PLEASE PRINT!!

FORM MUST BE COMPLETED FULLY. DO NOT LEAVE ANY SPACE BLANK.

DATE_____ HOME PHONE_____ AGE_____

E-MAIL _____ CELL PHONE_____

NAME _____ BIRTHDATE_____ SEX: M / F
FIRST MIDDLE LAST

ADDRESS _____ CITY_____ ZIP_____

OCCUPATION_____ SS #_____

EMPLOYED BY_____ WORK PHONE _____

REFERRED BY DOCTOR_____ PATIENTS STATUS ☐Single ☐ Married ☐Divc.

PARENTS / SPOUSE NAME_____ HOME PHONE _____

STUDENT PERMANENT ADDRESS_____ HOME PHONE _____

EMPLOYED BY_____ WORK PHONE _____

Have you ever been seen by Dr. Warthan under a different name/maiden name? Please list: _____

Family member who has received care at this clinic? _____

Have you seen Dr. Warthan before? YES / NO

DO YOU HAVE MEDICARE? YES / NO MEDICARE NUMBER_____

IF YOU HAVE INSURANCE PLEASE COMPLETE

GUARANTOR NAME: _____ D.O.B. _____

ADDRESS_____

NAME OF INSURANCE _____ ADDRESS_____

I.D. NUMBER SS#_____ GROUP #_____

MEDICINE ALLERGIES _____

CURRENT MEDICINE_____

PERSON TO CALL IF UNABLE TO REACH YOU

Name _____ Relationship to You _____

Street Address _____ Phone #_____

City / State _____ Zip _____

AUTHORIZATION FOR RELEASE OF INFORMATION
ASSIGNMENT OF INSURANCE BENEFITS AND PROMISE OF PAYMENT

ALL FEES AND CHARGES ARE TO BE PAID AT THE TIME OF SERVICE. I CERTIFY THAT THE INFORMATION IS TRUE AND I PROMISE TO PAY ALL FEES AND BILLS INCURRED FOR THE MEDICAL AND PROFESSIONAL SERVICES OF T. LYNN WARTHAN, M.D. I ALSO AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS ANY CLAIM AND I AUTHORIZE PAYMENT OF MEDICAL BENEFITS FILED TO MY INSURANCE COMPANY TO BE PAID TO THE PHYSICIAN.

SIGNED _____ DATE _____

WE ARE NOT A MEDICAID PROVIDER.
WE DO NOT SEE WORKER'S COMPENSATION PATIENTS OR ON-THE-JOB INJURIES.
WE DO NOT PARTICIPATE IN ANY MEDICARE ADVANTAGE PLANS.
PLEASE INFORM THE RECEPTIONIST IF YOU ARE ONE OF THESE.

T. LYNN WARTHAN, M.D.

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, T. Lynn Warthan, M.D. may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to T. Lynn Warthan, M.D.'s Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. T. Lynn Warthan, M.D. reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices maybe obtained by forwarding a written request to T. Lynn Warthan, M.D., Privacy Officer, at 4730 N.E. Stallings Drive, Nacogdoches, TX 75965.

With my consent, T. Lynn Warthan, M.D. may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, T. Lynn Warthan, M.D. may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With my consent, T. Lynn Warthan, M.D. may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that T. Lynn Warthan, M.D. restrict how it uses or discloses my PHI to carry out TPO.

However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to T. Lynn Warthan, M.D.'s use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, T. Lynn Warthan. M.D. may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

_____ _____
Patient's Name Date

_____
Print Name of Patient or Legal Guardian

Exhibit 5

INSURANCE INFORMATION

If you have insurance with a company we are signed up with, you may have to pay **ONLY** your **CO-PAY** for **YOUR OFFICE VISIT ONLY**. Please be aware that your **CO-PAY** applies **ONLY** to your **OFFICE VISIT**. If you have surgery or freezing done, or any other procedure, these **ARE NOT** considered part of an office visit or co-pay.

If you have not met your deductible, you will usually be responsible for paying the rest of the office visit, in addition to the co-pay. If you are unsure about your deductible, your co-pay, or the percentage you may be responsible for, you should contact your insurance company. You need to be aware of the amount of your deductible, whether or not you have met your deductible, and what percentage you are responsible for.

Also, you need to be aware that our contract with your insurance company requires that they pay your claim within a reasonable period of time, which is usually 30 days after we file your claim. If they do not pay in a timely manner, **YOU WILL BECOME RESPONSIBLE FOR PAYMENT OF YOUR BILL IN FULL**. For this reason, it is important for you to check with your insurance company periodically to be sure that have paid your claim. We know from experience that many insurance companies delay paying claims for many months.

I have read and understand the above information.

_____ _____

(Patient's Signature) (Date)