PERMISSION FOR TREATMENT

I, the undersigned, hereby voluntarily consent to medical care/diagnostic treatment and/or minor surgical treatment by West Florida Cardiology Consultants deemed advisable and necessary in the diagnosis and treatment of my condition. I am aware that the practice of medicine in not an exact science and I acknowledge that no guarantees have been made to me as a result of treatment or examination in the office. I authorize the release of any of my past/current medical records that are needed for my treatment from any prior healthcare providers.

Signature: _____ **Date:** _____

AUTHORIZATION AND ASSIGNMENT

I request that the payment of Authorized Medicare/Insurance Benefits be made either to me or on my behalf for any services furnished by West Florida Cardiology Consultants. I authorize any holder of medical information about me to release to CMS / Insurance Carriers and its agents any information needed to determine these benefits or benefits related to services.

I hereby authorize West Florida Cardiology Consultants to furnish information to Medicare / Insurance carriers/ any collections agency if necessary, concerning my medical condition, illness and treatment to determine the benefits for related services. I hereby authorize (assign) my Insurance Carrier(s)/Medicare to make payment direction to West Florida Cardiology Consultants for medical/diagnostic/surgical benefits payable for the services rendered. I understand that any unpaid balance not covered by this policy will be payable to me. I understand and agree (regardless of my insurance status) that I am ultimately responsible for the balance of any professional services rendered. I understand that I am responsible for any charges incurred if my account is sent to a collection agency and for any returned checks. I understand that Medicare and/or other insurance carriers do not cover all office services/procedures. **I agree to take full responsibility for any unpaid balances and that such payment will be made to this physician's office for services rendered.** I certify that the information I have given here is true and correct to the best of my knowledge. I will also notify you of any changes in my status or changes in the above information.

Signature: _____ **Date:** _____

DESIGNATED RELATIVE

I Authorize Discussion of My General Medical Condition and Diagnosis (including treatment, payment and health care operations) with:

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

Messages May Be Left on My Answering Machine Regarding My Health & Appointments Made: ☐Yes ☐No

If you are unable to object or agree to disclosure of protected health information, we may disclose such information as necessary if we determine that it is in your best interest based on our professional opinion.

Signature: _____ **Date:** _____

HIPAA PRIVACY NOTICE

I have received a copy of West Florida Cardiology Consultants Privacy Notice.

Signature: _____ **Date:** _____

- I consent for West Florida Cardiology Consultants to obtain my personal prescription history from other physicians.

Pt. Signature: _____ **Date:** _____