The Liver Institute
METHODIST DALLAS

Patient Registration

Patient Last Name | First Name | Middle Initial

Birth Date | Age | Sex | Social Security Number

Street Address (mailing address) | City | State | ZIP

Home Phone Number | Work Phone Number | Cell Phone Number | E-Mail Address

Race/Ethnicity | Religion | Primary Language | Marital Status

Alternate Contact Name | Alternate Contact Phone Number | Relationship

Patient Employer | Employer Phone Number

Spouse Employer | Spouse Employer Phone Number

Primary Insurance | Secondary Insurance

Primary Insurance Phone Number | Secondary Insurance Phone Number

Primary Insured's Name | Secondary Insured's Name

Primary Insured's Birth Date | Secondary Insured's Birth Date

Primary Insured's Social Security Number | Secondary Insured's Social Security Number

Referring Physician Name | Primary Care Physician Name

Referring Physician Address | Primary Care Physician Address

Referring Physician City, State & Zip | Primary Care Physician City, State & Zip

Referring Physician Phone Number & FAX | Primary Care Physician Phone Number & FAX

I hereby authorize the physician to release any and all information necessary concerning my diagnosis and treatment for the purposes of securing payment from my insurance company; and thereby authorize payment of the insurance benefits directly to the physician for any services rendered that are not paid for directly by me. I understand that I am financially responsible to pay any copayment, deductible and coinsurance amounts not paid by my health plan for services I receive at The Liver Institute. I further understand that I am financially responsible for all charges, in the event that I do not have health insurance coverage.

Signed: _____ Date: _____

Patient or Guarantor

Office Use Only – Demographic Verification & Update (Initial, 3mos, 6mos, 9mos, 1 year)

Date									
Initial									

The Liver Institute
METHODIST DALLAS

Consent for Disclosure/Release of Health Information

Is it permissible to:	Yes	No	Please provide:
Call your home?			**Home Phone #:**
Leave a message at home ?			**Primary: [ ] Secondary: [ ] Third: [ ]**
Call your work ?			**Work Phone #:**
Leave a message at work ?			**Primary: [ ] Secondary: [ ] Third: [ ]**
Call your cell phone ?			**Cell Phone #:**
Leave message on cell phone?			**Primary: [ ] Secondary: [ ] Third: [ ]**
Mail results to your home?			**Address:**
E-Mail results to your home?			**E-Mail Address:**
Medical results may be disclosed to others?			**Authorized Names:**

Additional contacts:

Contact #1: _____
Relationship: _____
Home #: _____
Work#: _____
Cell: _____

Contact #2: _____
Relationship: _____
Home #: _____
Work#: _____
Cell: _____

The Methodist Health System Notice of Privacy Practices (the "Notice") provides information about how The Liver Institute may use and disclose protected health information about you. You have the right to review the Notice before signing this consent. A copy of the current Notice is posted in the waiting room. The Notice contains on the first page, in the top right-hand corner, the effective date. As provided in our Notice, the terms of our Notice may change.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations, as described in our Notice. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent. You have the right to receive a copy of this consent for disclosure after signing, if you request one.

_____ _____
Patient Signature **Date**

_____ _____
Patient Print Name **(Relationship if other than the patient)**

_____ _____
Print – Witness/Translator **Witness/Translator Signature**

The Liver Institute
METHODIST DALLAS

Methodist Transplant Specialists General Office and Financial Policies

The Liver Institute at Methodist Dallas (Methodist Transplant Specialists) is delighted to have the opportunity to serve you. Our primary mission is to provide you with quality, cost-effective health care, and we regard your complete understanding of your financial responsibilities as an essential element of your care and treatment. The following are our general office and financial policies. If you have any questions regarding these policies, please discuss them with the office manager.

General Office Policies:

- Please arrive on time for your scheduled appointment.
  If you are more than 15 minutes late, it may be necessary to reschedule your appointment for a later time.
- Please realize that it is each individual's responsibility to keep track of appointments made. Please understand that patients are reminded of scheduled appointments the day before as a courtesy only. However, on occasion you may not receive a reminder call.
- If you need to cancel an appointment, please give the office 24 hours' notice, so that another patient may be scheduled in the time slot reserved for you. Methodist Transplant Specialists may charge you an administrative fee for missed appointments and/or procedures when 24 hours' notice of cancellation is not provided.
- **Administrative "NO SHOW FEES" are not billed to your insurance company. The fee must be paid prior to rescheduling the missed appointment**.
  *** $50 New Appt./FU Appt. * $100 Colonoscopy, EGD & Liver Biopsy * $250 ERCP**
- Patients who present without co-pay, insurance card and state photo ID will be rescheduled.
- Methodist Transplant Specialists charge a fee for processing FMLA or Disability Paperwork. Ask for more information.
- Methodist Transplant Specialists may charge a fee for processing medical records requests. Ask for more information.

Financial Policies:

- Unless other arrangements have been made in advance by either you or your health insurance carrier, co-payment, co-insurance and/or deductibles are due at the time of service. For your convenience, Methodist Transplant Specialists accept cash, check, debit card, VISA, MasterCard, Discover, and American Express. Some of our satellite clinics do not accept cash payments.
- The remainder of your bill will be sent to your insurance company for payment to Methodist Transplant Specialists.
- If you have insurance coverage with a plan for which your physician does not have a prior agreement, the bill for services will be prepared and sent to your health plan on an assigned basis, billing for services out-of-network. A portion of the charges for your care and treatment are due at the time of service.
- In the event that your health plan determines a service to be "not covered," you will be responsible for the complete charge. Payment is due upon receipt of a statement from your physician.
- Methodist Transplant Specialists will bill your health plan for all physician services provided in the hospital. Any balance due is your responsibility and is due upon receipt of a statement from your physician.
- For all services rendered to minor patients, the adult accompanying the patient and the parent or guardian with custody will be responsible for payment.
- A $25.00 NSF fee will be charged for returned checks.
- Accounts not paid by the 120th day following the date of service will be turned over to an outside collection agency, unless arrangements have been made in advance. If you have multiple delinquent accounts, you may be asked to transition your care to another office.

I have read and understand the above general and financial policies, and understand and agree to the terms herein. I understand that this office will file an insurance claim on my behalf. I understand that I will be fully responsible for payment of any and all medical services denied by my insurance company to the extent permissible under state and/or federal law.

Patient Signature	**Date**
Print Patient Name	**(Relationship if other than the patient)**
Print - Witness/Translator	**Witness/Translator Signature**

The Liver Institute
METHODIST DALLAS

Physician Extenders
(Physician Assistant and Advanced Practice Nurse Consent)

This facility has on staff Physician Extenders (Physician Assistants and Advanced Practice Nurses) to assist in the delivery of medical care.

A Physician Extender is not a doctor. They are graduates of a certified training program and are licensed by the Texas state board. Under supervision of a Physician, a Physician Extender can diagnose, treat and monitor common acute and chronic diseases as well as provide health maintenance care. "Supervision" does not require the constant physical presence of the supervising Physician, but rather overseeing the activities of the extender and of accepting responsibility for the medical services provided.

A Physician Extender may provide such medical services that are within his/her education, training and experience. These services may include, but are not limited to:

- Obtaining histories and performing physical exams.
- Developing and implementing a treatment plan.
- Monitoring the effectiveness of therapeutic interventions.
- Offering counseling and education.
- Supplying sample medications and writing prescriptions.

I understand that at anytime I can refuse to see the Physician Assistant or Advanced Practice Nurse and request to see a Physician. **I also understand that should I make this request at the time of my visit, my Physician may not be readily available and my appointment may need to be rescheduled.**

I have read the above and hereby consent to the services of a Physician Extender for my health care needs.

_____ _____
Patient Signature Date

_____
Print Patient Name

_____
Witness Signature - Patient under 18 years of age

_____
Witness (Print Name)

_____
Translator (Signature)

_____
Translator (Print Name)

The Liver Institute
METHODIST DALLAS

Patient Acknowledgement of Independent Practice

I, the undersigned patient (or patient representative), hereby acknowledge and understand that The Liver Institute at Methodist Dallas is an outpatient clinic of Methodist Dallas Medical Center (MDMC) where several independently practicing physicians and physician groups provide liver transplant and/or liver transplant related medical services, gastroenterology, general hepatology and surgical services. Specifically, I acknowledge and understand that Methodist Transplant Specialists, Digestive Health Associates of Texas, P.A., and any health care provider employed or otherwise engaged by any such group including, but not limited to, Maisha Barnes, M.D., Stephen Cheng, M.D., Richard Dickerman, M.D., Ed Dominguez, M.D., Carlos Fasola, M.D., Adil Habib, M.D., Parvez Mantry, M.D., Alejandro Mejia, M.D., Hector Nazario, M.D., Mangesh Pagadala, M.D., and Jeffrey Weinstein, M.D. (collectively all such named groups and individuals are referred to as "Providers") are not agents, employees or representatives of The Liver Institute, of MDMC or of Methodist Health System (MHS). I further acknowledge and understand that The Liver Institute, MDMC and MHS have no right to control the details of the medical services provided by any Provider.

_____ _____

Patient Signature **Date**

_____ _____

Print Patient Name **(Relationship if other than the patient)**

_____

Witness/Translator Signature

_____

Print - Witness/Translator

The Liver Institute
METHODIST DALLAS

Authorization to Release Information

1. **Authorization to Release Information:**

I authorize Methodist Transplant Specialists and Digestive Health Associates of Texas, (who oversee the business practices of the Physicians of The Liver Institute), to furnish requested information from the patient's medical and other records to: (1) any insurance company or third party payor for the purpose of obtaining payment on behalf of Methodist Transplant Specialists or Digestive Health Associates of Texas, (2) any other person(s) or entities financially responsible for the patient's care or treatment, and (3) representatives of local, state, or federal agencies in accordance with law. Such information may include, but is not limited to, information concerning communicable diseases such as Acquired Immune Deficiency Syndrome (AIDS). I authorize the release of information from or the review of the patient's records for purposes of conducting medical audits, utilization reviews, or quality assurance reviews.

2. Assignment of Benefits:

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not covered by your insurance. In order to control your cost of billing, we request that office visit charges be paid at the beginning of each visit.

If this account is assigned to an attorney for collection and or suit, the prevailing party shall be entitled to reasonable attorney's fees for costs of collection.

I understand that I am responsible for providing the Liver Institute all insurance information at the time of registration to allow for verification of benefits, and regardless of my assigned insurance benefits, I am responsible for the total charges for services rendered.

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled including Medicare, private insurance, and other health plans to The Liver Institute. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.

3. Medicare/Medicaid Assignment of Benefits:

a. I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize the release of information concerning me to Social Security Administration or its intermediaries or carriers as well as any information needed for filing a Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign benefits payable for services to the physician or organization submitting a claim to Medicare for me. For services not covered by Medicare, the Liver Institute will provide me an Advanced Beneficially Notice at the time of service.

Initial: _____

b. I understand that Medicaid recipients are responsible for payment of any medical care or service received that is beyond the amount, duration and/or scope of the Texas Medicaid Program, as determined by the Medicaid Department or its health insuring agency. All payments for non-covered services are due and payable prior to each office visit unless prior payment arrangements have been made.

Initial: _____

4. **Authorization:**

I authorize The Liver Institute to disclose and release my protected health information to Methodist Health System for the purpose of maintaining a database of potential liver transplant recipients among the patients of The Liver Institute and to coordinate follow up care that I may receive.

I understand that I have the right to revoke this authorization at any time by providing a written revocation to:

The Liver Institute at Methodist Dallas
1411 N. Beckley Ave., Pavilion III, Suite 268
Dallas, Texas 75203

I understand that the revocation will not apply to information that has already been released pursuant to this authorization.

Expirations or termination of authorization:
This authorization will remain in effect until termination by you, your personal representative or another individual(s) or legal entity authorized to do so by court order or law.

Re-disclosure:
The providing entity has no control over the covered entity receiving the information. Therefore, the protected health information disclosed under this authorization will no longer be the responsibility of the entity providing the protected health information.

_____ _____
Patient Signature **Date**

_____ _____
Print Patient Name **(Relationship if other than the patient)**

_____
Witness/Translator Signature

_____
Print - Witness/Translator

The Liver Institute
METHODIST DALLAS

Initial Patient Assessment / History

Patient Name _____ **Date** _____

Age _____ **Sex** _____ **Race** _____ **Referred by** _____**(MD)**

Primary Care / Family Physician _____ **(MD)**

History of Present Illness

Main reason for Visit _____

1. **When were you first diagnosed with liver problems?** _____
2. **What type of liver problems were you diagnosed with?** _____
3. **Have you ever been treated for your liver problems (Circle One) Yes No**
   If so, what were you treated with? (Modifying Factors) (Check All that Apply)

☐ **Pegylated Interferon** ☐ **Ribavirin** ☐ **Interferon** ☐ **Steroids** ☐ **Phlebotomy** ☐ **Other** _____

4. **How did/does this treatment make you feel? Worse or Better**

Date Treatment Started _____ **Date Ended/Stopped** _____
Date Treatment Started _____ **Date Ended/Stopped** _____
Date Treatment Started _____ **Date Ended/Stopped** _____
Side effects experienced while on treatment _____
_____
_____

5. **Have you ever had a liver biopsy? (Circle One) Yes / No**
   If so, When? _____ **Where? (Hospital)** _____

6. Have you ever had any of the following tests?

			Date	Comment (Physician/Staff only)
Liver UltraSound	**Yes**	**No**	_____	_____
Abdominal CAT Scan	**Yes**	**No**	_____	_____
MRI of the Liver	**Yes**	**No**	_____	_____
Upper Endoscopy (EGD)	**Yes**	**No**	_____	_____
Colonoscopy	**Yes**	**No**	_____	_____

Comment (Physician/Staff only) _____

_____

Risk Factors for Liver Disease

			Date	Comments
1. Have you ever used IV drugs?	**Yes**	**No**	_____	_____
2. Have you ever gotten a tattoo?	**Yes**	**No**	_____	_____
3. Have you had a blood transfusion?	**Yes**	**No**	_____	_____
4. Have you ever snorted cocaine?	**Yes**	**No**	_____	_____
5. Have you had any body-piercings?	**Yes**	**No**	_____	_____
6. Have you had multiple sex partners?	**Yes**	**No**	_____	_____

7. Have you ever been stuck by a dirty or infected needle? **Yes / No** **When?** _____

8. Do you drink alcohol or have you drank alcohol in the past? **Yes / No**

Amount: _____ **Type:** _____ **How often?** _____

When did you start? _____ **When did you stop?** _____

9. Do you have any family history of liver disease? **Yes / No**

If so, relationship? _____ **Type:** _____

Current Symptoms of Liver Disease

Do you currently **have any of the following symptoms?**

Yes	No		Date	Comment (Physician/Staff only)
☐	☐	**Fatigue/Tiredness**	_____	_____
☐	☐	**Rash**	_____	_____
☐	☐	**Abdominal Pain**	_____	_____
☐	☐	**Joint Swelling**	_____	_____
☐	☐	**Joint Pain**	_____	_____

10. Rate your pain/other symptom from 1-10 scale **1, 2, 3, 4, 5, 6, 7, 8, 9, 10**

11. What is the quality of pain/other symptoms? Mild / sharp / radiating / throbbing / cramping / tingling

Symptoms of Severe Liver Disease

Have you ever **had any of the following symptoms?**

Yes	No		Date	Comment (Physician/Staff only)
☐	☐	**Itching**	_____	_____
☐	☐	**Ascites (fluid in abdomen)**	_____	_____
☐	☐	**Swelling of feet / ankles**	_____	_____
☐	☐	**Variceal Bleed (vomiting blood)**	_____	_____
☐	☐	**Jaundice (yellow skin/eyes)**	_____	_____
☐	☐	**Encephalopathy (mental confusion Forgetfulness / drowsiness)**	_____	_____

12. When do you feel these symptoms? Day / Night **Constantly / Occasionally**

Past Medical History

Yes	No		**Comments**
☐	☐	**Diabetes**	_____
☐	☐	**Diabetic Complications**	_____
☐	☐	**High Blood Pressure**	_____
☐	☐	**Heart Disease**	_____
☐	☐	**Kidney Disease**	_____
☐	☐	**Auto-Immune Disease**	_____
☐	☐	**Lung Disease (COPD, Asthma, Emphysema)**	_____
☐	☐	**Cancer**	_____
☐	☐	**HIV**	_____
☐	☐	**Seizure Disorder**	_____
☐	☐	**Thyroid Disease**	_____
☐	☐	**Chronic Low-back Pain**	_____
☐	☐	**Weight Loss**	_____
☐	☐	**High Cholesterol, High Lipids**	_____
☐	☐	**Other** _____	_____

Past Surgical History

Previous Surgery (Circle One) Yes No If yes, type of surgery and date performed.

Date/Procedure: _____
Date/Procedure: _____
Date/Procedure: _____

Past Family History

Has anyone in your family (blood relative) had the following?

Yes	No		
☐	☐	**Liver Disease**	_____
☐	☐	**Cancer**	_____
☐	☐	**Heart Disease**	_____
☐	☐	**Diabetes**	_____

Has your partner been tested for Hepatitis C? (Circle One) Yes No N/A
Has your partner been tested for Hepatitis B? (Circle One) Yes No N/A

Social History

Marital Status (circle one) Single Married Separated Divorced Widowed

Number of children _____

Are you currently employed? (Circle One) Yes / No If so, do you work full time? (Circle One) Yes / No

What type of work do you do? _____

Do you smoke? (Circle One) Yes / No
If yes, how much? _____ How long have you smoked? _____

Have you ever been in AA (Alcoholics Anonymous) or any other type of rehab program?
(Circle One) Yes / No If yes, when? _____

Psychiatric History

Do you suffer from depression and/or anxiety? (Circle One) Yes / No
Are you currently under the care of a psychiatrist? (Circle One) Yes / No
Do you currently have suicidal ideation? (Circle One) Yes / No
Have you ever been admitted to a hospital or institution for psychiatric reasons?
(Circle One) Yes / No If yes, when? _____

Medications

Please list all medications you are currently taking, including all over-the-counter medications.

Medication Name / Dosage / How often

1) _____ 7) _____
2) _____ 8) _____
3) _____ 9) _____
4) _____ 10) _____
5) _____ 11) _____
6) _____ 12) _____

Allergies

Are you allergic to any medications? (Circle One) Yes No Unknown

Do you have environmental or food allergies? (Circle One) Yes No Unknown

Allergy	Type of Reaction
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Review of Symptoms (check all that apply)

Constitutional **Comments**

- ☐ **Fever or Chills** ☐ **Fatigue** _____
- ☐ **Weight Loss** ☐ **Decreased Appetite** _____
- ☐ **Weight Gain** ☐ **Increased Appetite** _____
- ☐ **Trouble Sleeping**

EYES

- ☐ **Redness** ☐ **Yellowness** _____
- ☐ **Visual Changes** _____

NOSE/THROAT

- ☐ **Sore Throat** ☐ **Mouth Sores** _____
- ☐ **Nasal or Sinus Inflammation / Infection** _____

Respiratory

- ☐ **Cough** ☐ **Difficulty Breathing** _____
- ☐ **Shortness of Breath (without exertion)** _____

Heart/Cardiac

- ☐ **Chest Pain** ☐ **Heart Palpitations** _____
- ☐ **Shortness of Breath (with exertion)** _____

Gastrointestinal

- ☐ **Abdominal Pain** ☐ **Abdominal Swelling** _____
- ☐ **Nausea** ☐ **Vomiting** _____
- ☐ **Diarrhea** ☐ **Constipation** _____
- ☐ **Vomiting Blood** ☐ **Rectal Bleeding** _____
- ☐ **Black or Pale Stool** ☐ **Heartburn** _____

Reproductive / Urinary

- ☐ **Blood in Urine** ☐ **Frequent Urination** _____
- ☐ **Burning with Urination** ☐ **Dark Urine** _____

Skin/Integumentary

- ☐ **Rash** ☐ **Itching** _____
- ☐ **Injection Site Reaction** ☐ **Hair Loss** _____

Musculoskeletal

- ☐ **Joint Pain** ☐ **Back Pain** _____
- ☐ **Swelling in Extremities** _____

Neurological

- ☐ **Headache** ☐ **Dizziness** _____
- ☐ **Weakness** _____
- ☐ **Tingling / Numbness in Extremities** _____

☐ **ALL SYSTEMS NEGATIVE EXCEPT NOTED IN HPI**

The Liver Institute
METHODIST DALLAS

Authorization to Disclose Health Information

Name of Patient: (Please Print)_____

Date of Birth: _____ Social Security #: _____

I authorize the following individual or organization to disclose the above named individual's health information:

_____ Address: _____

This information may be disclosed and used by the following individual or organization:

The Liver Institute at Methodist Dallas
1411 N. Beckley Ave., Pavilion III, Suite 268
Dallas, Texas 75203
PH: 214-947-4400 or 877-4A-LIVER
FX: 214-947-4404

The type and amount of information to be used or disclosed is as follows: (Please check):

- ❒ All pertinent medical information (physician H&P, progress notes, other medical, imaging & laboratory reports) relative to liver disease or _____
- ❒ Operative Report or Procedure Report, specifically _____
- ❒ Liver Biopsy Slides
- ❒ Other _____

I understand that the information in the Patient's health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

This information is being disclosed for the following purpose(s): _____

I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company, when the law provides my insurer with the right to contest a claim under my policy.

Unless otherwise revoked, this authorization will expire in one year.

I understand that once the information is disclosed pursuant to this authorization, it may be re-disclosed by the recipient and the information may not be protected by federal privacy regulations.

I understand that I will be given a copy of this authorization form after signing, only if I request one.

_____ Date: _____
Signature of patient/Responsible Party or Legal Representative

_____ Date: _____
If signed by Legal Representative, Relationship to Patient

_____ Date: _____
Signature of Witness

The Liver Institute
METHODIST DALLAS

Appointment Reminder Consent

Methodist Transplant Specialists (MTS) may need to use your name, phone number, email address ("Contact Information"), and your clinical records to contact you with appointment reminders and information about treatment alternatives. If this communication is made by phone and you are not available, a message will be left on your voice mail or with the person answering the phone. By signing this form, you are consenting for MTS to contact you with appointment reminders and information and to leave messages on a voice mail or with individuals at your home.

Information that we use or disclose based on this consent may be subject to re-disclosure by anyone who has access to the reminder and may no longer be protected by federal privacy rules.

You have the right to refuse to give MTS your consent to use your telephone number and/or email address for appointment reminders and treatment alternatives. If you choose to give your consent, you have the right to revoke it, in writing, at any time in the future. If you refuse to give MTS this consent or revoke it in the future, it will not affect the treatment we provide to you.

I understand it is my responsibility to notify MTS of any changes in my contact information and I understand that there shall be no liability on MTS's part should I forget to do so. Unless I otherwise revoke, this consent will remain valid with MTS.

I CONSENT to the following forms of communication for appointment reminders (please initial all that apply):
_____ e-mail address _____ phone number _____ text message to be used in the manner described above.
I also acknowledge that I have received a copy of this consent.

_____ _____
Patient Name: Date:

_____
Signature of Patient/Responsible Party/Legal Representative

_____ _____
Printed Name of Responsible Party/Legal Representative Preferred Telephone Number

_____ _____
If Signed by Responsible Party/Legal Representative, Relationship to Patient Preferred Email Address Number

If different, than above, Preferred Number for Text Messages
I acknowledge that I have a received a copy of this consent but **DECLINE** to give MTS consent to use my contact information and clinical records to contact me with appointment reminders and information about treatment alternatives.

_____ _____
Patient Name: Date:

_____
Signature of Patient/Responsible Party/Legal Representative

_____
Printed Name of Responsible Party/Legal Representative

_____
If Signed by Responsible Party/Legal Representative, Relationship to Patient

Please note the text messaging service is a complimentary service provided by MTS, but standard messaging rates from your wireless carrier may still apply. If you have questions, please contact your wireless carrier.