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I understand that, in the opinion of Roger M. Traxel, M.D., the services or items that I have requested to be provided to me on the below dates, may not be covered under the Texas Medical Assistance Program as being resonable and medically necessary for my care. I understand that the Texas Department of Human Services or its health insuring agent determines the medical necessity of the services or items that I request and receive. I also understand that I am responsible for payment of the services or items I request and receive if these services or items are determined not to be reasonable and medically necessary for my care.

X _____
PATIENT OR GUARDIAN SIGNATURE DATE

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