H E A R T M A S T E R S M E D I C A L A S S O C I A T E S P C

RELEASE OF INFORMATION

Instructions: Please read this form carefully, initial all applicable spaces, and sign.

Insurance Authorization-Patient Release Authorization

_____ I hereby give authorization for payment of insurance benefits made directly to ***Heart Masters Medical Associates***, and any assisting physician, for all services rendered, now and in the future. I understand that I am financially responsible for all charges whether or not they are covered by my insurance. In the event of default, I agree to pay all cost of collection and reasonable attorney fees. I further agree that a photocopy of this agreement shall be as valid as the original. I acknowledge that if my insurance requires a referral and I do not furnish one at the time of my appointment/s, I will be responsible for payment.

_____ I further authorize the release of any medical information required by my insurance carrier(s), for payment of claims.

Medicare Authorization-Patient Release and Authorization

_____ I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct.

_____ I authorize any holder of medical or other information about me, to release to the Social Security Administration or it's intermediaries or carriers, any information to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

Notice: Anyone who misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine and imprisonment under Federal Law.

Notice of Privacy Practices and other important information

_____ I received a copy of the Patient Rights and Responsibilities, the procedure for filing a grievance, and Patient Health Information (PHI) for confidentiality.

_____

Patient's Name (Printed)

_____ _____

Authorized Signature **Date**

CONSENT FOR TREATMENT

I hereby authorize Heart Masters Medical Associates to perform the treatments or procedures approved by my referring physician, or by Dr. Dawson upon examination.

I acknowledge that no guarantees, either expressed or implied, have been made to me regarding the outcome of any treatments and/or procedures. I fully understand that it is impossible to make any guarantees regarding the outcome of any medical treatment or procedure.

_____ _____ _____

Patient's Name (Printed) **Authorized Signature** **Date**