

**731 E. SOUTHLAKE BLVD., SUITE 110
SOUTHLAKE, TEXAS 76092
817-898-7277
FAX 817-527-5119**

Your copayment is due at the time of your visit. Your insurance company requires us to collect the copay each time you see the doctor. If you have questions regarding your copay amount, please contact your insurance company.

You can pay your copay by check, credit card, cash today, or we can reschedule your visit.

If you have any questions regarding our copayment policy, please contact the office manager at the number listed above.

Thank you.

Eric I. Ray, M.D.

Print Name: _____ Date: _____

Patient Signature: _____

Acknowledgment Form

I acknowledge receipt of this Notice of Privacy Rights which I have reviewed and give my permission to Dr. Eric Ray MD to use and disclose my health information in accordance with it.

Name of Patient

Signature of Patient

Date

Signature of Parent or Guardian

I give permission to SOUTHLAKE PAIN CENTER / Dr Eric Ray MD to release medical information to the following person(s):
(Please print names below).

Name: _____ Phone #: _____

Name: _____ Phone #: _____

Name: _____ Phone #: _____

This authorization is given freely with the understanding that:

- I may revoke this authorization in writing at any time, but not retroactively.
- The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the information I have authorized.
- This Authorization will expire in two (2) years from the above date unless written revocation is received.