John D. Bray, MD

606 B North Kent Street * Midland, Texas 79701* 432-561-8183

Consent to examination, treatment and statement of financial policy & responsibility.

By my signature below I attest that I am capable of reading and comprehending this form without assistance and have signed the form of my own free will. I agree that I have been made aware of the availability of assistance and/or interpreter to help me in completing this form and declined any aid. By my signature below I hereby authorize John D. Bray MD of Allergy Alliance and Sleep Center of the Southwest, with the assistance of other health care providers and assistants selected by them, to provide medical care and treatment to me. I further agree to undergo any examinations, x-rays, blood tests and/or any other diagnostic modalities that Dr. Bray may determine to be important and/or relevant to my care. By my signature below I authorize Dr. Bray to treat or correct any unexpected conditions or problem found during the examination, diagnostic procedure and/or care, treatment, therapy or remedy listed above. I agree to ask for clarification if needed. By my signature below I understand that there are certain risks inherent to the diagnosis and treatment of any disease, physical trauma or condition. I agree that Dr. Bray will explain other relevant and available alternatives, including associated risks to the examination, diagnostic procedure and/or treatment proposed. I agree that I will be provided with the opportunity to discuss relevant and available alternatives. I agree to ask for clarification if needed. I further agree that Dr. Bray will explain the risks of not having the examination/diagnostic procedure/treatment proposed. I agree to ask for clarification if needed. By my signature below I agree that I am submitting to the examination, diagnostic procedure and /or treatment of my own free will. I further agree that I can ask questions and raise concerns with Dr. Bray about my condition, the risks inherent to the examination, diagnostic procedure and /or treatment and any treatment options. I agree that my questions and concerns will be discussed and answered to my satisfaction. I further attest that I understand that I may ask questions concerning my examination or treatment and that I may stop treatment at any time for clarifications of treatment options. By my signature below I attest that I have stated or noted my past medical history to the best of my ability, and further attest that I have not taken any disclosed medications or drugs prior to the exam/or treatment. By my signature below I agree that, as part of the examination, diagnostic procedure and/or care, treatment, therapy or remedy provided, the doctor may obtain certain protected health information, including past medical history. I understand that this will include a review, if necessary, of past, current or future health records, including records of procedures such as physical exam, x-rays, blood or urine tests. I understand that further information will be gleaned, as necessary, from direct and telephonic conversations with the doctor and/or his health care staff, or from my responses to any questionnaire submitted prior to the initiation of the proposed examination, diagnostic procedure and/or care, treatment, therapy or remedy. I understand that the information sought may include, but is not necessarily limited to the following:

- Documentation of past medical history
- Records of physical exams and procedures
- Laboratory, x-ray, MRI and other test results
- Records of medication or drug usage
- Records of implanted or external medical devices
- Information related to diagnosis and treatment of a mental health condition
- Information about HIV/AIDS
- Information about hepatitis infection
- Information about sexually transmitted diseases
- Information about infectious diseases that must be reported to Public Health authorities

I understand and agree to pay all deductibles, co-payments and fees due, less insurance payments. As a courtesy to you, we will submit your claim to your insurance company. Any portion not covered by your insurance company, such as you coinsurance or deductible amount is due and payable at the time of service. Additionally, some insurance companies do not cover all procedures necessary in the treatment you may need or be required to have in order to provide you with the best possible healthcare. You are responsible for these non- covered services. We practice preventative healthcare and want to keep you at your best thought at times this may require procedures NOT covered by insurance. **You may opt to not receive the procedures not covered by insurance, but you MUST let Dr. Bray know BEFORE the procedure is done and at the risk of being asked to find another doctor as this could alter the care that you receive as we strive to provide you with the most thorough, meticulous medical care possible.** I may stop treatment at any time for clarification of treatment option and amount of procedures not covered by insurance. You, the patient, are responsible for understanding your insurance and what is required of you, the patient, for processing of claims. Dr. Bray and his staff will not mediate between divorced parents and we expect both parties to handle whatever personal issue that may arise in the best interest of the patient. Failure to make payment in full or failure to make arrangements for payment may result in your account being placed with a collection agency or being pursued by small claims court. Should it become necessary to send your account to the collection agency, collections costs may include, but are not limited to, collection agency fees, court costs, attorney fees, interest on unpaid balances and any other fees or costs associated with the collection of an unpaid balance. A$35.00 returned check fee will be added to your account for all returned checks.

Print Patient Name_____ Date of First Visit_____

Signature of Patient or Legal Guardian _____ Witness _____