Disclosure and Authorization Form for Patient Referral to Other Non-participating Physicians or Facilities Advocacy for Patient Freedom of Choice for Provider

Patient Name:
Diagnosis:
Treatment:
Patient Plan In-Network

Physician Name:
*Physicians: Erwin Lo, Sujin Yu, Arshad Khan, Hassan Chahadeh

In order to better serve you with the highest quality care and safety at the most affordable costs, sometimes it is necessary and important to have other additional providers/entities to join our team to complete or continue your medical procedures or treatment in order to ensure speedy recovery for you. We would like to keep you informed of your choice and our recommendation of these other providers/entities and obtain your informed consent before our referral and scheduling for your next procedure. While no provider/entity could be participating in every managed care network, such as the one your health plan has contracted with, these other providers/entities may or may not be in your health plan network. This disclosure and authorization form is used to inform you of our verification that the above name providers/entities are or may be non-participating providers/entities with your health plan.

We have verified your insurance coverage for non-participating providers/entities and the recommended treatment/procedures and obtained pre-certification if applicable for all services as a courtesy to you. Please understand that the insurance verification is not a guarantee of insurance payment according to your health plan. If you have any questions concerning whether you have out of network benefits or your financial obligations under your benefit plan if you use an out of network provider/entities, please call the member services number on your insurance card.

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 and patient satisfaction, and my knowledge in decision-making in exercising my rights with respect to the in-network or out-of-network coverage and cost sharing, my attending doctor/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 providers/entities/facility: (A) affiliation, if any, with the doctor or facility for whom the patient the patient is referred and (B) that he/she will receive directly or indirectly remuneration for referring upon my such request and exercising my right of freedom of choice for the providers and facility under the in-network or out-of-network coverage as provided by my health plan, as protected by all applicable federal and state laws, including Medicare, ERISA, PPACA.

Doctor or Facility with affiliation and remuneration: Erwin Lo, MD, SUJIN YU, MD, Arshad Khan DPM, David Singleton, MD, Baominh Yinh, MD, Hassan Chahadeh, MD, Craig Charleston, Mark Larson, David Singleton MD, Karan Madan, MD, Scott Lin, MD, Pin Oak Medical Center, Katy Pain & Spine, Trinity Pearland Medical Center, Country Palace Medical Centre, Interventional Pain Center, Brain and Spine Center, Woodlands Way Medical Center, 145 Medical Center, League Line Medical Center North Mesa Medical Center, Southwest Texas Medical Center Victory Campus, Steeplechase Medical Center, Northwest Houston Medical Center, Dowlen Center for Pain, Metropolitan Park Medical Center, Victory Medical Center Houston, SpineTECH Surgery Center, True Island Medical Center. Any other physicians contracted by or affiliated with these providers/entities. Any other Physician Owned Entity that may have been referred to by these providers/entities.

*I certify that the advocacy for patient freedom of Choice for providers with the above specific disclosure from my providers is in full compliance with the section 102.006 of Texas Occupations Code, in a manner otherwise permitted under section 102.001, in accepting remuneration to advocate, protect, secure. or solicit a patient or patronage for a person licensed, certified, or registered by a state health care regulatory agency.

*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 staff if I choose an alternative provider or entity

*I certify that my attending physician has made referrals to 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 the provider's professional reputation and patient satisfaction in order to provide me with quality and affordable healthcare that I personally expected under my health plan due to out-of-network coverage.

*I have read and fully understand the disclosure and authorization form. I hereby authorize this referral to non-participating and out-of-network providers/entities as named above.

Patient Signature Patient Name Date