

PO Box 660599
 Dallas, TX 75266-0599

 022313:000347-0000348
ABNER, CLARENCE FRANKLIN
 6827 LATTA PKWY
 DALLAS, TX 75227-6043

PAYMENT BY CHECK

AMOUNT ENCLOSED:

PAYMENT BY CREDIT CARD


CARD NO.	EXP. DATE
PRINT NAME	AMT \$
SIGNATURE	

PLEASE MAKE YOUR CHECK PAYABLE TO:

 Parkland
 P.O. Box 660599
 Dallas, TX 75266-0599

Guarantor Name: ABNER, CLARENCE FRANKLIN
Guarantor Account: 100689594 **Balance:** \$10.00

Please Detach and return the top portion with payment

Guarantor: ABNER, CLARENCE FRANKLIN
Guarantor Account: 100689594
Statement Date: 02/23/13

Patient: ABNER, CLARENCE FRANKLIN
Patient Account: 611993836 **Date:** 02/14/13 **Visit Type:** Outpatient

Charges	Payments/Adjustments	Balance
\$493.00	\$-483.00	\$10.00
Balance Now Due:		\$10.00

 214-590-4900
 Questions?
 Telephone Payments
 Monday - Friday 8am - 5pm

Parkland




February 26, 2013

Dear Clarence Abner,

To access the information you will need Adobe Reader (<http://get.adobe.com/reader/>), the patient's name and date of birth. When prompted, you will enter the password. The password is the patient's last name followed by the two digits for the month of birth and the two digits for day of birth (LastNameMMDD).

For example:

Patient's Name Jane **Smith**
Patient's Date of Birth **08/30/1960**

Password = **smith0830**

If you have any questions please contact Health Information Management Release of Information Department at 214.590.5470 or my direct line listed below.

The information contained on the electronic media is Protected Health Information and must be kept in a secured manner. The information contained in the media is intended only for the use of the individual or entity to which it is addressed, and contains information that is CONFIDENTIAL and protected by law. This information should not be redisclosed without the written consent of the patient. If you are not the intended recipient, you are prohibited from copying, distributing, or using the information. Please contact the sender immediately.

Sincerely,

Michelle Banks

Clinical Documentation Specialist I
214-590-5255



PO Box 660599
Dallas, TX 75266-0599



032813:000686-0000690
ABNER, CLARENCE FRANKLIN
6827 LATTA PKWY
DALLAS, TX 75227-6043

PAYMENT BY CHECK
AMOUNT ENCLOSED:

PAYMENT BY CREDIT CARD



CARD NO. _____
PRINT NAME _____ EXP. DATE _____
SIGNATURE _____ AMT \$ _____

PLEASE MAKE YOUR CHECK PAYABLE TO:

Parkland
P.O. Box 660599
Dallas, TX 75266-0599



Guarantor Name: ABNER, CLARENCE FRANKLIN
Guarantor Account: 100689594 **Balance:** \$20.00

Please Detach and return the top portion with payment

Guarantor: ABNER, CLARENCE FRANKLIN
Guarantor Account: 100689594
Statement Date: 03/28/13

Patient: ABNER, CLARENCE FRANKLIN
Patient Account: 612053529 **Date:** 02/26/13 **Visit Type:** Outpatient

Charges	Payments/Adjustments	Balance
\$536.55	\$-526.55	\$10.00

Patient: ABNER, CLARENCE FRANKLIN
Patient Account: 611993836 **Date:** 02/14/13 **Visit Type:** Outpatient

Charges	Payments/Adjustments	Balance
\$493.00	\$-483.00	\$10.00

Past Due

Balance Now Due: \$20.00

214-590-4900
Questions?
Telephone Payments
Monday - Friday 8am - 5pm



Parkland



PO Box 660599
Dallas, TX 75266-0599

042813:000567-0000569

ABNER, CLARENCE FRANKLIN
6827 LATTA PKWY
DALLAS, TX 75227-6043**Guarantor Name:** ABNER, CLARENCE FRANKLIN
Guarantor Account: 100689594 **Balance:** \$10.00

Please Detach and return the top portion with payment

Guarantor: ABNER, CLARENCE FRANKLIN
Guarantor Account: 100689594
Statement Date: 04/28/13**Patient:** ABNER, CLARENCE FRANKLIN
Patient Account: 612053529 **Date:** 02/26/13 **Visit Type:** Outpatient

Charges	Payments/Adjustments	Balance	
\$536.55	\$-526.55	\$10.00	Past Due
Balance Now Due:		\$10.00	

PAYMENT BY CHECK

AMOUNT ENCLOSED:

PAYMENT BY CREDIT CARD

CARD NO.

PRINT NAME

EXP. DATE

SIGNATURE

AMT \$

PLEASE MAKE YOUR CHECK PAYABLE TO:

Parkland
P.O. Box 660599
Dallas, TX 75266-0599

214-590-4900

Questions?

Telephone Payments

Monday - Friday 8am - 5pm

**Parkland**



Parkland

Credit Card Receipt(Customer Copy)

Parkland Health & Hospital System
(214) 590-4900

DATE/TIME: 07/03/2013 13:10

MASTER CARD SALE *****2622 S

AMOUNT: \$5.00

AUTH CODE & RECEIPT ID: 031050

REFERENCE NBR: 2013184209-8

"Dedicated to the health and well-being of individuals and communities entrusted to our care"

Abner, Clarence * - 4258376 DOB: 07/10/1962 Age: 50 yrs
6827 Latta Parkway Sex: Male
Dallas Texas 75227 Reg Sts: Pending (02/07/2013)
Home: 214-799-1296 Work: 214-275-4195 HCL: SS#: 463-43-2659

Account Name Account# Sts Use Payor-Plan Pat Balance

Date	Time	Lng	Dept	Prv/Rsc	Visit Type	Notes
02/21/13 Thu	3:00P	60	PT	ARAMATH, BINU	INIT EVAL	OSAYANDE, AMIMI SANDRA
02/25/13 Mon	8:30A	S30	PT	ARAMATH, BINU	F/U	OSAYANDE, AMIMI SANDRA
02/26/13 Tue	7:45A	25	FMED	NEWTON, HALEY*	F/U	spot on face
02/27/13 Wed	10:00A	S30	PT	ARAMATH, BINU	F/U	OSAYANDE, AMIMI SANDRA
03/04/13 Mon	9:30A	S30	PT	ARAMATH, BINU	F/U	OSAYANDE, AMIMI SANDRA
03/06/13 Wed	10:00A	S30	PT	ARAMATH, BINU	F/U	OSAYANDE, AMIMI SANDRA

214-590-8139

From accident on Jan 25-2013

Physical Therapy

Exercise 2: Neck extension in sitting

Extension means bending backwards. This exercise should always follow Exercise 1.

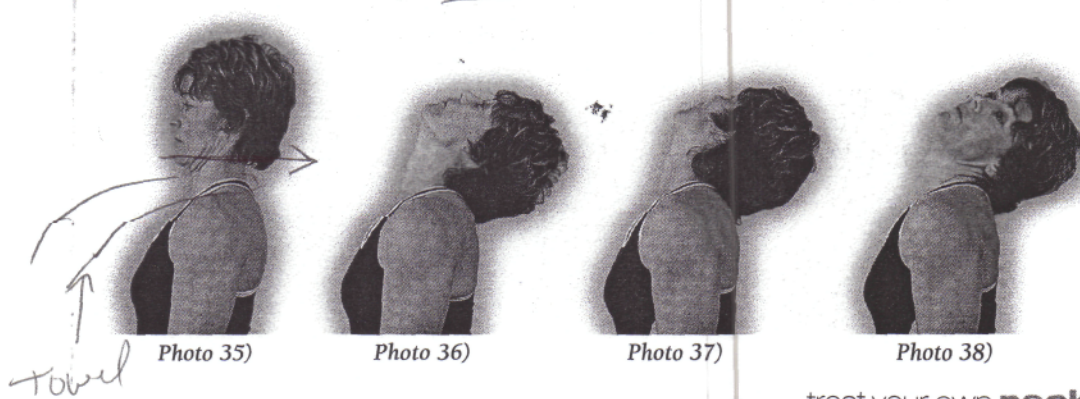
- Remain seated, repeat Exercise 1 a few times, and then hold your head in the retracted position (Photo 35). Now you are ready to start Exercise 2.
- Lift your chin up and tilt your head backwards as in looking up at the sky (Photo 36). Do not allow your neck to move forwards as you do this.
- With your head tilted back as far as possible, you must rotate your head from side to side so that your nose moves just half an inch (about 2 cm) to the right and then to the left of the midline (Photos 37 and 38), all the time attempting to move head and neck even further backwards. This movement should be repeated quite rhythmically and not too slowly.
- Once you have done this for a few seconds, you should return your head to the starting position. Again, each time you repeat this movement cycle you must make sure that neck extension is performed to the maximum possible degree.

This exercise can be used both in the treatment and in the prevention of neck pain.

Exercise 2 is to be performed ten times per session and the sessions should be spread evenly six to eight times per day until you go to bed. If your pain is too severe to tolerate Exercise 2, you should replace it with Exercise 3: Head retraction in lying.

Once you are fully practiced in Exercises 1 and 2 separately, you can combine these two exercises successfully into one exercise.

USE TOWEL



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atching
g, place a

lumbar roll in the small of your back, about the level of your beltline, whenever you sit in an easy chair, car or office chair (Photos 17-22).

The Original McKenzie® range of lumbar rolls are available from OPTP as seen on the back cover of this book. Royalties from the sale of the Original McKenzie® spinal supports have been, and continue to be, donated for research into improved methods of treatment for musculoskeletal disorders and to provide relevant education for health care professionals.

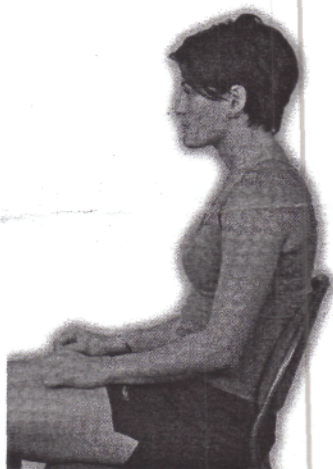


Photo 13) Poor neck posture: the result of insufficient low back support



Photo 14) Good neck posture made possible with low back support



Photo 15) The Original McKenzie® SuperRoll™



Photo 16) The Original McKenzie® Lumbar Roll

Exercise 1: Head retraction in sitting

Head retraction means pulling the head backwards.

- Sit on a chair or stool, look straight ahead and allow yourself to relax completely. Your head will protrude a little as you do this (Photo 32). Now you are ready to start the first and most important exercise.
- Move your head slowly but steadily backwards until it is pulled back as far as you can manage (Photo 33). It is important to keep your chin tucked down and in as you do this. In other words, you must remain looking straight ahead and should not tilt the head backwards as in looking up. When your head is pulled back as far as possible, you have assumed the retracted head posture (Photo 33).
- Once you have maintained this position for a few seconds, you should relax and automatically your head and neck will protrude again (Photo 32).
- Each time you repeat this movement cycle you must make sure that the backward movement of head and neck is performed to the maximum possible degree.
- The exercise can be made more effective by adding overpressure. This is done by placing both hands on the chin and firmly pushing the head back even further (Photo 34).

This exercise is used mainly in the treatment of neck pain.

When used in the *treatment* of neck pain, the exercise should be repeated ten times per session and the sessions should be spread evenly six to eight times throughout the day until you go to bed at night. This means that you should repeat the sessions about every two hours. When used in the *prevention* of neck pain, the exercise should be repeated five or six times as often as required.

Should you experience severe pain on attempting this exercise, you must replace it with *Exercise 3: Head retraction in lying*.

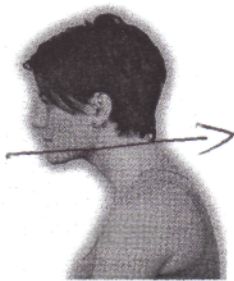


Photo 32)



Photo 33)

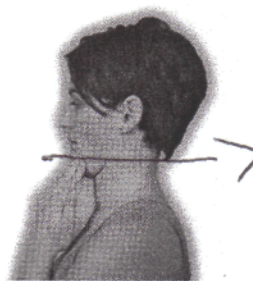


Photo 34)



Photo 35)

Ph

5x

5x

Every Hour

Exercise

Extension
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This exercise c
of neck pain.

Exercise 2 is to
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If your pain is t
with Exercise 3:

Once you are fu
combine these t

3-6-13

This exercise can be used in the treatment as well as the prevention of neck pain.

When used in the treatment of pain or stiffness of the neck, the exercise is to be performed ten times per session and the sessions are to be spread evenly six to eight times throughout the day. Whether centralization or reduction of the pain has taken place or not, Exercise 6 must always be followed by Exercises 1 and 2. When used in the prevention of neck problems, the exercise should be repeated five or six times every once in a while or as often as required (for example, when stiffness is first felt).

Note that in the majority of cases, stiffness on rotation is caused by a blockage at the back of the joint that must be dealt with by performing Exercises 1 and 2. Only do Exercise 6 if your neck pain or headache is not helped by Exercises 1 and 2.



Photo 50)



Photo 51)



Photo 52)

3-6-13

Exercise 5: Sidebending of the neck

- Sit on a chair, repeat Exercise 1 a few times, and then hold your head in the retracted position (Photo 45). Now you are ready to start Exercise 5.
- Bend your neck sideways and move your head towards the side on which you feel most of the pain (Photo 46). Do not allow the head to turn so that your nose moves towards your shoulder; in other words, you should keep looking straight ahead and bring your ear towards your shoulder. It is important that you keep the head well retracted as you do this.
- The exercise can be made more effective by placing the hand of your most painful side over the top of your head and gently but firmly pulling your head even further towards the painful side (Photo 47)
- Once you have maintained this position for a few seconds, you should return the head to the starting position.

This exercise is used specifically for the treatment of pain felt only to one side of the neck that does not improve with Exercises 1 and 2, or for the treatment of pain felt much more to the one side than to the other.

Until the symptoms have centralized, Exercise 5 is to be repeated ten times per session and the sessions are to be spread evenly six to eight times throughout the day.



Photo 45)

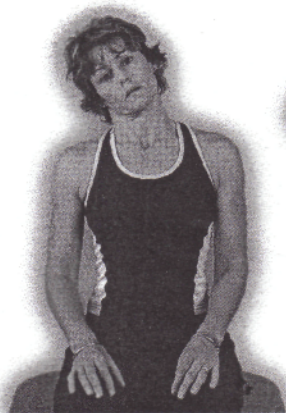


Photo 46)



Photo 47)

Clarence Abner
Med. Parkland.

Hite

PARKLAND HEALTH HOSPITAL BUS
5201 HARRY HINES 1ST FL
DALLAS, TX 752357708
PHONE #(214) 590-8566

Merchant ID: 008109521300

Ref #: 0072

Sale

XXXXXXXXXXXX2622
MASTERCARD

Entry Method: Swiped

Total: \$ 6.00

02/21/13 15:56:21

Inv #: 000072 Appr Code: 055619

Apprvd: Online Batch#: 000007

Customer Copy

THANK YOU
HAVE A NICE DAY!

PARKLAND HEALTH HOSPITAL BUS
5201 HARRY HINES 1ST FL
DALLAS, TX 752357708
PHONE #(214) 590-8566

Merchant ID: 008109521300

Ref #: 0045

Sale

XXXXXXXXXXXX2622
MASTERCARD

Entry Method: Swiped

Total: \$ 6.00

02/27/13 10:37:16

Inv #: 000045 Appr Code: 003713

Apprvd: Online Batch#: 000013

Customer Copy

THANK YOU
HAVE A NICE DAY!

PARKLAND HEALTH HOSPITAL BUS
5201 HARRY HINES 1ST FL
DALLAS, TX 752357708
PHONE #(214) 590-8566

Merchant ID: 008109521300

Ref #: 0017

Sale

XXXXXXXXXXXX2622
MASTERCARD

Entry Method: Swiped

Total: \$ 6.00

02/25/13 09:15:07

Inv #: 000017 Appr Code: 091505

Apprvd: Online Batch#: 000011

Customer Copy

THANK YOU
HAVE A NICE DAY!

all state

PARKLAND PARKING SRVC
5201 HARRY HINES BLVD
DALLAS, TX, 75235
214-590-4163

TERMINAL ID.: 005
MERCHANT #: 5566566

MASTERCARD
XXXXXXXXXXXX2622 EXP:***
SALE SWIPED

BATCH: 000001 INV: 000255

Mar 04, 13 10:17

RRN: 000255000256 AUTH: 001658

TOTAL \$6.00

CLARENCE F ABNER

CUSTOMER COPY

INSURANCE

draw

~~Wite~~

racetrac 498
2506 Inwood Rd.,
Dallas, TX 75235

For Guest Experience
Comments, Please
Call 888.636.5589 or
go to racetrac.com
Term: JD48035794003
Appr: 255583
Seq#: 024963

PUMP No. 07
Grade: Unl-87, Sel
Gallons: 20.499 G
Price: \$3.659/Gal
Total Fuel: \$75.01
TOTAL SALE \$75.01
CREDIT \$75.01

Debit
XXXXXXXXXXXX2622

02/26/2013 11:21:23

HOW ARE WE DOING?
WWW.TELLRACETRAC.COM
OR CALL 800.251.6970
FOR FREE BAKERY ITEM

5920 Forest Park Rd.
Suite 601
Dallas TX 75235-6411
214-266-0312

1/31/2013

MEDICAL RECORD # -- 4258376

Clarence Franklin Abner
6827 Latta Parkway
Dallas TX 75227

Dear Clarence Franklin Abner:

This is a reminder that you have a(n) Follow Up Blocked appointment scheduled with Nguyen, Jessica Ngan, DO, at 10:30 AM on February 14, 2013.

Please bring all medications and your picture ID with you. Copayments or fees are due at the time of your appointment/procedure. Copayments and fees vary from clinic to clinic.

You must arrive on time for your appointment. If you are late for your appointment, you may need to be rescheduled. For questions or if you are unable to keep this appointment, please notify our office at 214-266-0312 at least 24 hours in advance.

Thank you, from the staff of FAMILY MEDICINE CLINIC DEPARTMENT.

Estimado (a) Clarence Franklin Abner:

Esta carta es para recordarle que tiene una Follow Up Blocked cita con Nguyen, Jessica Ngan, DO, a las 10:30 AM an esta dia February 14, 2013.

Favor de traer todas sus medicinas consigo asi como tambien una identificacion con foto de usted, y si la tiene: tarjeta de la clinica.

Los co-pagos o cargos se deben a la hora de su cita/procedimiento. Los co-pagos y cargos son diferentes de una clinica a otra.

De haber preguntas en cuanto a los co-pagos o cargos en especifico a la clinica o en caso de que no pueda asistir a su cita/procedimiento, llame por telefono a la clinica en donde tiene la cita.

Usted tiene que llegar a tiempo para su cita. Si usted no llega a tiempo, tal vez se tenga que posponer la cita para otra fecha. Si tiene preguntas o en caso que no puede asistir a su cita, por favor llame a nuestra oficina a lo menos 24 horas por anticipado al 214-266-0312.

Muchas gracias, de parte del personal de FAMILY MEDICINE CLINIC DEPARTMENT.

Clarence Franklin Abner
1/31/2013 10:30 AM Office Visit

Department: Family Medicine
Description: 50 year old male
Location: Clinic
Provider: David Wayne
Phone: 214-266-0312
Candelario, DO

Your Protected Health Information (Su información de salud protegida)

Patient Name	MRN	Sex	DOB	Address	Phone
Abner, Clarence Franklin	4258376	Male	7/10/1962	6827 Latta Parkway Dallas TX 75227	214-799-1296 (Home) 214-275-4195 (Work)

Your Primary Care Provider (Su proveedor de atención primaria)

PCP	Location
Haley Colleen Newton, DO	FAMILY MEDICINE CLINIC[2304]

Reason for Visit (Motivo de la visita)

Follow-up	ER visit
-----------	----------

Vitals (Signos vitales) - Last Recorded

BP	Pulse	Temp(Src)	Resp	Height	Weight	BMI
138/92	75	36.4 °C (97.6 °F) (Tympanic)	18	69" (175.3 cm)	82.101 kg (181 lb)	26.73 kg/m2

Allergies (Alergias)

HYDROCODONE

Your Goals (5 Years of Data)

None

Current Medications (Medicinas actuales)

	Dosage
cyclobenzaprine 10 mg tablet	Take 1 Tab by mouth 3 times a day as needed for muscle spasms.
etodolac 400 mg tablet	Take 1 Tab by mouth twice a day as needed for pain.
pantoprazole EC 40 mg tablet	Take 1 Tab by mouth one time a day.
ASCORBATE CALCIUM (VITAMIN C ORAL)	Take by mouth.
DOCOSAHEXANOIC ACID/EPA (FISH OIL ORAL)	Take by mouth.
MULTIVITAMINS,THERAPEUTIC (THERAPEUTIC MULTIVITAMIN ORAL)	Take by mouth.
albuterol 90 mcg/actuation HFA inhaler	Inhale 2 Puffs by mouth every 4 hours as needed for shortness of breath.
fluticasone 50 mcg/actuation nasal spray	Use 2 Sprays in each nostril one time a day.

Future Appointments (Citas futuras)

Date & Time	Provider	Department
2/14/2013 10:30 AM	Jessica Ngan Nguyen, DO	Family Medicine Clinic
2/26/2013 7:45 AM	Haley Colleen Newton, DO	Family Medicine Clinic

Please call to confirm the appointment around the following date, if not already booked. (Favor de llamar para confirmar la cita alrededor de la siguiente fecha, si no está ya reservada.)

Return in about 2 weeks (around 2/14/2013) for MVA f/u and urinary symptoms.

Check-out Note

Please have patient sign a release so we can get the xrays from Doctors hospital.

Patient Instructions (Instrucciones al paciente)

Radiology----- No appointment needed 214-590-0062.

Medications Ordered/Reordered this Visit (Las medicinas ordenadas/reordenadas en esta visita)

cyclobenzaprine 10 mg tablet

Take 1 Tab by mouth 3 times a day as needed for muscle spasms.

Other Orders Placed Today. Referral Orders - Please call 214-590-5601 to schedule your appointment within 48 hours. (Otras órdenes colocaron hoy. Órdenes de remisión - Favor de llamar al 214-590-5601 para hacer una cita dentro de las 48 horas.)

Future Orders

**XR LUMBAR SPINE AP & LATERAL
STANDING**

Immunizations (Inmunizaciones) administered on date of encounter

Reviewed on 1/31/2013

- 1/31/2013

No immunizations on file.

Patient satisfaction survey (Encuesta de satisfacción del paciente)

You may receive a survey in the mail regarding your visit. Patients' responses to the survey are very important for quality and service improvement. Please remember to return your survey if you receive one.

Es posible que reciba una encuesta por correo con respecto a su visita al hospital. Las respuestas de los pacientes a la encuesta son muy importantes para mejorar la calidad y servicio. Por favor, recuerde devolver su encuesta si usted recibe una.

MyChart

MyChart is a free service to Parkland patients. With MyChart you can see select test results, health issues, and past or future appointments. If you want to sign up please speak to Parkland staff at your next appointment. They can give you an activation code and sign up instructions. You can also go to <https://mychart.pmh.org>. Click the FAQs link to see frequently asked questions about MyChart.

**Medication
List**Parkland Health & Hospital System 5201 Harry Hines Blvd Dallas, Texas 75235 214-
590-8000**Discharge Medication Reconciliation Report**Patient Name: **Abner, Clarence Franklin**
Allergies: **Hydrocodone**MRN: **4258376**Admission Date: **Patient not admitted****Important Information!**

This is a list of your medications based on available information. Take these medications as directed. If you are taking medications not on this list and have questions about them, ask your doctor or call your pharmacist for more information. Please bring this list and your medications to every visit or appointment.

Medications to Take At Home

Medication Name	Dose Instructions	Comments/Reason for Prescription
albuterol 90 mcg/actuation HFA inhaler	Inhale 2 Puffs by mouth every 4 hours as needed for shortness of breath.	> >
ASCORBATE CALCIUM (VITAMIN C ORAL)	Take by mouth.	> >
cyclobenzaprine 10 mg tablet	Take 0.5 Tabs by mouth at bedtime as needed for muscle spasms.	> >
DOCOSAHEXANOIC ACID/EPA (FISH OIL ORAL)	Take by mouth.	> >
etodolac 400 mg tablet	Take 1 Tab by mouth twice a day as needed for pain.	> >
fluticasone 50 mcg/actuation nasal spray	Use 2 Sprays in each nostril one time a day.	> >
MULTIVITAMINS, THERAPEUTIC (THERAPEUTIC MULTIVITAMIN ORAL)	Take by mouth.	> >
pantoprazole EC 40 mg tablet	Take 1 Tab by mouth one time a day.	> >

Medication List Comments:

10/6/11: Patient also taking a pain medication but can't recall the name of the medication. R.Daniels, RN

Discharge medications last reviewed by:User
NEWTON, HALEY COLLEEN, DO [HNEWTO]Date and Time
11/26/2012 9:06 AM



Parkland

Parkland Health & Hospital System
(214) 590-4900

Receipt

Your Reference Number:

2013031070-8

01/31/2013 10:25 AM

TRANSACTIONS

Patient Payment	\$10.00
2013031070-8-1	

MRN: 4258376

MEMBER NAME: ABNER, CLARENCE
FRANKLIN

ACCOUNT NBR: 100689594

Hospital Account Payment \$10.00

TOTAL AMOUNT: \$10.00

PAYMENT

Master Card Credit Sale S	\$10.00
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PATIENT STATEMENT OF RESPONSIBILITY

MRN: 4258376 DOS: 01/31/13
ABNER, CLARENCE FRANKLIN M
DOB: 07/10/1962 50 y FMED
HAR: 611949286
CSN: 335942587



PSR189

Patient Medication Assistance Programs

PHHS may be able to receive credit from Patient Medication Assistance Programs for some of the medications that I receive, if I meet the qualifications. If PHHS receives this credit, charges associated with these medications will be deducted from my bill. My signature below authorizes PHHS to sign, on my behalf, application forms necessary to obtain available reimbursement from Patient Medication Assistance Programs. I give my consent to release my information to Pharmaceutical Companies for Prescription Bulk Replacement Programs for Auditing Purposes only.

Financial Obligations/Assignments of Benefits

I understand:

- Withholding or providing false information could result in criminal or civil penalties under Texas law.
- I am responsible for payment of all charges related to medical services rendered which are not covered by insurance or a third-party program. I further understand that such charges are due upon dismissal.
- PHHS has the right to pursue full collection efforts including credit checks, asset inquiries and litigation.
- I will receive separate bills for services I receive from physicians, and other healthcare providers.
- My signature below authorizes payment directly to PHHS of all benefits otherwise payable to me by any third-party payor.
- I may receive services from a facility-based physician (radiologist, anesthesiologist, pathologist, emergency department physician or neonatologist), who is not a participating provider with the same insurance companies as PHHS. I may receive a bill for medical services from a facility-based physician for the amount unpaid by my insurance company. I may request information from a facility-based physician on whether the physician has a contract with my insurance company and under what circumstances I may be responsible for payment of any amount not paid by my insurance company. I may request a list of names and contact information for facility-based physicians.

PHHS is: N/A In-Network Out-of-Network with my insurance payor.

I have read and understand the above, they have been explained to me to my satisfaction, I accept and agree to the items contained in this Statement of Responsibility.

[Signature] Clarence Franklin Abner 1/31/13 10:15 a.m.
 Signature (Patient, Guardian or Legally Authorized Representative) Printed Name (Patient, Guardian or Legally Authorized Representative) Date Time

Relationship to Patient (if applicable) Spouse Parent/Guardian Other: (specify) _____

[Signature] [Signature] 1000 1/31/13 1020 a.m.
 PHHS Representative Signature Printed Name ID # Date Time

[Signature] [Signature] 1000 1/31/13 1020 a.m.
 Interpreter Signature, if applicable Printed Name ID # Date Time

CONSENT TO MEDICAL TREATMENT



CFT282

Consent for Medical Treatment and Photography

- I do hereby voluntarily consent to and authorize Parkland to provide care encompassing all diagnostic and therapeutic treatments, including HIV testing, considered necessary or advisable in the judgment of the attending physician or his/her designee. By signing this form, I do not waive my right to refuse recommended tests or treatments.
- I understand that Parkland functions in part as a teaching institution and I hereby acknowledge and consent to the use of myself and related records, laboratory work and specimens and diagnostic results from time to time for instructional purposes or machine testing at the sole discretion of Parkland.
- I understand that photographs, videotapes, digital and other images may be recorded to document my care, and I consent to this. I understand that these images will be stored in a secure manner that will protect my privacy and that they will be kept for the time period required by law or outlined in Parkland procedures. Images that identify me will be released or used outside Parkland only upon written authorization from me or my legal representative.

Acknowledgement of Use and Disclosure of Protected Health Information

I understand:

- Parkland personnel and my physician create and maintain a record of the care and services provided to me.
- Information relating to my treatment, payment or health care operations may be used or disclosed in the management and delivery of care and services provided by Parkland.
- I have received a copy of Parkland's Notice of Privacy Practices that describes how my protected health information may be used or disclosed.
- I have received, read and understand the Patient Bill of Rights located on the back of this form.

Notice of Exchange of Medical Record

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Preservation of Records

Parkland Health & Hospital System (PHHS) MAY authorize disposal of medical records relating to the patient on or after the time periods specified in the Texas Health and Safety code.

Valuables

I understand that Parkland does not assume the responsibility for the safekeeping of any personal property that I choose to keep on my person or in my hospital room during my stay.

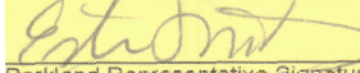
I have read and understand the above, they have been explained to me to my satisfaction, I accept and agree to the items contained in this Consent to Medical Treatment.

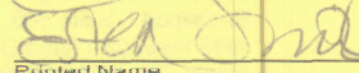

 Signature (Patient, Guardian or Legally Authorized Representative)

Clearance Agent
 Printed Name (Patient, Guardian or Legally Authorized Representative)

1/31/13 10:15
 Date Time

Relationship to Patient, if applicable: Spouse Parent/Guardian Other: (specify) _____


 Parkland Representative Signature


 Printed Name

10377
 ID #

1/31/13 10:20
 Date Time

Interpreter Signature, if applicable

Printed Name

ID #

Date

Time

PATIENT STATEMENT OF RESPONSIBILITY



PSR189

Patient Medication Assistance Programs

PHHS may be able to receive credit from Patient Medication Assistance Programs for some of the medications that I receive, if I meet the qualifications. If PHHS receives this credit, charges associated with these medications will be deducted from my bill. My signature below authorizes PHHS to sign, on my behalf, application forms necessary to obtain available reimbursement from Patient Medication Assistance Programs. I give my consent to release my information to Pharmaceutical Companies for Prescription Bulk Replacement Programs for Auditing Purposes only.

Financial Obligations/Assignments of Benefits

I understand:

- Withholding or providing false information could result in criminal or civil penalties under Texas law.
- I am responsible for payment of all charges related to medical services rendered which are not covered by insurance or a third-party program. I further understand that such charges are due upon dismissal.
- PHHS has the right to pursue full collection efforts including credit checks, asset inquiries and litigation.
- I will receive separate bills for services I receive from physicians, and other healthcare providers.
- My signature below authorizes payment directly to PHHS of all benefits otherwise payable to me by any third-party payor.
- I may receive services from a facility-based physician (radiologist, anesthesiologist, pathologist, emergency department physician or neonatologist), who is not a participating provider with the same insurance companies as PHHS. I may receive a bill for medical services from a facility-based physician for the amount unpaid by my insurance company. I may request information from a facility-based physician on whether the physician has a contract with my insurance company and under what circumstances I may be responsible for payment of any amount not paid by my insurance company. I may request a list of names and contact information for facility-based physicians.

PHHS is: N/A In-Network Out-of-Network with my insurance payor.

I have read and understand the above, they have been explained to me to my satisfaction, I accept and agree to the items contained in this Statement of Responsibility.

[Signature]
Signature (Patient, Guardian or Legally Authorized Representative)

Claveria Aguirre
Printed Name (Patient, Guardian or Legally Authorized Representative)

2/1/13 10:21 a.m.
Date Time p.m.

Relationship to Patient (if applicable) Spouse Parent/Guardian Other: (specify) _____

A Hernandez ppr
PHHS Representative Signature

A Hernandez
Printed Name

35590 2/1/13
ID # Date

10:28 a.m.
Time p.m.

Interpreter Signature, if applicable

Printed Name

ID #

Date

Time

a.m.
p.m.

CONSENT TO MEDICAL TREATMENT

MRN: 4258376 DOS: 02/14/13
ABNER, CLARENCE FRANKLIN M
DOB: 07/10/1962 50 y FMED
HAR: 611993836
CSN: 335964493



CFT282

Consent for Medical Treatment and Photography

- I do hereby voluntarily consent to and authorize Parkland to provide care encompassing all diagnostic and therapeutic treatments, including HIV testing, considered necessary or advisable in the judgment of the attending physician or his/her designee.
I understand that Parkland functions in part as a teaching institution and I hereby acknowledge and consent to the use of myself and related records, laboratory work and specimens and diagnostic results from time to time for instructional purposes or machine testing at the sole discretion of Parkland.
I understand that photographs, videotapes, digital and other images may be recorded to document my care, and I consent to this. I understand that these images will be stored in a secure manner that will protect my privacy and that they will be kept for the time period required by law or outlined in Parkland procedures. Images that identify me will be released or used outside Parkland only upon written authorization from me or my legal representative.

Acknowledgement of Use and Disclosure of Protected Health Information

I understand:

- Parkland personnel and my physician create and maintain a record of the care and services provided to me.
Information relating to my treatment, payment or health care operations may be used or disclosed in the management and delivery of care and services provided by Parkland.
I have received a copy of Parkland's Notice of Privacy Practices that describes how my protected health information may be used or disclosed.
I have received, read and understand the Patient Bill of Rights located on the back of this form.

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Preservation of Records

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Valuables

I understand that Parkland does not assume the responsibility for the safekeeping of any personal property that I choose to keep on my person or in my hospital room during my stay.

I have read and understand the above, they have been explained to me to my satisfaction, I accept and agree to the items contained in this Consent to Medical Treatment.

Signature (Patient, Guardian or Legally Authorized Representative)
Printed Name (Patient, Guardian or Legally Authorized Representative)
Date
Time

Relationship to Patient, if applicable: [] Spouse [] Parent/Guardian [] Other: (specify)
Parkland Representative Signature
Printed Name
ID #
Date
Time

Interpreter Signature, if applicable
Printed Name
ID #
Date
Time

PATIENT STATEMENT OF RESPONSIBILITY

MRN: 4258376 DOS: 02/14/13
ABNER, CLARENCE FRANKLIN M
DOB: 07/10/1962 50 y FMED
HAR: 611993836
CSN: 335964493



PSR189

Patient Medication Assistance Programs

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Financial Obligations/Assignments of Benefits

I understand:

- Withholding or providing false information could result in criminal or civil penalties under Texas law.
I am responsible for payment of all charges related to medical services rendered which are not covered by insurance or a third-party program. I further understand that such charges are due upon dismissal.
PHHS has the right to pursue full collection efforts including credit checks, asset inquiries and litigation.
I will receive separate bills for services I receive from physicians, and other healthcare providers.
My signature below authorizes payment directly to PHHS of all benefits otherwise payable to me by any third-party payor.
I may receive services from a facility-based physician (radiologist, anesthesiologist, pathologist, emergency department physician or neonatologist), who is not a participating provider with the same insurance companies as PHHS. I may receive a bill for medical services from a facility-based physician for the amount unpaid by my insurance company. I may request information from a facility-based physician on whether the physician has a contract with my insurance company and under what circumstances I may be responsible for payment of any amount not paid by my insurance company. I may request a list of names and contact information for facility-based physicians.

PHHS is: [] N/A [] In-Network [] Out-of-Network with my insurance payor.

I have read and understand the above, they have been explained to me to my satisfaction, I accept and agree to the items contained in this Statement of Responsibility.

Signature (Patient, Guardian or Legally Authorized Representative) Printed Name (Patient, Guardian or Legally Authorized Representative) Date Time a.m. p.m.

Relationship to Patient (if applicable) [] Spouse [] Parent/Guardian [] Other: (specify)

PHHS Representative Signature Printed Name ID # Date Time a.m. p.m.

Interpreter Signature, if applicable Printed Name ID # Date Time a.m. p.m.

Your Protected Health Information (Su información de salud protegida)

Patient Name	MRN	Sex	DOB	Address	Phone
Abner, Clarence Franklin	4258376	Male	7/10/1962	6827 Latta Parkway Dallas TX 75227	214-799-1296 (Home) 214-275-4195 (Work)

Your Primary Care Provider (Su proveedor de atención primaria)

PCP	Location
Haley Colleen Newton, DO	FAMILY MEDICINE CLINIC[2304]

Reason for Visit (Motivo de la visita)

Follow-up follow up - Refill on Meds. & Needs Dr. Note for Work.

Vitals (Signos vitales) - Last Recorded

SP	Pulse	Temp(Site)	Resp	Height	Weight	BM
139/89	94	36.7 °C (98.1 °F) (Tympanic)	18	69" (175.3 cm)	83.462 kg (184 lb)	27.17 kg/m2

Allergies (Alergias)

HYDROCODONE

Your Goals (5 Years of Data)

None

Current Medications (Medicinas actuales)

	Dosage
cyclobenzaprine 10 mg tablet	Take 1 Tab by mouth 3 times a day as needed for muscle spasms.
ibuprofen 600 mg tablet	Take 1 Tab by mouth every 6 hours as needed for pain.
etodolac 400 mg tablet	Take 1 Tab by mouth twice a day as needed for pain.
pantoprazole EC 40 mg tablet	Take 1 Tab by mouth one time a day.
ASCORBATE CALCIUM (VITAMIN C ORAL)	Take by mouth.
DOCOSAHEXANOIC ACID/EPA (FISH OIL ORAL)	Take by mouth.
MULTIVITAMINS,THERAPEUTIC (THERAPEUTIC MULTIVITAMIN ORAL)	Take by mouth.
albuterol 90 mcg/actuation HFA inhaler	Inhale 2 Puffs by mouth every 4 hours as needed for shortness of breath.
fluticasone 50 mcg/actuation nasal spray	Use 2 Sprays in each nostril one time a day.

Future Appointments (Citas futuras)

Date & Time	Provider	Department
2/26/2013 7:45 AM	Haley Colleen Newton, DO	Family Medicine Clinic

Patient Instructions (Instrucciones al paciente)

None

Medications Ordered/Reordered this Visit (Las medicinas ordenadas/reordenadas en esta visita)

cyclobenzaprine 10 mg tablet Take 1 Tab by mouth 3 times a day as needed for muscle spasms.

Other Orders Placed Today. Referral Orders - Please call 214-590-5601 to schedule your appointment within 48 hours. (Otras órdenes colocaron hoy. Órdenes de remisión - Favor de llamar al 214-590-5601 para hacer una cita dentro de las 48 horas.)

POC URINALYSIS

URINE CULTURE

Future Orders

EVALUATE & TREAT (PT) - (214) 590-5603

Immunizations (Inmunizaciones) administered on date of encounter

Reviewed on 2/14/2013

- 2/14/2013

No immunizations on file.

Patient satisfaction survey (Encuesta de satisfacción del paciente)

You may receive a survey in the mail regarding your visit. Patients' responses to the survey are very important for quality and service improvement. Please remember to return your survey if you receive one.

Es posible que reciba una encuesta por correo con respecto a su visita al hospital. Las respuestas de los pacientes a la encuesta son muy importantes para mejorar la calidad y servicio. Por favor, recuerde devolver su encuesta si usted recibe una.

MyChart

MyChart is a free service to Parkland patients. With MyChart you can see select test results, health issues, and past or future appointments. If you want to sign up please speak to Parkland staff at your next appointment. They can give you an activation code and sign up instructions. You can also go to <https://mychart.pmh.org>. Click the FAQs link to see frequently asked questions about MyChart.

PATIENT STATEMENT OF RESPONSIBILITY



PSR189

Patient Medication Assistance Programs

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Financial Obligations/Assignments of Benefits

I understand:

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- PHHS has the right to pursue full collection efforts including credit checks, asset inquiries and litigation.
- I will receive separate bills for services I receive from physicians, and other healthcare providers.
- My signature below authorizes payment directly to PHHS of all benefits otherwise payable to me by any third-party payor.
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PHHS is: N/A In-Network Out-of-Network with my insurance payor.

I have read and understand the above, they have been explained to me to my satisfaction, I accept and agree to the items contained in this Statement of Responsibility.

[Signature] Clavencia Abner 2/2/13 _____ a.m.
 Signature (Patient, Guardian or Legally Authorized Representative) Printed Name (Patient, Guardian or Legally Authorized Representative) Date Time
 _____ p.m.

Relationship to Patient (if applicable) Spouse Parent/Guardian Other: (specify) _____

[Signature] Eira Reyes 38778 2/2/13 2:46 _____ a.m.
 PHHS Representative Signature Printed Name ID # Date Time
 _____ p.m.

 Interpreter Signature, if applicable Printed Name ID # Date Time
 _____ a.m.
 _____ p.m.

Your Protected Health Information (Su información de salud protegida)

Patient Name	MRN	Sex	DOB	Address	Phone
Abner, Clarence Franklin	4258376	Male	7/10/1962	6827 Latta Parkway Dallas TX 75227	214-799-1296 (Home) 214-275-4195 (Work)

Your Primary Care Provider (Su proveedor de atención primaria)

PCP	Location
Haley Colleen Newton, DO	FAMILY MEDICINE CLINIC[2304]

Reason for Visit (Motivo de la visita)

Follow-up follow up - spot on face

Vitals (Signos vitales) - Last Recorded

BP	Pulse	Temp(Src)	Resp	Height	Weight	BMI
135/92	86	36.7 °C (98.1 °F) (Tympanic)	18	69" (175.3 cm)	83.915 kg (185 lb)	27.32 kg/m2

Allergies (Alergias)

HYDROCODONE

Your Goals (5 Years of Data)

None

Current Medications (Medicinas actuales)

	Dosage
cyclobenzaprine 10 mg tablet	Take 1 Tab by mouth 3 times a day as needed for muscle spasms.
ibuprofen 600 mg tablet	Take 1 Tab by mouth every 6 hours as needed for pain.
doxazosin 1 mg tablet	Take 1 Tab by mouth daily at bedtime.
pantoprazole EC 40 mg tablet	Take 1 Tab by mouth one time a day.
ASCORBATE CALCIUM (VITAMIN C ORAL)	Take by mouth.
DOCOSAHEXANOIC ACID/EPA (FISH OIL ORAL)	Take by mouth.
MULTIVITAMINS,THERAPEUTIC (THERAPEUTIC MULTIVITAMIN ORAL)	Take by mouth.
albuterol 90 mcg/actuation HFA inhaler	Inhale 2 Puffs by mouth every 4 hours as needed for shortness of breath.
fluticasone 50 mcg/actuation nasal spray	Use 2 Sprays in each nostril one time a day.

Future Appointments (Citas futuras)

Date & Time	Provider	Department
2/27/2013 10:00 AM	Binu Aramath, PT	PHYSICAL THERAPY
3/4/2013 9:30 AM	Binu Aramath, PT	PHYSICAL THERAPY
3/6/2013 10:00 AM	Binu Aramath, PT	PHYSICAL THERAPY

Patient Instructions (Instrucciones al paciente)

None

cyclobenzaprine 10 mg tablet

Take 1 Tab by mouth 3 times a day as needed for muscle spasms.

ibuprofen 600 mg tablet

Take 1 Tab by mouth every 6 hours as needed for pain.

doxazosin 1 mg tablet

Take 1 Tab by mouth daily at bedtime.

Other Orders Placed Today. Referral Orders - Please call 214-590-5601 to schedule your appointment within 48 hours. (Otras órdenes colocaron hoy. Órdenes de remisión - Favor de llamar al 214-590-5601 para hacer una cita dentro de las 48 horas.)

TETANUS & DIPHTHERIA TOX & PERT VACC

Immunizations (Inmunizaciones) administered on date of encounter

Reviewed on 2/26/2013

- 2/26/2013

Tdap

2/26/2013

Patient satisfaction survey (Encuesta de satisfacción del paciente)

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CONSENT TO MEDICAL TREATMENT

MRN: 4258376 DOS: 02/26/13
ABNER, CLARENCE FRANKLIN M
DOB: 07/10/1962 50 y FMED
HAR: 612053529
CSN: 335810843



#10.00
Prof

CFT282

Consent for Medical Treatment and Photography

- I do hereby voluntarily consent to and authorize Parkland to provide care encompassing all diagnostic and therapeutic treatments, including HIV testing, considered necessary or advisable in the judgment of the attending physician or his/her designee. By signing this form, I do not waive my right to refuse recommended tests or treatments.
- I understand that Parkland functions in part as a teaching institution and I hereby acknowledge and consent to the use of myself and related records, laboratory work and specimens and diagnostic results from time to time for instructional purposes or machine testing at the sole discretion of Parkland.
- I understand that photographs, videotapes, digital and other images may be recorded to document my care, and I consent to this. I understand that these images will be stored in a secure manner that will protect my privacy and that they will be kept for the time period required by law or outlined in Parkland procedures. Images that identify me will be released or used outside Parkland only upon written authorization from me or my legal representative.

Acknowledgement of Use and Disclosure of Protected Health Information

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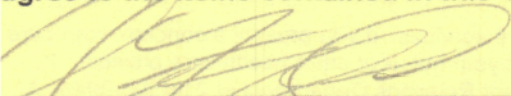
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 Signature (Patient, Guardian or Legally Authorized Representative)

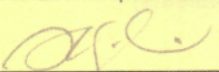
Clarence Franklin Abner
 Printed Name (Patient, Guardian or Legally Authorized Representative)

2/26/13
 Date

7:30
 Time

a.m.
 p.m.

Relationship to Patient, if applicable: Spouse Parent/Guardian Other: (specify) _____


 Parkland Representative Signature

Amanda K
 Printed Name

33930
 ID #

2-26-13
 Date

7:35
 Time

a.m.
 p.m.

Interpreter Signature, if applicable

Printed Name

ID #

Date

Time

a.m.
 p.m.

PATIENT STATEMENT OF RESPONSIBILITY

MRN: 4258376 DOS: 02/26/13
 ABNER, CLARENCE FRANKLIN M
 DOB: 07/10/1962 50 Y FMED
 HAR: 612053529
 CSN: 335810843



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PHHS is: N/A In-Network Out-of-Network with my insurance payor.

I have read and understand the above, they have been explained to me to my satisfaction, I accept and agree to the items contained in this Statement of Responsibility.

[Signature] Clarence Abner 2/26/13 7:30 a.m.
 Signature (Patient, Guardian or Legally Authorized Representative) Printed Name (Patient, Guardian or Legally Authorized Representative) Date Time p.m.

Relationship to Patient (if applicable) Spouse Parent/Guardian Other: (specify) None

[Signature] Amanda K 35836 2-26-13 7:35 a.m.
 PHHS Representative Signature Printed Name ID # Date Time p.m.

 Interpreter Signature, if applicable Printed Name ID # Date Time p.m.

Transaction Approved - Thank you for your Payment

Account Number: DTX0079362818

Service Provided By: EMCARE-DTX-EMERG-PHYSICIANS
DOCTORS HOSP AT WHITE ROCK LAKE
DALLAS, TX

Payment Date: 06/10/2013

Charges will Appear as: EmCare Physicians

Authorization Number: 090744

Name of Payer: CLARENCE ABNER

Payment Method: Credit / Debit

Payment Type: MCARD

Credit / Debit Account: *****2622

Amount Submitted: \$10.00

Email: hitc.skip@gmail.com

A Confirmation Receipt Email Has Been Sent To:

hitc.skip@gmail.com