Texas Health Heart & Vascular Hospital℠ ARLINGTON

DISCLOSURE OF PHYSICIAN OWNERSHIP

NOTICE TO PATIENTS

Please carefully review the information contained in this notice.

1. Dr. _____ is an owner of Texas Health Heart & Vascular Hospital Arlington.

2. You have the right to choose the provider of your health care services. Therefore, you have the option to use a health care facility other than Texas Health Heart & Vascular Hospital Arlington.

3. You will not be treated differently by your physician if you choose to obtain health care service at a facility other than Texas Health Heart & Vascular Hospital Arlington.

If you have any questions concerning this notice, please feel free to ask your physician or any representative of Texas Health Heart & Vascular Hospital Arlington.

By signing this Disclosure of Physician Ownership, your acknowledge that you have had a sufficient time to read and consider the information presented on this form, and you understand the foregoing notice and hereby understand that your physician has an ownership interest in Texas Health Heart & Vascular Hospital Arlington.

_____ Signature of Patient

_____ Signature of Parent or Guardian (if applicable)

_____ Print name of Patient

_____ Print name of Parent or Guardian

Dated: _____

Patient Name: _____ Date of Birth: _____ Today's Date: _____