

Patient's Name _____ Account Number _____
Last First MI

Financial Agreement/ Extension of Credit and Authorization for Treatment

I authorize treatment of the person named above and agree to pay all fees and charges for such treatment. I agree to pay all charges for person named above, shown by statement, promptly upon presentation thereof, unless credit arrangements are agreed upon.

In accordance with the Federal Truth-in-Lending Act, which requires us to give our patients information in connection with extension of credit, please be advised of the following policies that apply in this clinic. The responsible party agrees:

1. That if payments are extended beyond 90 days from the date of patient responsibility to pay, a \$3.00 per month billing fee on the unpaid balance will be assessed.
2. To pay cost and/or reasonable attorney fees if any delinquent balance is placed with an agency or attorney for collection or suit.

It is agreed that payments will not be delayed or withheld because of any insurance coverage or the pending of claims thereof, and all proceeds of insurance are assigned to this office where applicable, but without their assuming responsibility for the collection thereof. A copy of this assignment is as valid as the original.

SIGNATURE: _____ **DATE:** _____

DO YOU HAVE A LIVING WILL? YES _____ NO _____
DO YOU HAVE A DURABLE POWER OF ATTORNEY FOR HEALTH CARE? YES _____ NO _____

The existence or execution of a living will, durable power of attorney for health care or other written advance directive is not a condition of receiving health care services and may not otherwise be used to discriminate against an individual.

SIGNATURE _____ **DATE** _____

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. Cardiology Associates, PLLC uses electronic medical record systems and electronic billing systems to store and communicate information from our main office to our satellite facilities, insurance companies, and hospitals. Our computer systems use state-of-the-art security features, which make it extremely difficult for anyone to access confidential medical or financial information inappropriately. Nevertheless, you should be aware that these systems communicate over public utilities including telephone lines, private computer connections as well as the Internet in some instances. In addition to sophisticated computer security features, the staff of Cardiology Associates is specifically trained to protect the security and confidentiality of your records. While every precaution has been taken to protect the confidentiality of your information, we cannot be responsible for intentional break-ins or misuse of information by other parties once it leaves our control. Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed and how you can access you information.

I have read and understand the above information. I acknowledge receipt of the Notice of Privacy Practices.

SIGNATURE: _____ **DATE:** _____

MEDICARE PATIENTS ONLY – LIFETIME AUTHORIZATION

I request that payment of authorized Medicare benefits be made on my behalf to Cardiology Associates, PLLC, for any services furnished me by the listed provider. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents, any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

SIGNATURE: _____ **DATE:** _____