

COLUMBIA CARDIOLOGY, LLC

In consideration of the care and treatment to be provided to the patient whose name appears at the bottom of this page at Columbia Cardiology, LLC, I, the undersigned, consent and agree to the following conditions.

CONSENT FOR TREATMENT

I voluntarily consent to healthcare treatment and diagnostic procedures by Columbia Cardiology, LLC and its associated physicians, clinicians, and other personnel. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made as to the result of treatments or examinations.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I consent to the use and disclosure of my protected health information for purposes of obtaining payment for services rendered to me, treatment and health care operations consistent with the Columbia Cardiology, LLC Notice of Privacy Practices.

ASSIGNMENT OF BENEFITS AND PAYMENT

I guarantee payment of all charges made for or on account of me. Unless my account is paid in full upon discharge, I hereby assign the following to the physician and Columbia Cardiology, LLC: (1) my rights to any and all insurance benefits I have or to which I may become entitled; (2) the proceeds of all claims resulting from or relating to the liability of or payment made by a third party or by any person, employer or insurance company on the third party's behalf to or for the patient; (3) other funding. I understand that I am responsible for any charges not covered by the insurance company or other forms of benefits. I understand Columbia Cardiology, LLC can obtain my credit report for review in collection of this debt.

For Medicare Beneficiaries: I have provided all necessary information for proper assignment of Medicare benefits.

PATIENT FINANCIAL POLICY

It is the goal of Columbia Cardiology, LLC to provide the best care on your behalf. Therefore, it is important for you to fully understand our insurance and collection policies. Please read the following information carefully and feel free to ask any questions.

Upon registration, a copy of your insurance card(s) will be required for verification of insurance coverage and benefits. **If you have been referred to this office by your primary care physician and belong to an insurance company that requires pre-certification or referral for this office visit, we request that you have this information available before you visit the physician. Failure to supply this information may postpone your visit to Columbia Cardiology, LLC or make you responsible for the full balance of your account.**

Your health insurance is an agreement between you and your insurance carrier to pay for medical care. Your doctor's bill is an agreement between you and this office. **You are ultimately responsible for the payment of your bill regardless of the status of your insurance claim.** We will file all claims for those patients who are covered by insurance companies that our office has contracted with to provide services within their fee schedule. The contracts are subject to change with or without notice. All co-pays are due at the time of service. If your insurance has a deductible, you will be required to pay any/all charges allowed by your insurance at the time of the service. If you have your Explanation of Benefits (EOB) from your insurance company (must be current year) that demonstrates that the deductible has been met, you will only be required to pay the percentage allowed by your particular insurance. You will receive regular statements, as a courtesy, every 30 days from our office informing you of the status of your balance. Please feel free to call our office, if you should have any questions. If we have not received any payment after 90 days from the date of service, we reserve the right to refer your account balance to our Patient Financial Services department where you will be responsible for all collection and legal fees. There will be a \$25.00 fee for all checks presented for payment with non-sufficient funds (bad checks). You will also be billed separately for the hospital or other sources, if it applies, for certain lab fees, radiology fees and/or outpatients or inpatient procedures and medical supplies.

NOTICE OF PRIVACY PRACTICES

I acknowledge receipt of Columbia Cardiology Notice of Privacy Practices.

_____ If not, why? _____
Initials

PRINT NAME OF PATIENT

DATE

SIGNATURE OF PATIENT

or

PERSONAL REPRESENTATIVE

(Circle one: Parent, Legal Guardian, Legal Authorized Representative)

Verification of Personal Representative by: _____

WITNESS (Columbia Cardiology Employee)