AMARILLO
HEADACHE CLINIC
APRIL HUNLEY NP

Patient Information:

Full Name: _____ Home Phone: _____

Address: _____ Cell Phone: _____

City: _____State: _____ Zip: _____ Work Phone: _____Ext: _____

Date of Birth: _____ Gender: M F Social Security #: _____

Marital Status: Married Single Divorced Widowed Email: _____

Primary Care: _____ Referring Provider: _____

Employer: _____

Address: _____ City: _____State: _____ Zip: _____

Preferred Pharmacy: _____

Responsible Party Information:

Full Name: _____ Relationship to Patient: _____

Address: _____ Home / Cell Phone: _____

City: _____State: _____ Zip: _____ Work Phone: _____Ext: _____

Date of Birth: _____ Gender: M F Social Security #: _____

Insurance (Primary) NAME: _____

Policy Holder Name: _____

Policy Holder Birth Date: _____

Policy Holder Phone #: _____

Policy Holder SS#: _____

Relationship to Patient: _____

Insurance (Secondary) NAME: _____

Policy Holder Name: _____

Policy Holder Birth date: _____

Policy Holder Phone #: _____

Policy Holder SS#: _____

Relationship to Patient: _____

Reason for your Visit Today: _____

_____

PATIENT NAME: _____

FAMILY HISTORY: (list A = alive, if alive and list health history or D = deceased, if deceased and list cause of death):

Father (DOB): _____ Mother (DOB): _____
Paternal Grandfather: _____ Paternal Grandmother: _____
Maternal Grandfather: _____ Maternal Grandmother: _____

LIST TOTAL NUMBERS BELOW:

Brothers: _____ = _____ Alive; _____Deceased Sisters: _____ = _____ Alive; _____ Deceased

Sons: _____ = _____ Alive; _____ Deceased Daughters: _____ = _____ Alive; _____ Deceased

PLEASE ANSWER (Y = yes or N = no):

	Living Will		Seatbelts
	Fall Risk		Smoke/Vape
	Alcohol		Caffeine
	Exercise		Recreational Drugs
	Sexually Active		

YEAR OF LAST:
Tetanus Shot: _____ TB Test: _____ Flu Vaccine: _____ Shingles: _____

Pneumovax: _____ Prevnar 13: _____

Last Colonoscopy / Cologuard: _____ Due: _____

Last EGD: _____ Due: _____

Last Mammogram: _____ Due: _____

Last Bone Density: _____ Due: _____

Last Pap (Females Only): _____ Due: _____

Last PSA/DRE (Males Only): _____ Due: _____

Past Surgeries: _____

_____

_____

Specialists that you currently see: _____

_____

_____

Chronic Medical Conditions: _____

Patient Portal Authorization on the Web

Amarillo Headache Clinic offers the opportunity to use the power of the web to track the most important aspects of your healthcare through our office. The Patient Portal enables patients to communicate with our staff easily, safely, and securely via the internet.

Patients are sent, via email, a secure User ID and password, enabling them to access our secure Patient Portal to view their health records, including in office lab results, educational information, billing statements, and other health information. You can also send a message to the office through the Portal.

In order to provide you access to the Patient Portal, please provide us your email address or select one of the boxes below:

EMAIL ADDRESS: _____

☐ I do not have an email address
☐ I do not want to share my email address
☐ I do not want t access the Patient Portal
☐ Other: _____

Consent for Medical Treatment

I voluntarily present to Amarillo Headache Clinic and consent to treatment of the physician on duty and whomever they may designate as their assistant, associate, treating physician and patient care staff to provide my care. Such care may include, but is not limited to, diagnostic procedures, radiological evaluations and procedures, and the administration of medications considered advisable in my diagnosis, treatment, and course of care. I acknowledge that no guarantee can be made or has been made as to the results of treatment or examinations and I understand that all medical treatments contain inherent risks.

_____ _____

Patient or Authorized Person's Signature Date

_____

Patient's Printed Name

Patient's Consent to Obtain External Prescription History

I grant permission to the healthcare providers at Amarillo Headache Clinic, to view my prescription history from other external sources (other pharmacies and/or providers). I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff, and it may include prescriptions back several years.

_____ _____

Patient or Authorized Person's Signature Date

_____

Patient's Printed Name

FINANCIAL POLICY

AMARILLO HEADACHE CLINIC

Welcome to Amarillo Headache Clinic! We want to ensure the timely management of your account and help you in obtaining reimbursement from your insurance company. To accomplish this, we need your understanding and acceptance of our financial policy.

PARTICIPATING PROVIDER

We are providers for several networks and Medicare Part B. However, due to the complexity of managed care plans, it is difficult for us to know the details of each patient's plan. **Therefore, it is your responsibility to ensure that your physician and ancillary providers are participating providers in your plan. You should verify this information by contacting your insurance plan or reviewing your provider list *before* making an appointment.** You will be responsible for payment in full for services rendered by your physician if he/she is not a provider in your plan.

For non-contracted plans, you will need to pay in full and file your own claim.

YOU MUST PRESENT A VALID INSURANCE CARD AT THE TIME OF SERVICE IN ORDER FOR US TO FILE A CLAIM FOR YOU.

CO-PAYMENTS

We require your co-payment at check-in. We will verify insurance and collect payment based on the information provided by your insurance company.

DEDUCTIBLE AND COINSURANCE

If you have a deductible, we will verify insurance and collect payment based on the information provided by your insurance company. We collect deductible, co-insurance and any balance owing at each visit.

REFERRALS, PRECERTIFICATION, AND PRE-AUTHORIZATIONS

Referrals, precertification, and pre-authorization of additional medical services is an area in which we strive to help you. Due to the varying policy provisions of all of our patients plans, it is impossible for us to know each patients specific plan provisions. **If you fail to disclose precertification requirements PRIOR to services being rendered, you may be responsible for payment of all related fees in full.**

***** IT IS YOUR RESPONSIBILITY TO BE AWARE OF AND INFORM US OF WHICH MEDICAL FACILITIES ARE APPROVED BY YOUR PLAN FOR X-RAY, LABORATORY, DIAGNOSTIC AND REHABILITATION FACILITIES *****

SECONDARY INSURANCE

We will file secondary insurance as a courtesy to you. Please keep in mind that payment of your account is ultimately your responsibility. We will look to you for payment, if we are unsuccessful in obtaining reimbursement by your insurance.

RESPONSIBLE PARTY (GUARANTOR)

The guarantor of the account is the patient who comes in for treatment or the adult who brings in a minor child for treatment, regardless of any court decisions or insurance coverage. If someone other than the guarantor brings a minor child in, that person will be required to pay for services rendered and they will be provided a receipt. It is not the policy of Amarillo Headache Clinic to become involved in medical bill payment disputes resulting from divorce, etc.

LIABILITY OR AUTO ACCIDENT CLAIMS

We do not become involved in automobile or liability lawsuits, nor do we file liability claims or wait on "settlements". You will be required to pay in full for services rendered. We will provide you with the information necessary to be reimbursed. You may contact our office for a copy of HCFA.

WORKER'S COMPENSATION CLAIMS

We do not participate in Worker's Compensation and are unable to file claims on your behalf. We do not see patients for any work related injuries.

No-Show / Cancelled & Rescheduled Appointments

We ask that you provide us with a 24-hour notice of cancellation or rescheduling of any appointments. Any appointments not cancelled / rescheduled within that time period will be subject to a fee of $45.00. This will include cancelled / rescheduled appointments the day of and all no-show / late arrival appointments.

BILLING OF ACCOUNT BALANCES

You will receive a statement for which payment is due upon receipt.

NSF CHECKS

Checks returned for NSF, will have a $35.00 fee added.

NON-PAYMENT OF ACCOUNTS

Accounts for which we are unable to collect the balance due will be referred to an outside collection agency. We also reserve the right to report this activity to a national credit-reporting agency. Each physician reserves the right to discontinue patient care for non-payment or non-compliance. In this instance, a sufficient prior notice will be given and records provided.

CONSULTATION WITH YOUR OWN ATTORNEY:

AGREEMENT AS TO GOVERNING LAW AND FORUM: The patient and health care provider rendering or providing health care to patient agree: (1) that all health care rendered shall be governed exclusively and only by the Texas Law and in no event shall the law of any other state apply to any health care rendered to patient; and (2) in the event of a dispute, any lawsuit, action, or cause of which in any way relates to health care provided to the patient shall only be brought in a Texas District Court in the county where all or substantially all of the health care was provided or rendered and in no event will any lawsuit, action, or cause of action ever be brought in any other state or in any Federal Court. The choice of law and forum selection provisions of this paragraph is mandatory and is not permissive.

ACCEPTANCE OF FINANCIAL POLICY

The undersigned hereby certifies that he/she has read, understood and agrees to the financial policy of Amarillo Headache Clinic.

_____

Signature of Patient or Legal Guardian Date

ASSIGNMENT OF BENEFITS

The undersigned hereby requests that payment from authorized insurance carrier or state benefits program be made directly to Amarillo Headache Clinic office provider who rendered services on their Behalf for the period of: LIFETIME. The undersigned also releases the disclosure of medical information for use in obtaining reimbursement by an authorized insurance carrier.

_____

Signature of Patient or Legal Guardian Date

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO YOUR FAMILY OR OTHER INDIVIDUALS

In accordance with federal government privacy rules implemented through the Health Insurance Portability and Accountability Act of 1966, in order for the physician or staff of Amarillo Headache Clinic to give copies of and/or discuss your condition/exams/procedures/x-rays with members of your family or other individuals that you designate other than your primary care doctor or specialist, we must obtain your authorization prior to doing so. In the event of a critical episode or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived.

AUTHORIZATION TO DISCUSS FINANCIAL INFORMATION

In accordance with federal government privacy rules implemented through the Health Insurance Portability and Accountability Act of 1966, we must obtain your authorization to discuss financial information with members of your family or other individuals that you designate other than insurance companies or third-party payers and their agents.

If you wish for a family member or other representative to have access to your information, please list their names below:

Name	Relationship	Phone
Name	Relationship	Phone
Name	Relationship	Phone
Name	Relationship	Phone

I authorize Amarillo Headache clinic to release all information (including verbal information, copies of x-rays and medical paperwork) concerning my medical care as well as discuss financial information with the individuals listed above.

_____ I DO NOT authorize Amarillo Headache Clinic to release any information concerning my care to any individual

Signature of Patient or Parent/Guardian _____ Date _____

RECEIPT OF HIPPA PRIVACY NOTICE

I acknowledge receipt of the Notice of Privacy Practices with detailed information about how Amarillo Headache Clinic may use and disclosure my medical information as set forth herein, prior to any service being provided to me.

RELEASE AND USE OF PATIENT INFORMATION

I authorize the release of my medical records, information, treatment and advice, and specific health information to:

1. TREATING PHYSICIANS on staff at Amarillo Headache Clinic and their staff, agents or another healthcare facility if direct transfer to another facility is required, and to my primary care physician or any referred consultants for follow-up care.
2. AN EMPLOYER who requests services. This may include your personal medical history, physical, laboratory and diagnostic tests, and drug screening (including the presence of drugs, alcohol, or marijuana).
3. INSURANCE COMPANY or other third-party payer and their agents as well as any review organization or government agency for the purpose of determining eligibility and available benefits, obtaining payment for services provided, and insuring government compliance.
4. EDUCATIONAL OR SCIENTIFIC INSTITUTIONS, authorized health care professionals in training, internal quality improvement, risk management and legal counsel when it is judged that my ongoing medical care, medical research, quality improvement, healthcare education or science will benefit; for any purpose authorized by law.

I understand that if I refuse to authorize access to my records for coordination of care, my treatment could be adversely affected and that I could be held liable for the full cost of services provided Amarillo Headache Clinic. I understand that this information may contain my personal medical history, physical, and treatments (if necessary), radiographic and laboratory results, and more specifically results in reference to alcohol/drug abuse, mental health, or infectious disease (including human immune-deficiency virus, hepatitis, or other infectious diseases). I understand that I have the right to revoke this authorization.

_____ _____

Signature of Patient or Parent/Guardian Date

Consent for Health Information Exchange – PRISMA

PRISMA is the health information exchange that brings together records from small clinics to large-scale hospital systems whose medical records systems participate in the Carequality and CommonWell health alliance networks. PRISMA also aggregates patient information from insurance payers and patients' wearable devices to promote better interoperability and patient health outcomes.

Initial beside the option of your choice:

OPT IN: Send and Receive Documents

_____ Amarillo Headache Clinic will send clinical documents when requested by external connected sites (PRISMA) and will also request clinical documents from external connected sites (PRISMA) and display them in our electronic medical records

OPT OUT

_____ Amarillo Headache Clinic will neither send clinical documents to nor request clinical documents from external connection sites

_____ _____

Patient or Authorized Person's Signature Date

_____

Patient's Printed Name

CINDY HUTSON DO PA
PANHANDLE PRIMARY CARE / AMARILLO HEADACHE CLINIC
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW IT CAREFULLY
EFFECTIVE 02-16-2026

OUR COMMITMENT TO YOUR PRIVACY

Panhandle Primary Care / Amarillo Headache Clinic is committed to protecting the privacy of health information. We are required by law to maintain the privacy of your protected health information (PHI), provide you with this Notice of Privacy Practices (Notice) of our legal duties and privacy practices regarding your PHI, and follow the terms of the Notice currently in effect

This Notice tells you about the ways in which we may use and disclose health information about you. It also describes your rights and certain obligations we have regarding the use and disclosure of your health information. The privacy practices described in this Notice will be followed by all members of the workforce at Panhandle Primary Care / Amarillo Headache Clinic, including health care professionals, employees, trainees, students, and volunteers. Additionally, third parties ("business associates") that provide services on our behalf will be required to comply with all applicable provisions.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

The following sections describe different ways we may use and disclose your health information. We abide by all applicable laws related to the protection of this information. Not every use or disclosure is listed. All of the ways we are permitted to use and disclose health information, however, will fall within one of the following categories:

TREATMENT

We may use and disclose your health information to provide, coordinate, or manage your healthcare and related services. This includes consultation with other healthcare providers regarding your treatment and referral to another provider. For example, your primary care physician may share your health information with a specialist to coordinate your care.

PAYMENT

We may use and disclose your health information to obtain payment for services we provide. This includes billing activities, claims management, and collection activities. For example, we may send claims to your health insurance company containing certain health information to obtain payment for services we provided.

HEALTHCARE OPERATIONS

We may use and disclose your health information for our healthcare operations, which include internal administration and planning and various activities that improve the quality and cost-effectiveness of care. For example, we may use health information to evaluate the performance of our staff, assess the quality of care, or conduct training programs.

SUBSTANCE ABUSE TREATMENT

We are required to protect the privacy and security of your substance use disorder patient records in accordance with 42 U.S.C. § 290dd–2 and 42 C.F.R. Part 2, the Confidentiality of Substance Use Disorder Patient Records ("Part 2"), in addition to HIPAA and applicable state law. In a civil, criminal, administrative, or legislative proceeding against an individual, we will not use or share information about your SUD treatment records unless a court order requires us to do so (after notice and an opportunity to be heard is provided to you, as provided in 42 CFR part 2) or you give us your written permission You may report suspected violations to the U.S. Attorney for the judicial district in which the violation occurs. Contact information for the U.S. Attorney office where we operate is below:

Ryan R. Raybould
500 S. Taylor St., Suite 300
(Amarillo National Plaza II)
Amarillo, TX 79101

Suspected violations by an opioid treatment program may be reported to the Substance Use and Mental Health Services Administration (SAMHSA), Opioid Treatment Program Compliance Office by phone at 204-276-2700 or online at OTP-extranet@opiod.samhsa.gov.

OTHER USES AND DISCLOSURES WE MAY MAKE WITHOUT YOUR AUTHORIZATION:

As Required by Law. We may disclose health information when required by federal, state, or local law.

- **Law Enforcement**. We may disclose health information to law enforcement officials for law enforcement purposes as permitted by law.
- **Coroners, Medical Examiners, and Funeral Directors**. We may disclose health information to coroners, medical examiners, and funeral directors to carry out their duties.
- **Organ and Tissue Donation.** We may disclose health information to organizations involved in the procurement, banking, or transplantation of organs, eyes, or tissue.
- **Research**. We may use or disclose health information for research purposes when an institutional review board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of your information.
- **To Avert a Serious Threat to Health or Safety.** We may use or disclose health information when necessary to prevent a serious threat to the health or safety of you, another person, or the public.
- Specialized Government Functions. We may disclose health information for military, national security, protective services, or correctional institution purposes as authorized by law.
- **Workers' Compensation**. We may disclose health information as authorized by workers' compensation laws.
  • Unless you say no, to anyone involved in your care or payment for your care, such as a friend, family member, or any individual you identify.

USES AND DISCLOSURES THAT REQUIRE YOUR WRITTEN AUTHORIZATION:

We will obtain your written authorization before using or disclosing your health information for purposes other than those described above. Specifically, we will obtain your authorization before using or disclosing:

- Psychotherapy notes (with limited exceptions)
- Health information for marketing purposes
- Health information in a manner that constitutes a sale of PHI

Additionally, with certain limited exceptions, we are not allowed to sell or receive anything of value in exchange for your health information without your written authorization. If you provide us with authorization to use or disclose your health information about you, you may revoke your authorization, in writing, at any time.

However, uses and disclosures made before the revocation of your authorization are not affected by your action and we cannot take back any disclosures we may have already made with your authorization or that may have been made on reliance of your authorization.

USE OF UNSECURE ELECTRONIC COMMUNICATIONS

If you choose to communicate with us via unsecure electronic communications, such as regular email or text message, we may respond to you in the same manner in which the communication was received and to the same email address or account from which you sent your original communication.

In addition, if you provide your email address or cell phone number to a health care provider, we may send you emails or text messages related to appointment reminders, surveys, or other general informational communications. For your convenience, these messages may be sent unencrypted.

Before using or agreeing to use of any unsecure electronic communication to communicate with us, note that there are certain risks, such as interception by others, misaddressed/misdirected messages, shared accounts, messages forwarded to others, or messages stored on unsecured, portable electronic devices.

By choosing to correspond with us via unsecure electronic communication, you are acknowledging and agreeing to accept these risks. Additionally, you should understand that the use of email or other electronic communications is not intended to be a substitute for professional medical advice, diagnosis, or treatment.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

You have the following rights regarding the health information we maintain about you:

RIGHT TO INSPECT AND COPY You have the right to inspect and obtain a copy of your health information that may be used to make decisions about your care, including medical and billing records. To inspect or copy your health information, submit a written request to our Privacy Officer. We may charge a reasonable fee for copying and mailing costs.

RIGHT TO AMEND If you believe that information in your record is incorrect or incomplete, you may request that we amend it. To request an amendment, submit a written request to our Privacy Officer that includes the reason for your request. We may deny your request in certain circumstances, and if we do, we will provide you with a written explanation.

RIGHT TO AN ACCOUNTING OF DISCLOSURES You have the right to receive a list of certain disclosures we have made of your health information. To request an account, submit a written request to our Privacy Officer specifying the time period for which you want the accounting (not to exceed six years). The first accounting in a 12-month period will be provided free of charge; subsequent requests may incur a reasonable fee.

RIGHT TO REQUEST RESTRICTIONS You have the right to request restrictions on how we use or disclose your health information for treatment, payment, or healthcare operations, or to restrict disclosures to family members or others involved in your care. We are not required to agree to your request except in one situation: if you pay for a service or item out of pocket in full, you can ask us not to share information about that service or item with your health insurer for payment or healthcare operations purposes, and we will honor that request.

RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS You have the right to request that we communicate with you about health matters in a certain way or at a certain location. To request confidential communications, submit a written request to our Privacy Officer specifying how or where you wish to be contacted. We will accommodate reasonable requests.

RIGHT TO A PAPER COPY OF THIS NOTICE You have the right to a paper copy of this Notice of Privacy Practices at any time. We have copies available at the front desk or you may also obtain a copy of this Notice by visiting panhandleprimarycare.com / headacheclinicamarillo.com or by contacting our Privacy Officer at the address provided at the end of this Notice.

RIGHT TO BE NOTIFIED OF A BREACH You have the right to be notified in the event that we discover a breach of your unsecured health information. Right to a Paper Copy of this Notice.

CHANGES TO THE TERMS OF THIS NOTICE We can change the terms of this Notice, and the changes will apply to all information we have about you. The new Notice will be available upon request, in our facility, and on our web site.

COMPLAINTS

If you have any questions about this Notice or our privacy practices, or if you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, contact our Privacy Officer at the address and phone number below. You will not be retaliated against for filing a complaint. you wish to exercise your HIPAA rights or make a complaint, please contact our Privacy Officer.

CONTACT INFORMATION

Cindy Hutson DO PA
Attn: Ashley Belter
2703 Mockingbird Lane
Amarillo TX 79109
806-351-2000
ashleybelter@panhandleprimarycare.com

TO FILE A COMPLAINT WITH HHS

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201
1-877-696-6775
www.hhs.gov/ocr/privacy/hipaa/complaints/

AMARILLO
HEADACHE CLINIC

2703 MOCKINGBIRD LANE
AMARILLO, TX 79109
Phone (806)351-2000
Fax (806) 351-2060

We ask that you provide us with a 24-hour notice of cancellation / rescheduling of any appointments. Any appointments not cancelled / rescheduled within that time period will be subject to a fee of $45.00. This will include cancelled / rescheduled appointments the day of and all no-show / late arrival appointments

Cancellations can be made by:

- **Phone – 806.351.2000 (please leave if message if not during office hours)**
- **Patient Portal (Healow) Message**
- **Email – danaratliff@panhandleprimarycare.com**

ANY QUESTIONS ABOUT CHARGES CAN BE DIRECTED TO
ashleybelter@panhandleprimarycare.com

We understand everyone's schedule is hectic and that changes can arise quickly and unexpectedly. We value your time and will do our best to accommodate your scheduling needs. We appreciate you being considerate of our time and providing advanced notice if you are unable to keep your scheduled appointment so we may accommodate other patients.

_____ _____

Signature of Patient or Legal Guardian Date

AMARILLO
HEADACHE CLINIC

PATIENT CONTRACT

We here at Amarillo Headache Clinic are making a commitment to work with you in your efforts to dial down your headache burden and improve your quality of life. To help you in this work, we agree that:

- We will help you schedule regular appointments for medicine refills. If we have to cancel or change your appointment for any reason, we will make sure you have enough medication to last until your next appointment.
- We will make sure that this treatment is as safe as possible. We will check regularly to make sure you are not having bad side effects and your medication is not interacting with any other medication you take.
- We will help connect you with other forms of treatment to help you with your condition, such as physical therapy, chiropractic, massage, etc.
- We will work with your medical insurance providers to make sure you do not go without medicine because of paperwork or other things they may ask for.

In return, we ask that you:

- DO NOT seek out treatment for headache management, with the exception emergency/abortive treatment, that is different than the treatment plan the Amarillo Headache Clinic has prescribed. Chronic conditions such as migraines or other headache types can be difficult to manage but they can become more difficult if many providers are prescribing medications for the same condition.
- Communicate with us. We are here to be on your team and to help you. Communication is very important when treating chronic conditions.
- We want to minimize any medication interactions and maximize the benefits of treatments. Also, if we must get treatments approved through insurance, it is important to know all the treatments, dates, doses, etc.
- Let us know if you have to go to the ER/clinic after hours; If you have to do so often, your treatment regimen probably needs to be changed.
- If you choose to change your treatment regimen and go with another headache provider, please let us know and our prescribing of any medications will terminate on that date.

If you come to us after being treated by another provider for headaches, we will ask if you want to continue with Amarillo Headache Clinic or your previous provider. We do NOT believe in most cases it is a good idea for 2 providers to be treated with the same condition, especially if there is no communication (not the same EMR, etc.). In some cases, we are happy to continue to treat if you are seen by a subspecialist (example if you see someone at the Mayo Clinic once a year or if you see a provider in Houston once a year and those providers are aware you are seen in our clinic and are willing to communicate with us).

By signing this form, I agree to continued treatment at the Amarillo Headache Clinic and agree to notify them if that should change. I understand that by going to other clinics for headache treatment, I will no longer be seen at Amarillo Headache Clinic. I understand this is so that the best treatment may be provided to me.

_____ _____

Patient signature Date