CARY CARDIOLOGY, P.A.

CONSENT FOR TREATMENT
ASSIGNMENT OF INSURANCE BENEFITS AND GUARANTEE OF PAYMENT
ACKNOWLEDGEMENT OF RECEIPT OF PATIENT PRIVACY NOTICE

By signing this form, I consent to treatment and care by the physicians and healthcare providers of Cary Cardiology, PA. I understand treatment services may include but are not limited to: Lab Tests, Screening Tests, Diagnostic Tests, and Routine Exams. I understand that no promises have been made to me about the results of any treatment or services. I further understand that in order to ensure proper care, Cary Cardiology, PA may require certain periodic lab testing or follow ups prior to certain medication refills. I understand it is important to be an active participant in my healthcare.

I also authorize Cary Cardiology to release any information acquired in the course of my examination or treatment to specific insurance carriers, third party payers, or others involved in processing and collection of payment for services in accordance with the HIPAA Patient Confidentiality Act of 1996.

I understand that I am financially responsible for, agree to pay, and guarantee payment for any and all services rendered by Cary Cardiology, PA physicians and healthcare professionals involved in providing my treatment or consultation, even if such treatment is not covered by insurance. I understand that my bill will be sent to the address I have provided unless I complete a request for my bill to be sent to an alternate address.

I authorize payment of any refund due for overpaid insurance benefits to be paid to the appropriate payor in accordance with my insurance policy conditions or any applicable benefit provisions where my coverages are subject to a coordination of benefits clause. If any refund is now or in the future due to me, I authorize the immediate application of any such refund to any amount that I am personally legally obligated to pay for care and services provided by Cary Cardiology, PA. I understand that any remaining credit due after payment of these outstanding amounts will be refunded to me.

If your account becomes past due, we will take the necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all the collection costs including a collections fee that may be added to the account. If we have to refer collection of the balance to a lawyer, you agree to pay all the lawyers' fees that we incur, plus all the court costs. If we need to send the account balance to collections because of non-payment of the account, our physicians may no longer be able to provide care. In this case, the person responsible for the account will be notified of this by certified mail and given adequate time to find a new medical provider. All accounts sent to a collection agency will be reported to the Credit Bureau and may be subject to a collection fee of $50.

By signing below, I am indicating that I understand and agree to the above releases, authorizations, and assignments of benefits.

Patient/Representative Signature: _____ **Date:** _____

Witness: _____

Acknowledgment of receipt of Cary Cardiology Privacy Practices. If I am a first time patient, I have a received a copy of the Cary Cardiology Privacy Practices. If I am a returning patient, I certify that I have been offered a copy of the Cary Cardiology Privacy Practices.

Patient/Representative Signature: _____ **Date:** _____

Witness: _____

Office Use:

☐ Patient unable to sign due to condition and/or level of consciousness
☐ Patient refused to sign after receiving Privacy Notice
☐ Other: _____

Place sticker here

Completed by: _____ Date: _____ Time: _____

(Rev 08.04.2022)