

PRIME RHEUMATOLOGY CLINIC OF HOUSTON PLLC

Dr. Gwendoline Menga Phone: (832) 821-5550 Fax: (936) 207-4109

> 17191 St Luke's Way Suite 220 The Woodlands TX 77384

DISCLOSURE OF PHYSICIAN OWNERSHIP INTEREST NOTICE TO PATIENTS

Please carefully review this notice.

In order to allow you to make a fully-informed decision about your health care, the physicians of Prime Rheumatology Clinic of Houston would like to inform you that at some point during the course of your treatment, the Practice may use certain labs, imaging and pharmacy services. The Practice wishes to advise you that Dr Gwendoline Menga have a direct ownership interest in:

RARx LP: 1911 Church Street -Suite 202. Nashville, TN 37203 Essential Imaging: 111 Vision Park Blvd. Ste 130, Shenandoah, TX 77384

Our physicians will make referrals to these services based upon the best interests of a patient's health and any other factors that a patient would like his or her physicians to consider, regardless of any ownership interest or compensation arrangement that a physician may have with a particular facility.

You, as the patient, have the right to choose the provider of your healthcare services and the laboratories, imaging, pharmacy, and other facilities where you receive services or treatment. You have the right to have your laboratory, imaging and pharmacy services provided by the companies listed above or to choose to have the services provided by an alternative companies. For information about alternative laboratories, please ask your physician or a member of our staff. If you choose another services, you will not be treated differently by any of the physicians affiliated with the Practice.

If you have any questions concerning this notice, please feel free to ask your physician or any member of our staff. We welcome you as a patient and value our relationship with you.

By signing below, you acknowledge that you have read and fully understand this notice.

Signature of Patient	Signature of Parent or Guardian (if applicable)
Typed or Printed Name of Patient	Typed or Printed Name of Parent or Guardian (if applicable)
Date	