909 N. Jackson Rd McAllen TX 78501 Date: ___________________

ASSIGNMENT OF BENEFITS

I certify that I or my dependent(s) have coverage and assign directly to Laser Surgical Solutions RGV PLLC (LSSRGV PLLC) all insurance benefits, if any, otherwise payable to me for the services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctors(s) of LSSRGV PLLC to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all submissions.

Insurance Coverage Company: _______________________________

Responsible Party:______________________

Relationship:___________________________

909 N. Jackson Rd McAllen TX 78501 Date: ___________________

NOTICE OF PRIVACY ACKNOWLEDGEMENT

LSSRGV PLLC keeps on file a medical and billing record of all health care services that are provided to you by the LSSRGV PLLC office. This my include, but not limited to , physicians notes, lab, radiology reports, consult notes, and other healthcare information that helps provide you with quality healthcare.

Patient Rights to Medical Records

It is your right to ask to obtain a copy free or charge for the first request. You may also ask for the record to be corrected if you see a discrepancy. The offices of LSSRGV PLLC will not disclose this information without your authorization. We may use and disclose, without you consent, authorization, or opportunity to object your protected health information to the extent whether the law requires us to do so. Should you desire copies of your medical record or other health information please contact our office. Request for medical records may be made in person at 909 N Jackson Rd McAllen TX 78501.

Patient Signature: __________________________

Legal Authorized Individual:____________________Relationship:____________

Printed Name:_____________________________

909 N. Jackson Rd McAllen TX 78501 Date: ___________________

AUTHORIZATION FOR RELEASE OF INFORMATION

PATIENT NAME: ______________________ DOB________________

ADDRESS:____PHONE #_______________

The following individual or organization is authorized to abide by the disclosure:

____

Information is being disclosed and used by the providers at Laser Surgical Solutions RGV PLLC (LSSRGV PLLC) .

This includes consent for LSSRGV PLLC to obtain my Rx history. I understand the information in my record may include sensitive information relating to sexually transmitted diseases, Acquired Immunodeficiency Syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about mental health services or treatment for alcohol/drug abuse.

RIGHT TO REVOKE- I understand I must submit a written request or LSSRGV PLLC. I understand the revocation will not apply to information already released based on a prior authorization.

PATIENTS RIGHTS- I can refuse to sign this authorization. I do not need to sign this form to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed. If I have any questions I may contact the Compliance Officer at 956-992-9161 or email admin@lssrgv.com

Signature of Patient:_______________________

Legal Representative:______________________

909 N. Jackson Rd McAllen TX 78501 Date: ___________________

PHOTO CONSENT FORM

PATIENTS NAME:___________________________

I consent for medical photographs to be taken of me by Laser Surgical Solutions RGV PLLC and all providers/staff employed. I understand that the information may be used in my medical record, for purposes of medial teaching, or for publication in medical textbooks or journals. By consenting tho these medical photographs I understand that I will not receive payment from any party. Although these photographs will be used without identifying information such as my name, I understand that it is possible that someone may recognize me.

PATIENTS RIGHTS- Refusal to consent to photographs will in no way affect the medical care I will receive. If I wish to withdraw my consent in the future I may do so with a written request in person at the office or email to admin@lssrgv.com

I authorize the use of thes images: (Please Initial indicating YES or NO below)

____Yes _____NO Office Photo Album

____Yes _____NO On our Website

____Yes _____NO In print advertisements and/or professional journals

By signing this form below I confirm that this consent form has been explained to me in terms which I understand.

Patient Signature:____________________

Witness Signature:___________________