CONSENT FOR TREATMENT

PATIENT:_____ DATE: _____/_____/_____TIME: _____

1. CONSENT FOR MEDICAL AND SURGICAL TREATMENT: I authorize Cardiology Associates (CA) to furnish the necessary medical or surgical treatments or procedures, including diagnostic, x-ray and laboratory procedures, anesthesia, hospital services, drugs and supplies as may be ordered by the attending physician(s) , his assistants or his designees. I am aware the practice of medicine and surgery is not an exact science and I acknowledge no guarantees have been made to me as to the result of treatment, diagnostic procedures or examinations by CA. I recognize the physicians who practice at CA are not employees or agents of the CA but are independent physicians. CA may delegate to these independent physicians those services physicians normally provide and any questions relating to care that my physician has given or ordered should be directed to him/her.

2. STATEMENT OF FINANCIAL RESPONSIBILITY: I agree to pay CA for any and all charges for services rendered. All CA accounts are due at the time of service. However, I understand CA may accept assignment of insurance benefits in lieu of an equal amount of payment at time of service.

I further understand that CA will attempt to collect the assigned insurance benefits. However, the full amount due will still be my responsibility. I realize that CA may take whatever steps necessary to collect the balance due, including use of a collection agency. I agree to pay all collection costs including attorney fees and fees on appeal.

3. ASSIGNMENT OF INSURANCE BENEFITS: In consideration of CA services to be received, I assign to CA the amount due to me or that becomes due to me under the policies mentioned on the reverse side of this form. I authorize and direct payments to be made directly to CA. In the event payment is received by CA from any other source for CA services, I authorize application of the proceeds received to any other CA bill of mine or any member of my family for whose hospital bill I would be legally responsible, subject to the rules of coordination of benefits, if applicable. I also recognize that if payment is made directly to me by the insurance company, the amount received up to the amount of the CA bill for patient services received is the property of CA and should be paid to CA immediately. I understand I am personally liable to CA for charges not paid by this assignment. I also assign all rights to payment due me for medical and/or surgical services under said policies to the radiologist, pathologist, anesthesiologist, cardiologist, neurologist, speech pathologist, an audiologist involved with my care. I authorize payment directly to the above physicians and practitioners for charges not covered under this authorization.

4. AUTHORIZATION FOR RELEASE OF INFORMATION: I authorize CA to release any information, including information regarding diagnosis and treatment requested by the insurance company, necessary to collect benefits under the policies stated at the time of admission, or any policies that I subsequently make claim against for hospital services, including related physicians services on this or a related date of service. This authorization includes, but is not limited to, the release of information relating to drug, alcohol and/or psychiatric treatment. I further authorize any physician or institution that attended this patient previously to furnish medical records or information that may be requested by CA or attending physician.

THIS FORM HAS BEEN FULLY EXPLAINED TO ME AND I ACKNOWLEDGE THAT I UNDERSTAND ITS CONTENTS.

Signature_____ _____

Patient, next of kin or legal guardian — Relationship to patient

_____ _____

Witness — Date

LIFETIME ASSIGNMENT OF MEDICARE BENEFITS:

1. ACKNOWLEDGMENT OF MEDICARE: I certify I am a participant in the Medicare Program and I am not enrolled in a health maintenance organization (HMO), or any other prepaid group practice. I understand if it is found I am a participant in any of the above mentioned practices, I will be considered a self-pay patient and required to pay in full immediately.

2. PATIENT CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST: I certify 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 its intermediaries of Professional Review Organization, any information needed for this or a related Medicare claim. I request payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me. I understand I am responsible for any deductible and co-insurance amounts and any personal charges incurred. I permit a copy of this authorization to be used in place of the original and I request payment of authorized benefits be made on my behalf.

Signature_____ _____

Patient, next of kin or legal guardian — Relationship to patient

_____ _____

Witness — Date

If this account should go to collection, patient will be responsible for all reasonable collection fees, court costs and/or attorney fees.

Name of Beneficiary _____

Health Insurance Claim Number _____

Medigap Policy Number _____

*I request that payment of authorized Medigap benefits be made on my behalf to Cardiology Associates for any services furnished me by Cardiology Associates . I authorize any holder of medical information about me to release to Cardiology Associates any information needed to determine these benefits or the benefits payable for related services. I understand that I do not need to provide my supplemental insurer with information concerning this medicare claim, because my signing this authorization will cause Medicare payment information to cross over automatically.*_____