you have a history of bad scarring? If yes, where? YES ☐ NO ☐

Any chance you are pregnant? YES ☐ NO ☐

FACIAL PLASTIC SURGERY ASSOCIATES

NEW PATIENT QUESTIONNAIRE

Please help us help you by filling out the following information. It is our intention to make your consultation and surgical experience with us productive, enjoyable and goal directed. Your complete and specific information is essential to our communication and achieving the optimal results.

1. What is the primary reason that you are here?

2. What three aesthetic changes would you like to effect?

1.

2.

3.

3. What are your concerns or road blocks to having a procedure?

4. What are your short-term and long-term goals?

5. If you have had any experience with plastic surgery, please explain briefly.

6. What would you expect from this office, from the front office staff, the doctor and the medical team?

OVER ▶

7. Have you visited other doctors for consultation regarding any of the previous reasons?

8. What were their comments and/or recommendations?

9. What do you expect to achieve for yourself and your life with any aesthetic improvement?

10. Do you believe your expectations are realistic for improvement?

11. How likely is it that you would be satisfied with improvement and not "perfection"?

12. Do you have the time to invest to achieve the most optimal cosmetic improvements?

Thank you again for completing this information as completely and honestly as possible. This information will be valuable in allowing us to make your experience as positive and pleasant as possible.

NAME

DATE

FACIAL PLASTIC SURGERY ASSOCIATES

HIPAA AUTHORIZATION FORM

Authorization for Release of Information

Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R.Parts 160 and 164)

1. **AUTHORIZATION:** I authorize **FPSA** to use and disclose the protected health information described below to

_____ (individual seeking the information).

☐ All ☐ Please specify what we cannot share, if not all: _____

2. **EFFECTIVE PERIOD:** This authorization for release of information covers the period of healthcare from:

a. _____ to _____ **OR** ☐ All past, present, and future periods.

3. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

4. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

5. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

6. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

PATIENT SIGNATURE	DATE
WITNESS	DATE

OR, IF YOU DO NOT AUTHORIZE FPSA DISCLOSE PROTECTIVED HEALTH INFOMATION TO ANYONE, SIGN BELOW.

PATIENT SIGNATURE	DATE
WITNESS	DATE

NAME	DATE

Thank You for Choosing FPSA

FACIAL PLASTIC SURGERY ASSOCIATES

PRIVACY NOTICE

THE FOLLOWING NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED.

1. Your confidential healthcare information may be released to other healthcare professionals within Facial Plastic Surgery Associates for the purpose of providing you with quality healthcare.

2. Your confidential healthcare information may be released to your insurance provider for the purpose of Facial Plastic Surgery Associates receiving payment for providing you with needed healthcare services.

3. Your confidential healthcare information may be released to public or law enforcement officials in the event of an investigation in which you are a victim of abuse, a crime or domestic violence.

4. Your confidential healthcare information may be released to other healthcare providers in the event you need emergency care.

5. Your confidential healthcare information may be released to a public health organization or federal organization in the event of a communicable disease or to report a defective device or untoward event of a biological product (food or medication).

6. Your confidential healthcare information may not be released without your written authorization for any other purpose than that which is identified in section 1-5.

7. Your confidential healthcare information may be released for purposes other than those described in section 1-5 only after receiving written authorization from you. You may revoke your permission to release confidential healthcare information at any time.

8. You may be contacted by Facial Plastic Surgery Associates to remind you of any appointments, healthcare treatment options or other health services that may be of interest to you.

9. You may be contacted by Facial Plastic Surgery Associates for the purposes of raising funds to support the organization's operations.

10. You have the right to restrict the use of your confidential healthcare information. However, Facial Plastic Surgery Associates may choose to refuse your restriction if it is in conflict of providing you with quality healthcare or in the event of an emergency situation.

11. You have the right to receive confidential communication about your health status.

12. You have the right to review and photocopy any/all portions of your healthcare information.

13. You have the right to make changes to your healthcare information as long as the changes maintain the integrity of the medical record and/or continue to accurately describe the care provided.

14. You have the right to know who has accessed your confidential healthcare information and for what purpose.

15. You have the right to possess a copy of the Privacy Notice upon request. This copy can be in the form of an electronic transmission or on paper.

16. Facial Plastic Surgery Associates is required by law to protect the privacy of its patients. It will keep confidential any and all patient healthcare information and will provide patients with a list of duties or practices that protect confidential healthcare information.

17. Facial Plastic Surgery Associates will abide by the terms of this notice. The organization reserves the right to make changes to this notice and continue to maintain the confidentiality of all healthcare information. Patients will receive a mailed copy of any changes to this notice within 60 days of making the changes.

18. You have the right to complain to Facial Plastic Surgery Associates if you believe your rights to privacy have been violated. If you feel your privacy rights have been violated, please mail your complaint to:
ATTN: Practice Administrator, Facial Plastic Surgery Associates, 6655 Travis Street, #900, Houston, Texas 77030

ALL COMPLAINTS WILL BE INVESTIGATED. NO PERSONAL ISSUE WILL BE RAISED FOR FILING A COMPLAINT WITH THE ORGANIZATION.

- For further information about this Privacy Notice, please contact: Practice Administrator: (713) 526-5665
- This notice is effective as of Date of Effectiveness. This date must not be earlier than the date on which the notice is printed or published.

PATIENT SIGNATURE	DATE
WITNESS	DATE

PATIENT STICKER

FACIAL PLASTIC SURGERY ASSOCIATES

FINANCIAL POLICY

1. Payment is due at the time of service unless arrangements have been made in advance. We accept Visa, MasterCard, Discover, American Express, CareCredit, personal checks, and cash.

2. We understand there are situations where an appointment may need to be cancelled or rescheduled. Failure to give 24-hour notice will result in the forfeit of any scheduling fees. The courtesy of 24 hours allows us ample time to fill the appointment time slot.

3. Returned checks are subject to charged fees and a returned check fee of $50.00

4. We do not accept Medicare or Medicaid.

5. The physicians of Facial Plastic Surgery Associates do not accept insurance. However as a service to you, we will provide you with the needed codes so you are able to submit on your own behalf. This means you will submit the claim to your insurance and any approved payments will come directly to you. Therefore, our charges for your care are due at time of service. Not all insurance plans cover all services. In the event your insurance plan determines a service "not covered," you will be responsible for payment in full prior to the service.

6. If you receive services by our providers in the office and/or the hospital, you may be billed separately for: hospital, anesthesia, radiology, pathology and laboratory services. These are additional charges that will be your responsibility.

7. If any additional services were provided during the time of surgery you will receive a statement for the remaining balance. This is due in full upon invoice. Our practice does not have payment plans or carry balances. We accept Visa, MasterCard, Discover, American Express, personal checks and cash for these balances. We do offer a special plan called "Care Credit." This will allow you to make payments over 6, 12 or 18 months interest free. Please see www.carecredit.com.

8. After services have been provided credit balances of $50 or less will be applied to future services unless you request a direct refund.

The physicians of Facial Plastic Surgery Associates have a financial interest in Memorial Hermann Kirby Glen Surgery Center. They have no financial interest in Houston Methodist Hospital or any other surgical center where they operate. Our suggestion of surgical centers is individualized and based on the patient's needs; patients are welcome to select another surgical center, provided that the operating surgeon is credentialed at that location and that the surgical center can adequately provide the level of care the patient requires.

If you have questions or would like to discuss any details of our financial policy, please call the office at 713.526.5665 to set up an appointment with one of our account specialists. We appreciate your cooperation and we will do all we can to assist you in your healthcare needs.

I have read and understand the practice's financial policy and I agree to be bound by its terms. I also agree to be responsible for 40% collection cost (collection agency fees, attorney fees and court costs) incurred in collecting a delinquent account.

PATIENT SIGNATURE	**DATE**
OTHER LEGALLY RESPONSIBLE PERSON SIGNATURE	**DATE**
WITNESS	**DATE**

PATIENT STICKER

FACIAL PLASTIC SURGERY ASSOCIATES

TELEMEDICINE CONSENT FORM

INSTRUCTIONS

This document explains the purpose of telemedicine – also known as "telehealth" and referred herein, collectively, as "telemedicine" – and outlines the benefits and risks of telemedicine. It is important that you read the whole document carefully. Please initial each page. Doing so means you have read the page. Signing the consent agreement means that you agree to a telemedicine session with your doctor or one of the doctor's assistants (i.e. nurse practitioner, physician assistant, etc.).

GENERAL INFORMATION

Telemedicine is the distribution of health-related services and information via electronic and telecommunication technologies, such as computers and mobile devices, to access and manage health care services remotely. Telemedicine may include technologies you use from home or that your doctor uses to improve or support health care services. Telemedicine allows out-of-office patient and clinician contact, care, advice, reminders, education, intervention, monitoring, and remote admissions. Examples of telemedicine include videoconferencing, teleconferencing, transmission of images, e-health including patient portals, and remote monitoring of vital signs.

ALTERNATIVE METHODS OF MEDICAL CARE BESIDES TELEMEDICINE

In-person care is an alternative method of medical care to telemedicine.

BENEFITS OF TELEMEDICINE

The benefits of telemedicine include the following:

- Make health care accessible to people who live in rural or isolated communities.
- Provide long distance clinical care.
- Make services more readily available or convenient for people with limited mobility, time or transportation options.
- Obtain expertise of specialists.
- Improve communication and coordination of care among members of a health care team and patient.
- Provide support for self-management of health care.
- Quick and efficient medical evaluation and management.

RISKS OF TELEMEDICINE

As with any medical care options, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

- Information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the physician and assistant(s);
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment;
- Security protocols could fail, causing a potential breach of privacy and/or inadvertent disclosure of personal identifying information and/or protected health information;
- Lack of access to complete medical records may result in adverse drug interactions, allergic reactions or other judgment errors;
- Overuse of medical care;
- Unnecessary or overlapping care;
- A complete diagnosis may not be rendered without a physical exam.

Initials:_____

PATIENT STICKER

FACIAL PLASTIC SURGERY ASSOCIATES

TELEMEDICINE CONSENT FORM

CONSENT FOR THE USE OF TELEMEDICINE

1. I understand that the purpose of telemedicine is to provide health care services.

2. I permit my doctor and the doctor's assistants to use telemedicine in my care.

3. I understand that telemedicine means using phone and/or video to communicate with my health care team instead of seeing my team in person (face-to-face).

4. I understand that reasonable efforts will be made to protect my privacy, though there may be risk of inadvertent disclosure of my personal identifying information and/or protected health information.

5. I understand that I can ask questions and discontinue the use of telemedicine at any time I choose.

6. I understand that telemedicine does not replace other types of medical assessment and care. If I am not improving and have serious health concerns, I will seek immediate medical attention at an emergency facility.

7. ALL OF MY QUESTIONS REGARDING TELEMEDICINE WERE ANSWERED, AND THE FOLLOWING WAS EXPLAINEDTO ME IN A WAY THAT I UNDERSTAND:

    a. THE CONCEPT OF TELEMEDICINE

    b. RISKS AND BENEFITS OF THE USE OF TELEMEDICINE

    c. ALTERNATIVE METHODS OF MEDICAL CARE

I CONSENT TO THE USE OF TELEMEDICINE IN MY MEDICAL CARE AND THE ITEMS THAT ARE LISTED ABOVE (1-7). I UNDERSTAND THE EXPLANATION AND HAVE NO MORE QUESTIONS.

PATIENT SIGNATURE	DATE

I am the parent or guardian of the above minor. I am authorized to sign this consent on his/her behalf, and I agree on my own behalf and his/her to the terms of the foregoing consent.

OTHER LEGALLY RESPONSIBLE PERSON SIGNATURE	DATE
WITNESS	DATE

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PATIENT STICKER

FACIAL PLASTIC SURGERY ASSOCIATES

MEDICARE CONTRACT
DR. RUSSELL KRIDEL

This contract is entered into by and between Russell W.H. Kridel, MD FACS (hereinafter called "physician"), whose principal medical office is located at 6655 Travis, Ste. 900 Houston, TX 77030 and _____ (hereinafter called "beneficiary"), who resides at _____, and shall become effective on this __ day of _____, 20__ and shall expire on the __ day of _____, 20__, unless otherwise renewed in accordance with the 42 U.S.C. 1395a; 42 C.F.R. 405, Subpart D.

Physician Obligations
The physician acknowledges that he is excluded from Medicare under sections 1128, 1156, 1892 or any other section of the Social Security Act. The physician acknowledges that this contract shall not be entered into with the beneficiary, or the beneficiary's legal representative, during a time when the beneficiary requires emergency care services or urgent care services, except that the physician may furnish emergency or urgent care services to a Medicare beneficiary in accordance with 42 C.F.R. § 405.440.

The physician acknowledges that he must retain this contract (with original signatures of both parties to this contract) for the duration of the opt-out period, and that it shall be made available to the Centers for Medicare & Medicaid Services (CMS) upon request.

The physician shall provide a copy of this contract to the beneficiary, or to his or her legal representative, before items or services have been furnished to the beneficiary under the terms of this contract. The physician acknowledges that he must enter into a contract for each opt-out period.

Beneficiary Obligations
The beneficiary, or his or her legal representative, accepts full responsibility for payment of the physician's charge for all services furnished by the physician. The beneficiary, or his or her legal representative, understands that no payment will be provided by Medicare for items or services furnished by the physician that would have otherwise been covered by Medicare if there was no private contract and a proper Medicare claim had been submitted. The beneficiary, or his or her legal representative, understands that Medicare limits do not apply to what the physician may charge for items or services furnished by the physician.

By signing this contract, I agree not to submit (or request that my physician submit) a claim to Medicare or its agents for services, even if such services would otherwise be covered. I agree to be responsible for payment of services rendered by Russell W.H. Kridel, MD and understand that no Medicare reimbursement will be provided for such services. I understand that there are no limits specified by law as to the amounts that may be charged by the physician for services provided.

The beneficiary, or his or her legal representative, agrees not to submit a claim, nor ask the physician to submit a claim, to Medicare for Medicare items or services, even if such items or services are otherwise covered by Medicare. The beneficiary acknowledges that this written private contract contains sufficiently large print to ensure that the beneficiary is able to read this contract. The beneficiary, or his or her legal representative, has entered into this contract with the knowledge that he or she has the right to obtain Medicare-covered items and services from physicians and practitioners who have not opted out of Medicare and for whom payment would be made by Medicare for their covered services, and that the beneficiary has not been compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted out.

I understand that I have the right to have such services provided by other physicians or practitioners for whom Medicare payment would be made. I understand that Dr. Kridel has elected not to participate in the Medicare program.

PATIENT STICKER

The beneficiary, or his or her legal representative, understands that Medigap plans do not, and other supplemental plans may elect not to, make payments for items and services not paid for by Medicare.

The beneficiary, or his or her legal representative, understands that this agreement shall not be entered into with the physician during a time when the beneficiary requires emergency care services or urgent care services, except that the physician may furnish emergency or urgent care services to a Medicare beneficiary in accordance with 42 C.F.R. § 405.440.

The beneficiary, or his or her legal representative, acknowledges that a copy of this contract has been provided to the beneficiary, or to his or her legal representative, before items or services have been furnished to the beneficiary under the terms of this contract.

I understand that during the opt-out period, a Medicare Advantage plan may not by law make any payments to the physician for any Medicare items and services furnished to the beneficiary under this contract.

Name of physician Russell W.H. Kridel, MD FACS

Signature _____

Date: April 1, 2013

Principal office address: 6655 Travis, Ste. 900, Houston, Texas 77003

Telephone number: 713-526-5665

National Provider Identifier: 1780821215

Name of beneficiary _____

PATIENT SIGNATURE	**DATE**
WITNESS	**DATE**

FACIAL PLASTIC SURGERY ASSOCIATES

MEDICARE CONTRACT
DR. SEAN DELANEY

This contract is entered into by and between Sean W. Delaney, MD (hereinafter called "physician"), whose principal medical office is located at 6655 Travis, Ste. 900 Houston, TX 77030 and _____ (hereinafter called "beneficiary"), who resides at _____, and shall become effective on this __ day of _____, 20__ and shall expire on the __ day of _____, 20__, unless otherwise renewed in accordance with the 42 U.S.C. 1395a; 42 C.F.R. 405, Subpart D.

Physician Obligations

The physician acknowledges that he is excluded from Medicare under sections 1128,1156, 1892 or any other section of the Social Security Act. The physician acknowledges that this contract shall not be entered into with the beneficiary, or the beneficiary's legal representative, during a time when the beneficiary requires emergency care services or urgent care services, except that the physician may furnish emergency or urgent care services to a Medicare beneficiary in ac-cordance with 42 C.F.R. § 405.440.

The physician acknowledges that he must retain this contract (with original signatures of both parties to this contract) for the duration of the opt-out period, and that it shall be made available to the Centers for Medicare & Medicaid Services (CMS) upon request.

The physician shall provide a copy of this contract to the beneficiary, or to his or her legal representative, before items or services have been furnished to the beneficiary under the terms of this contract. The physician acknowledges that he must enter into a contract for each opt-out period.

Beneficiary Obligations

The beneficiary, or his or her legal representative, accepts full responsibility for payment of the physician's charge for all services furnished by the physician. The beneficiary, or his or her legal representative, understands that no payment will be provided by Medicare for items or services furnished by the physician that would have otherwise been covered by Medicare if there was no private contract and a proper Medicare claim had been submitted. The beneficiary, or his or her legal representative, understands that Medicare limits do not apply to what the physician may charge for items or services furnished by the physician.

By signing this contract, I agree not to submit (or request that my physician submit) a claim to Medicare or its agents for services, even if such services would otherwise be covered. I agree to be responsible for payment of services rendered by Sean Delaney, MD and understand that no Medicare reimbursement will be provided for such services. I understand that there are no limits speci-fied by law as to the amounts that may be charged by the physician for services provided.

The beneficiary, or his or her legal representative, agrees not to submit a claim, nor ask the physician to submit a claim, to Medicare for Medicare items or services, even if such items or services are otherwise covered by Medicare. The beneficiary acknowledges that this written private contract contains sufficiently large print to ensure that the beneficiary is able to read this contract. The ben-eficiary, or his or her legal representative, has entered into this contract with the knowledge that he or she has the right to obtain Medicare-covered items and services from physicians and practitioners who have not opted out of Medicare and for whom payment would be made by Medicare for their covered services, and that the beneficiary has not been compelled to enter into private con-tracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted out.

I understand that I have the right to have such services provided by other physicians or practitioners for whom Medicare payment would be made. I understand that Dr. Delaney has elected not to participate in the Medicare program.

PATIENT STICKER

The beneficiary, or his or her legal representative, understands that Medigap plans do not, and other supplemental plans may elect not to, make payments for items and services not paid for by Medicare.

The beneficiary, or his or her legal representative, understands that this agreement shall not be entered into with the physician during a time when the beneficiary requires emergency care services or urgent care services, except that the physician may furnish emergency or urgent care services to a Medicare beneficiary in accordance with 42 C.F.R. § 405.440.

The beneficiary, or his or her legal representative, acknowledges that a copy of this contract has been provided to the beneficiary, or to his or her legal representative, before items or services have been furnished to the beneficiary under the terms of this contract.

I understand that during the opt-out period, a Medicare Advantage plan may not by law make any payments to the physician for any Medicare items and services furnished to the beneficiary under this contract.

Name of physician Sean W. Delaney, MD FACS

Signature _____

Date: _____

Principal office address: 6655 Travis, Ste. 900, Houston, Texas 77003

Telephone number: 713-526-5665

National Provider Identifier: 1285056903

Name of beneficiary _____

PATIENT SIGNATURE	**DATE**
WITNESS	**DATE**