



HIPAA Notice / Consent Form

Authorization for Treatment: The person named below (hereinafter called "Patient"). Consents that the Heart Center, a division of Hudson Valley Cardiovascular Practice, P.C. (hereinafter called the "Group"), its health care providers, clinical and technical employees and consulting physicians or any assistants, whom they may call to their aid, may administer any treatment deemed advisable in the care and treatment of the patient. Patient also consents to all procedures, that whether for diagnosis or treatment prior to or during the procedure may be deemed advisable in their care and treatment. Patient further understands that no guarantee of assurance has been made as to the results that may be obtained.

Assignment of Benefits: The patient and/or insured requests that payment of any existing insurance benefits is made on their behalf to all providers of service during this encounter. The patient understands that it is necessary for the Group to release certain medical information in order to receive payment of its debt from the third party insurers or governmental "providers".

Terms of Financial Agreement: The patient agrees to pay all charges made by the Group or other service providers for services rendered to the patient. Any portion of the bill not covered by insurance or other benefit is due in full at the time of services unless prior arrangements have been made. Patient understands that insurance is a contract between the subscriber and the insurance company and that the Group will bill the insurance carrier as a courtesy to the patient. All required authorizations, pre-certifications, and/or referral forms are the responsibility of the patient.

HIPAA Acknowledgement / Consent Notice Written Authorization:

I acknowledge receipt of The Heart Center, a division of Hudson Valley Cardiovascular Practice, P.C. Notice of Privacy Practices. I give consent to The Heart Center, a division of Hudson Valley Cardiovascular Practice, P.C. to obtain or disclose my protected health information for the purpose of treatment, payment or health care operations. I give my consent to The Heart Center to leave messages about my appointments or test results at my home on my answer machine or with another party as designated by myself. Should I choose to change my authorization I will contact The Heart Center by writing.

Patient Signature: _____ Date: _____

Print Name: _____

Designated Party Signature: _____ Date: _____

Print Name: _____