GENERAL CONSENT

(Initial each statement and sign below)

— I hereby authorize **Thomas C. Vinson, M.D. (DBA) Round Rock Cardiology** to release to the insurance company named on this form any information acquired in the course of my examination or treatment (if patient is a minor, parent or guardian must sign).

— I hereby agree to full responsibility for all expenses incurred by or on account of the patient and hereby assign **Thomas C. Vinson, M.D. (DBA) Round Rock Cardiology** any and all insurance benefits due me to the full extent of my financial obligation to said institute. I authorize my insurance benefits to be paid directly to the doctor.

— I understand that direct billing of insurance companies is done as a courtesy by Dr. Thomas Vinson's practice and that I am financially responsible for the full amount of charges that are not covered by insurance benefits.

— I understand that it is the patient's responsibility to verify that Dr. Thomas Vinson, Tax ID #743001682 is In Network for my current insurance plan.

— I understand that it is the patient's responsibility to obtain a Referral Number/Letter from their Primary Care Physician for a Specialist Visit to see Dr. Thomas Vinson, Cardiologist, if required by their insurance plan.

— I understand that a rebilling fee/financial charge complying with Texas State Law may be applied to any overdue balance. In the event of non-payment, I will bear the cost of collection and/or court costs and reasonable legal fees should that be required.

— My signature below gives my authorization for Dr. Thomas Vinson and his staff to provide me with reasonable and proper medical care by current laws and standards.

— My signature below authorizes Dr. Thomas Vinson's office to leave detailed messages on the phone number provided by me.

— I hereby authorize Dr. Thomas Vinson's office to share my Medical Records with other healthcare practitioners and entities whose care I am under.

X _____ _____

PATIENT SIGNATURE (PARENT/LEGAL GUARDIAN, IF MINOR) DATE

X _____

PATIENT NAME PRINTED

_____ _____

WITNESS (ROUND ROCK CARDIOLOGY STAFF) DATE

Round Rock Cardiology, Dr. Thomas Vinson, M.D.
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(512) 244-9944 (P) / (512) 244-9977 (F)