VITAL

HEART & VEIN

COMPLIANCE & DISCLOSURE UNDER TEXAS OCCUPATIONS CODE – SECTION 102.006

In compliance with Section 102.006 of Texas Occupations Code in connection with my informed consent and personal choice of doctors and facility solely based on the quality and safety of care, reputation of patient satisfaction, and my knowledge in my decision-making in exercising my rights with respect to the in-network or out-of-network coverage and cost sharing, my attending doctor(s) and/or clinic (facility) have disclosed to me at the time of initial contact and at the time of referral with respect to the choice of a doctor or facility solely in the interest of my healthcare quality and safety, as a result of my informed consent and personal choice of doctor(s) and/or facility; (A) his/her affiliation, if any, with the doctor or facility for whom the patient is referred and (B) that he/she will receive, directly or indirectly, remuneration for referring upon my such request and exercising my rights of freedom of choice for the provider(s) and facility under the in-network or out-of-network coverage as provided by my health plan, in compliance with all applicable federal and state laws, Medicare, ERISA, PPACA, and Section 102.006 of Texas Occupations Code.

Doctor or Facility with affiliation and remuneration:

Memorial Hermann Hospital - TMC

Memorial Hermann Hospital - Northeast

Memorial Hermann Hospital - Pearland

Kingwood Medical Center

Vital Heart & Vein ASC

Humble Dreams Sleep Center

Vital Heart & Vein Cath Lab

Genetix LDL Testing

I certify that I was informed of the effective alternative resources reasonably available at the time of my decision-making and my option to use one of the alternative resources, and that I was assured by my attending physician that I will not be treated differently by the physician and his/her staff if I choose an alternative provider or entity.

I certify that my attending physician(s) has made referrals to participating providers or the other non-participating providers or entities based only on the needs of my individual healthcare, the medical community standard of care and my informed choice for quality and safety of the care that I will be expecting and receiving, and for a provider's professional reputation and patient satisfaction in order to provide me with the quality and affordable healthcare that I personally expected under my health plan for out-of-network or in-network coverage.

I have read and fully understand this Disclosure and Authorization Form. I hereby authorize this referral to non-participating and out-of-network provider(s) or entities as named above.

Patient Name (Print): _____

Signature of Patient _____ Date _____