JASON R. BAILEY, MD

PLASTIC, RECONSTRUCTIVE + COSMETIC SURGERY

Lonestar Surgery Center
12121 Richmond Avenue
Suite 107
Houston, TX 77082
(281) 741-5910

Lonestar Surgery Consultation Center
12121 Richmond Avenue,
Suite 101
Houston, Texas 77082
(281) 741-5910

Cosmeteik Med Spa Location
12121 Richmond Avenue
Suite 107
Houston, TX 77082
(713) 360-6857
(713) 360-6868

Clear Lake
450 West Medical Center
Boulevard, Suite 520
Webster, Texas 77598
(832) 831-1990

Conroe
500 Medical Center
Boulevard Suite 240
Conroe, Texas 77304
(936) 224-4134

The Medical Center
7400 Fannin Street
Suite 1160
Houston, Texas 77054
(713) 360-6857

Northwest Houston
800 Peakwood Drive Suite
2D
Houston, Texas 77090
(832) 446-6547

Date: ____/____/____

Patient Name: First _____ Middle _____ Last _____

Date of Birth _____/_____/_____ ☐ F ☐ M SSN _____

Address _____ Apt # _____ City: _____

State _____ ZIP _____ E-Mail _____

Home Telephone _____ _____ may contact me _____ may leave a message

Office Telephone _____ _____ may contact me _____ may leave a message

Mobile Telephone _____ _____ may contact me _____ may leave a message

Appointment Notification Contact Method ☐ Text or Call ☐ Mobile ☐ Home

Married ☐ Y ☐ N Spouse Name _____

Driver's License Number & State License: _____
(Please provide us with a copy)

ID card Number: _____
(Please provide us with a copy)

Pharmacy Name _____ Pharmacy Number _____

Is the reason for the visit due to: ☐ Illness ☐ Accident ☐ Other: _____

What caused your current injury/ pain episode: _____

Is this a motor vehicle accident: _____ If yes, date of Injury: _____

I was referred to Dr. Jason R. Bailey M.D. by (name and relation): _____

If Physician, please provide address and phone number: _____

You're Primary Care Physician: _____

Address & Phone Number of Primary Care Physician: _____

Employment: Are you employed? ☐ YES ☐ NO ☐ RETIRED

Type of work you do or did: _____

Employer: _____ Supervisor: _____

Work Address: _____ Work Phone Number: _____

How long at job: _____

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Insurance: ☐ Medicare ☐ Commercial ☐ Worker's Compensation ☐ Auto

☐ Other (Crime Victims, Student Insurance, etc.): _____

	Primary Insurance	Secondary Insurance
Name	_____	_____
Address	_____	_____
Phone Number	_____	_____
Group Number	_____	_____
Policy Number	_____	_____
Policy Holder	_____	_____
Adjuster Name	_____	_____

Is your group health plan coverage based upon your current employment? ☐ YES ☐ NO

Policy Holder Name & Phone Number: _____

SPOUSE/OTHER FAMILY MEMBER INSURANCE PLANS

Is your group health plan coverage based upon your spouse, your parents and/or any other family member's current employment? YES ☐ NO ☐

Policy Holder/Subscriber's First & Last Name: _____

Name of Employer: _____

OTHER INSURANCE INFORMATION FROM ACCIDENTAL INJURY

If **YOU** are not getting any treatment for an illness or injury for which another party could be held **liable in which you are being treated for**, please print the date of illness or injury.

_____/_____/_____

Name of Third Party or Insured Name: _____

Name of Insurance Carrier: _____

Address: _____ Policy/ Claim Number: _____

Phone Number: _____

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Was a police report or accident report filed: YES ☐ NO ☐

If yes, what department/city and number of report: _____

Name of Attorney (if applicable): _____

Address: _____

Brief Description of Illness or Injury: _____

YOUR INSURANCE INFORMATION FROM ACCIDENTAL INJURY

If **YOU** are now getting any treatment for an illness or injury which could be covered under **no-fault, personal injury protection coverage, medical payments coverage, un/underinsured motorist coverage, and/or automobile insurance,** print the date of the illness or injury.

_____/_____/_____

Name of Insurance Carrier of your insurance company:

Address: _____ Policy Number: _____

Claim Number: _____ Adjuster: _____

Name of Attorney (if applicable): _____

Address: _____

Telephone Number: _____

Fax Number: _____

Brief Description of Illness or Injury: _____

YOUR INSURANCE INFORMATION FROM WORK RELATED INJURY

Is this a work related injury: YES ☐ NO ☐

If **YOU** are now getting any treatment for an illness or injury which could be covered under **workers compensation** print the date of the illness or injury.

_____/_____/_____

Name of Workers Compensation Carrier of your company: _____

Address: _____ Policy Number: _____

Claim Number: _____ Adjuster: _____

Number of Claims filed with State of Texas: _____

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Name of Attorney (if applicable): _____

Address: _____

Telephone Number: _____

Fax Number: _____

Brief Description of Illness or Injury:

Personal Habits:

Tobacco? _____ How many packs per day? _____ Smoked how many years? _____

Have you quit smoking? _____ If so, When did you quit?_____

Do you currently drink alcohol? _____ Beer? _____ Whiskey? _____ When? _____

How Much Coffee do you drink per day? _____

Do you use any recreational drugs? _____ What? _____

Health history:

I am **ALLERGIC TO THE FOLLOWING MEDICATIONS:** _____

I have the following additional **ALLERGIES:** _____

I have had the following **SURGERIES:** _____

I am presently under a **DOCTOR'S CARE** for the following conditions: _____

I have the following **MEDICAL CONDITIONS**: _____

I would describe my **PRESENT STATE OF HEALTH** as: _____

I take the following medications, hormonal supplements, vitamins, herbal supplements: _____

_____

_____

Whom may we contact in an emergency?

Name: _____ Relationship: _____

Telephone: _____ Mobile: _____

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I attest the above history is completed to the best of my knowledge and understand and accept that my failure to disclose any of the above information can adversely affect a prescribed course of treatment to meet my goals, my safety, or the outcome of any treatment I elect to undergo with Jason R. Bailey, MD or any member of her staff.

Treatment and payment agreement

I authorize examination and treatment for this and all following physician visits.
I authorize to release any medical information necessary to process any insurance billings.
I authorize payment and assignment of insurance benefits to the doctor's office.
I understand I am financially responsible for all charges and deductibles not covered by my insurance.
I am personally responsible for supplying accurate and current insurance information.
I authorize a photocopy of this statement to serve as an original.

Patient signature _____ Date _____

Print Name _____

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NOTICE OF PRIVACY PRACTICES for Jason R. Bailey MD PA

Your medical record is called Protected Health Information (PHI) under Federal Law 104-191 –The Health Insurance & Accountability Act of 1996 (HIPAA-1996, http://www.hhs.gov/ocr/hipaa/). We are required by law as of March 1, 2003, to notify you of your privacy rights, and will post any changes to these rights in the office. You may receive a copy of the Notice of Privacy Practices upon request.

Use of Protected Health Information with your authorization

By signing the authorization you agree that your PHI may be used or disclosed by our office staff for the purpose of treatment, payment, healthcare operations)TPO), or judicial proceedings and that we call you by name in our waiting room. You also may have authorized a release of your PHI by a written statement from your employer, attorney, or insurance carrier. Your PHI may be required for our business records, our computer/billing system, pharmacies, other physicians, laboratories, your employer, or therapists before they will process our request for TPO. You may revoke any authorization, provided we receive the request in writing.

What we mean by:

Treatment – other treating personnel, pharmacies, testing facilities.
Payment – for billing and electronic records, your diagnosis and treatment are disclosed. Healthcare operations – compliance audits, public health, office administration or contractual requests.
Judicial proceedings – any court orders, subpoenas, legal audits, or lawful demand.

Use of you Protected Health Information without your authorization

Your PHI may be disclosed as required by law, for public health activities, victims of abuse, health and oversight proceedings, law enforcement, judicial and administrative proceedings, funeral homes, research purposes or specialized governmental functions. In such cases we will release information only if we have received a written request with documentation that the PHI disclosed in expressly authorized by the order. What we mean by:

Law – if the law requires, we will notify you of such disclosure.
Public health activities – FDA, communicable disease, work related injury, instances of abuse or neglect.
Health and oversight – a legal oversight agency for any investigation in which you are not involved.
Law enforcement – properly issued subpoena, warrant, court order, or legal summons.

Disclosure of Protected Health Information requiring your authorization

This office does not engage in fundraising, e-mail, faxing information unless you request it in writing. We will not disclose your PHI to family members, personal representatives or guardians unless you request it. In an emergency we may disclose only relevant information if in our professional judgment it is in your best interest. You may request we modify or do not disclose any or part of your PHI in order to carry out treatment, payment or healthcare operations. This right to restrict does not extend to disclosures as required by law.

You may inspect or request a copy of your PHI (in writing) to be sent to you or an alternative location or by alternative means. Dr. Bailey has the right to charge a fee for cost or supplies, labor costs, postage and if you agree, the cost of preparing a summary explanation of the records. The records shall be sent within 30 days from receipt of the written request and we will notify you if it will take longer than 30 days.

I authorize the following people to have access to my PHI, and any and all of my medical information:

Name	Relationship	Date
Name	Relationship	Date

I have reviewed this notice of Privacy Practices and received the address location and contact information for the complete HIPAA-1996, the Privacy Officer for this office, and the Department and Health Services where complaints can be made.

Name **Signature** **Date**

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Financial Policy

Our office is available to discuss any question(s) you may have regarding your insurance or account. The following is our financial policy, please review carefully then sign and date at the bottom of the form.

All co-pays are due at the time of service.
We accept cash, credit, debit or check
Payment in full may be required at the time of service depending upon service rendered

Insurance: Your insurance policy is a contract between you and the insurance company we are not a party to that contract. We will bill your insurance plan for you, as long as you provide us with the correct and current information. Your contract dictates the services that are covered and the amount of payment for those services. You are ultimately responsible for payment of services provided.

Secondary Insurance: As Courtesy, we will bill your secondary insurance, but we require all the plan details at the time of service. Once the primary insurance pays, we allow 45 days for the secondary insurance to process their portion. At the end of 45 days, the balance becomes the patient's responsibility.

Worker's Compensation Claims/Self-insured claims: we request your private insurance information at the time of service. In the event State Labor and Industry or the third party administrator does not accept your claim, we will bill your private insurance. *You are ultimately responsible for your payment of services rendered, if your claim is not accepted.*

Doctor Referrals: You are responsible for obtaining the appropriate referral from your physician prior to your appointment. It is your responsibility to make sure we have a valid and current copy of your referral in the office at the time of your appointment.

Payment issues: if financial problems arise, please contact our office as soon as possible. If an account becomes past due, necessary action will be taken, up to and including turning the account over to our attorney or collection service. The undersigned understands that he/she, or his/her agent, is responsible for charges incurred.

Uninsured Patients: A $150 deposit is required at time of check-in for our patients without insurance and $50 for each subsequent follow up. Evaluation by the Doctor is needed before a surgical quote be given.

Cosmetic Patients: $50 for Cosmetic consultation only

No Shows: Patients who no show their appointment(s) are at risk of being discharged from the practice

I understand that I am financially responsible for all charges whether or not paid by my insurance. I understand that the benefits quoted to me are not a guarantee of claim payment. I understand that payment is dependent on my eligibility at the time of service and all terms and conditions of my insurance plan. I agree that I will not withhold or delay payment if my insurance company denies payment on any of my charges. I have carefully read the financial policy. I understand and agree to the terms therein.

Patient signature _____ Date _____

Print Name _____

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Conditions of Service and Assignment of Benefits

Jason R. Bailey, M.D., P.A. & Lone Star Surgical Partners, P.A.

Professional Services Agreement

I, the undersigned patient, or personal representative acting on the patient's behalf, hereby engages the services of the applicable medical providers for the provision of services and treatment of my medical condition.

Consent for Medical and Surgical Treatment

The patient hereby consents to the procedures(s), which may be performed on an inpatient and/or outpatient basis, including emergency treatment or service, which may include, but are not limited to, laboratory procedures, diagnostic testing, x-ray examinations, medical and surgical treatments or procedures, anesthesia, or special services rendered for the patient under the general and special instructions of the patient's physician or surgeon.

Assignment of Insurance Benefits

In consideration of provider foregoing payment before the treatment, which both parties (Provider and patient/personal representative) agree is valid and valuable consideration, I hereby appoint, assign and convey directly to Jason R. Bailey, M.D., P.A. and Lone Star Surgical Partners, P.A., together referred to as the **Providers**, as my designated and authorized representatives, all medical benefits, personal injury protection benefits and/or medical payment benefits, third party insurance benefits or insurance, and/or my insurance reimbursement, if any, otherwise payable to me for medical services, surgical procedures, diagnostic testing, medical treatments, therapies, and/or medications rendered/or provided by the entities listed above. I understand that I am financially responsible for all charges for medical treatment regardless of any applicable third party insurance, my insurance or benefit payments. I hereby agree to reimburse the **Providers** for any and all costs of collection incurred to recover payment due from me for all medical services and treatment rendered to me, including reasonable legal fees. I hereby authorize the **Providers** to notify any third party insurance company, person and/or entity of these terms and Conditions **of Service and Assignment of Benefits and give them a copy of this document.**

Authorization for Release of Information

I hereby authorize **Providers** to furnish requested patient information, including but not limited to, information relating to communicable diseases such as HIV and hepatitis, to the referring physician and to any insurance company, health plan or third party, third party entity, or payer for the purpose of obtaining payment and process my claims for the medical services and treatment rendered. Further, I authorize the **Providers** to release information from my medical record to any other health care facility to which I may be transferred. Additionally, I authorize any plan administrator fiduciary, third party insurer, insurer, and/or attorney to release to the **Providers** any and all Plan documents, summary benefit description, insurance policy, settlement documents, and/or settlement information upon written request by the **Providers** or their attorneys in order to facilitate their claim for direct payment of such medical benefits.

Administrative Claim Assignment

In further consideration of provider foregoing payment before the treatment, which both parties agree is valid and valuable consideration, in addition to the assignment of the medical benefits and/or insurance reimbursement above, I also assign and/or convey to the **Providers** any legal or administrative claim or action arising under any group health plan, health plan, employee benefits plan or health insurance concerning medical expenses incurred as a result of the medical services, medical treatments, diagnostic testing, therapies, and/or medications I receive from the **Providers**. This constitutes an express and knowing of ERISA breach or fiduciary duty claims and other legal and/or administrative claims. I intend by this assignment to convey to the **Providers** all of my rights to claim (or alternatively, place a lien on) the medical benefits related to the medical services, medical treatments, medical therapies, diagnostic testing and/or medications provided including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). The assignees and/or designated representative (above-named providers) is given the right by me to

(1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chose in action or right against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. The above named **Providers** as my assignees and my designated authorized representatives may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at **Provider**'s expense. This assignment is irrevocable and valid for all administrative and judicial reviews under PPACA (health care reform legislation), ERISA, Medicare and applicable federal and state laws. To my knowledge, there is no prohibition to any assignment in my plan, if there is any prohibition; I agree to sign any document to allow the provider to be paid directly for services rendered to me.

A photocopy of this assignment is to be considered valid, the same as if it was the original Initials_____

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Medicare Assignment (If covered by Medicare Insurance Coverage)

I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I request that payment of authorized benefits be on my behalf. I authorize the release of any information needed to act on this request. In further consideration of provider foregoing payment before the treatment, which both parties agree is valid and valuable consideration, I assign all reimbursements to which I may be entitled for direct payment to the above named **Providers** for medical services and treatment. I understand that I am responsible for any remaining balance not covered by any insurance.

Irrevocable Assignment of Interest (If you have a personal injury claim against any third party)

In further consideration of provider foregoing payment before the treatment, which both parties agree is valid and valuable consideration, I hereby give, grant and convey a irrevocable, undivided ownership right and lien on any such claim or cause of action an irrevocable, undivided interest in my claim and any settlement or payment to me for such injury up to the full amount billed by the **Providers** for such services, irrespective of partial payments received by any non-contracted third party insurance payers. I agree to notify **Provider** immediately of any changes in attorneys handling the subject claim. I hereby authorize the **Providers** to notify any third party insurance company, person and/or entity of these terms Conditions **of Service and Assignment of Benefits and give them a copy of this document.**

Worker's Compensation

In further consideration of provider foregoing payment before the treatment, which both parties agree is valid and valuable consideration, if the medical condition for which I seek treatment was caused by a work-related injury, I realize that I must, under Texas law and before any services rendered, inform the **Providers** of the work-related nature of my condition, the identity of my employer and any other information needed to allow the **Providers** to file a claim for the cost of its services from my employer or workers compensation carrier. **Providers** are required to submit a bill to the carrier within a certain time from once a provider knows the injury is work related.

The undersigned certifies that he/she has read and understands the foregoing, has authority to enter into this agreement, does so voluntarily and under their own free will and accord, has had an opportunity to have an attorney review this document before entering into it, received a copy thereof, and is the patient, patient's legal representative, or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

_____
Print name of Patient/Personal Representative

_____ _____
Signature of Patient/Personal Representative Relationship to Patient

_____
Print name of Witness

_____ ____/_____/_____
Signature of Witness Date

A photocopy of this assignment is to be considered valid, the same as if it was the original. Initials_____

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TEXAS DEPARTMENT OF INSURANCE
Compliance Division - Consumer Protection (111-1A)
333 Guadalupe, Austin, Texas 78701 ★ PO Box 149091, Austin, Texas 78714-9091
(800) 252-3439 | F: (512) 490-1007 | TDI.texas.gov | @TexasTDI

Health Insurance Mediation Request Form

Complete the form and mail, fax, or email it to

Mail Code 111-1A
Consumer Protection
Texas Department of Insurance
P.O. Box 149091
Austin, TX 78714-9091
Fax: 512-490-1007
Email: ConsumerProtection@tdi.texas.gov

Please provide the following information and sign at the bottom. **Bolded** items are required.

Please also attach copies of bills that are in dispute and the explanations of benefits (EOB) from the insurance company showing the amount the insurance company paid.

Enrollee Contact Information

Name (first, middle, last) _____

Address _____

City, State, ZIP Code _____

Daytime phone number _____

Email address _____

Attorney or Representative Information, if applicable

Attorney or representative name _____

Address _____

City, State, ZIP Code _____

Phone number _____

Carrier Information

Policyholder name (if different from above) _____

Enrollee subscriber number _____

Group policy number _____

Carrier or administrator's name _____

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Carrier or administrator's address _____

Carrier or administrator's phone number _____

Claim number assigned by carrier or administrator _____

Out-of-Network Hospital-Based Physician Information

Name _____

Address _____

City, State, ZIP Code _____

Phone number _____

Dates of service at issue _____

Hospital Information

Name of hospital where services were rendered _____

Address _____

City, State, ZIP Code _____

Brief Description of the Claim to be Mediated **(required)**

_____

_____

I certify that the claim(s) indicated above qualify for mandatory mediation pursuant to the requirements of Chapter 1467 of the Texas Insurance Code.

_____ _____

Enrollee / Claimant / Representative Signature Date

Eligibility for Mediation

You may request mediation if your claim meets the eligibility criteria:

- ☐ You have coverage through an insured preferred provider organization (PPO) plan or you have coverage through the Employees Retirement System of Texas (ERS). This program does not apply to self-funded ERISA plans, indemnity plans, Medicare, and Medicaid.
- ☐ Your claim is for a medical service or supply provided by an out-of-network hospital-based physician (such as a radiologist, an anesthesiologist, a pathologist, an emergency department physician, or a neonatologist). For services provided on or after September 1, 2015, mediation is also available for services provided by an assistant surgeon.
- ☐ You were provided a medical service or supply in a hospital that is a preferred provider under your preferred provider benefit plan

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- ☐ The amount you owe the hospital-based physician for services provided before September 1, 2015, (not including copayments, deductibles, coinsurance, and amounts paid by the insurer or administrator directly to you), is more than $1,000. For services provided on or after September 1, 2015, this threshold is reduced to $500.

Public Information

When submitting information to the Texas Department of Insurance (TDI), be aware that TDI is subject to the Texas Public Information Act. By law, much of the information you submit to TDI may be considered public record, but portions may be confidential. For example, your personal information might be protected by the doctrine of common law privacy, the Medical Practice Act, or the Texas Public Information Act. Sharing information for the purpose of this request does not waive these confidentiality protections.

Addtionally, under Chapter 552 of the Texas Government Code, you generally have a right to review or receive copies of information about yourself, including private information. You are also entitled to request that TDI correct information that TDI has about you that is incorrect. For more information about obtaining information from TDI or correcting information kept by TDI, please email us at AgencyCounsel@tdi.texas.gov or review TDI's correction procedures at this link: www.tdi.texas.gov/commish/legal/lccorprc.html.

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Authorization to Communicate and Disclose PHI via Email and/or Text Message

PATIENT INFORMATION	
NAME:	
DATE OF BIRTH:	

CONSENT AND AUTHORIZATION FOR DISCLOSURE OF PHI VIA EMAIL	
EMAIL ADDRESS:	

CONSENT AND AUTHORIZATION FOR DISCLOSURE OF PHI VIA TEXT MESSAGE	
TEXT NUMBER:	

Communication over the Internet or via text message pursuant to this Authorization will not be encrypted and is generally NOT considered a secure communication. There is no guarantee of privacy when sending information via email or text message. Yet, you may ask that we communicate with you via email or text message. To do so, you must complete this Authorization and return it to your physician. Your physician will not condition treatment, payment, enrollment, eligibility for benefits, or other healthcare operations based upon whether you choose to sign or not sign this Authorization.

NOTE:

a. Your physician will not share information that is specially protected by law. This includes HIV/AIDS, substance abuse and mental health information.

b. Your Authorization will not be effective until you receive and respond correctly to a test message to your email address and/or text number. Your physician or his/her office will send the test message to confirm the email address and/or text number. Please select the test question you want to use below and give the answer.

- ☐ My mother's maiden name: _____
- ☐ The name of my first pet: _____
- ☐ The name of my high school: _____

Please initial each blank and sign below:

_____ The email address on this Authorization is correct. I hereby authorize all disclosures of my protected health information ("PHI") as defined by HIPAA and state law via email sent to this email address.

_____ The text number on this Authorization is correct. I hereby authorize all disclosures of my protected health information ("PHI") as defined by HIPAA and state law via text message sent to this text number.

_____ I understand and acknowledge that communications over the Internet and via text message are not secure. There is **no** guarantee of privacy of information when shared this way.

_____ I fully understand and acknowledge the potential that any of my PHI disclosed over the Internet or via text message may be subject to redisclosure and is no longer protected by HIPAA once transmitted to the email address or text number on this Authorization.

_____ I agree to hold JASON R BAILEY MD PA and all individuals associated with it harmless from any and all claims and liabilities related to this Authorization.

Patient Signature Today's Date

EXPIRATION

Unless revoked below in writing, this Authorization will expire upon the later of the following events: (1) one (1) year after the date of my signature; or (2) the date on which I terminate care by JASON R BAILEY MD PA and its physicians and transfer my care to another physician or medical practice.

RIGHT TO REVOKE

I request that my physician no longer use the above email address and/or text number to communicate with me.
Patient Signature: Today's Date:

JASON R. BAILEY, MD
PLASTIC, RECONSTRUCTIVE + COSMETIC SURGERY

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Jason R. Bailey M.D., P.A. / Cosmeteik Med Spa

VIDEOTAPE AND PHOTOGRAPHS RELEASE AND AUTHORIZATION

I hereby irrevocably consent to and authorize the use and reproduction by Jason R. Bailey MD PA of any and all photographs, electronic images or video footage of me taken by Jason R Bailey MD PA, provided either by me or by a third party (collectively, Images) for the purpose of informing the medical profession and the general public about plastic surgery and plastic surgery procedures and techniques without compensation to me. Such use shall include, but not be limited to, distributing the Images via print, visual and electronic media, specifically including the Jason R Bailey MD PA/ Cosmeteik Med Spa website and social media sites such as YouTube, Facebook and Twitter. The Images (including any photographic negatives) shall be the sole property of Jason R Bailey MD PA. Jason R Bailey MD PA also shall have the right to use my name in connection therewith if it so chooses.

I hereby waive any right to inspect or approve the finished product, photograph, video, DVD, CD-ROM or matter that may be used in conjunction therewith or to the eventual use that it might be applied.

I hereby release, discharge and agree to hold harmless Jason R Bailey MD PA and their respective representatives, assigns, and employees, and any person acting under their permission or authority, from and against any claims whatsoever in connection with the use of my Images and name and the reproduction thereof as stated above, including any claim for payment in connection with distribution or publication of the video and/or photographs.

I hereby warrant that I am over twenty-one years of age, and competent to contract in my own name insofar as the above is concerned.

I have read and understand the foregoing release, authorization and agreement, before signing my name below, and enter into it knowingly and voluntarily.

Date:_____ Printed Name:_____

Signature:_____

I have read the above Release and Authorization. I am the parent, guardian, or conservatory of _____, a minor. I am authorized to sign this authorization on his/her behalf and I give this authorization in the interest of public education.

Date:_____ Printed Name: _____

Signature: _____

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JASON R. BAILEY, MD 12121 RICHMOND AVE., SUITE 104 HOUSTON,TX 77082 (281) 741-5910

INSURANCE AUTHORIZATION

TO: _____

POLICY NUMBER: _____

CLAIM NO.: _____

You are hereby authorized to release, talk, and provide any information to my physician group, **Jason R. Bailey, M.D., P.A., 12121 RICHMOND AVENUE, SUITE 104, HOUSTON, TEXAS, 77082**, and/or their employees, attorney, SETH ELLERIN,, agents and/or representatives, to discuss and obtain, medical bills, medical records, judgments, releases, any and all settlements, liens, amount of recovery from any source and documentation papers and writings, concerning my insurance and/or claim file with your office. This authorization specifically extends to and permits oral and written communications with me and my staff.

I HEREBY FURTHER AUTHORIZE THE USE OR DISCLOSURE OF MY HEALTH INFORMATION BY THE FOLLOWING INDIVIDUAL(S) OR ORGANIZATION(S) AS DESCRIBED BELOW

JASON R. BAILEY, MD

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Any and all of the following information are to be disclosed:

1. Medical Reports, records, charts, notes, and letters.
2. X-rays, films, MRIs, CT-scans and reports.
3. Patient's medical history, discharge summaries, laboratory results, and consultation reports.
4. Vocational, psychological, and psychiatric records and reports.
5. Personnel, attendance, employment, payroll, and wage records from employer(s) or school(s).
6. Insurance records, including all claims, itemized billing, correspondence, payments, and all documents within the file.

I understand that the information in my 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 or drug abuse. These records and information may be disclosed to and used by **Jason R. Bailey, M.D., P.A., 12121 RICHMOND AVENUE, SUITE 104, HOUSTON, TEXAS, 77082.** A copy or facsimile of this document shall be considered as effective and valid as the original.

I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the insurance company who is on the top of this authorization AND JASON R. BAILEY M.D, P.A.. Unless otherwise revoked, this authorization will not expire until the conclusion of my case.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand any disclosure of information carries with it potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. A photocopy of this authorization shall have the same force and effect as an original.

Name: _____

Date of Birth: _____ SS#: _____

Date: _____

_____
Signature

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To Attorney: _____

_____

_____

RE: PATIENT: _____

ATTORNEY AUTHORIZATION

I, _____, authorize **Jason R. Bailey, M.D., P.A., 12121 RICHMOND AVENUE, SUITE 104, HOUSTON, TEXAS, 77082**, and/or their employees, agents attorney, SETH ELLERIN, and/or agents and/or representatives, to discuss and obtain, any and all settlements, liens, amount of recovery from any source; and documentation, papers and writings, concerning my files with your office. This authorization specifically extends to and permits oral and written communications with our physicians and/or staff.

I HEREBY FURTHER AUTHORIZE THE USE OR DISCLOSURE OF THE MY HEALTH INFORMATION BY ENTITY BELOW:

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5. Personnel, attendance, employment, payroll, and wage records from employer(s) or school(s).
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Patient Name: _____

Date of Birth: _____ SS#: _____

Date: _____

_____
Signature of Patient