How did you learn about our practice? (circle all statements that apply)

- My doctor _____ referred me.
- My friend _____ told me about you.
- Your office is convenient.
- I noticed your name in the yellow pages.
- The hospital referral service recommended you.
- You are on my insurance plan.
- I saw your web site www.drcheco.com
- The Frisco Chamber of Commerce had you listed.
- I received your Welcome to Frisco letter.
- I read your column in Matt Lafata's Newsletter.
- Other:

E-mail address: _____May we send information there? Yes No

Emergency contact not living in household: _____

Name: _____ Home phone: _____

Relationship: Work / cell phone:

Our office will file insurance for all reimbursable services to both your primary and secondary insurance carriers. Please remember that you are responsible for all deductibles, copays, and non-covered service amounts. We ask that you make any required payments at the time of check in. You may review our payment policy or ask our staff if you have any questions.

PCP co-pay amount listed on your insurance card: _____

Method of payment for today's visit: ____cash ____check ____credit card

Consent for Release of Health Information

I hereby permit Preston Medical Associates, P.A. to release and furnish all medical and financial data related to my care that may be necessary now or in the future for purposes of treatment, payment or healthcare operations to assist with, aid in, or facilitate the collection of data for purposes of utilization review, quality assurance, or medical outcomes evaluation purposes. Such information may be released to insurance companies, HMO's and PPO's, managed care organizations, IPA's, Medicare, or other governmental or other third party payers, or any organizations contracting with any of the above entities to perform such functions.

Signed: _____ Date: _____
Patient or responsible party

Acknowledgement of Review of Privacy Policy

I have reviewed this office's Notice of Privacy Practices that explains how my health information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Signed: _____ Date: _____
Patient or responsible party

I authorize the payment of my medical and surgical insurance benefits to Preston Medical Associates, P.A.

Signed: _____ Date: _____
Patient or responsible party