Cardio-Thoracic & Vascular Surgical Associates, P.C.
Patient Consent Form

Please Read and Sign

Consent for Services

The undersigned consents for Cardio-Thoracic & Vascular Associates, P.C. and its authorized representatives to provide appropriate medical services including diagnostic and therapeutic procedures, administration of medicines, and other treatment considered advisable or necessary for the patient's care.

Financial Obligation

The undersigned in consideration for services to be provided, agrees to pay all remaining charges, deductibles, and/or co-insurance amounts determined not allowable by health insurance payors. It is customary to pay for services when rendered unless other arrangements have been made. The undersigned agrees to make payments according to the physicians' terms.

Assignment of Benefits

The undersigned authorizes Cardio-Thoracic & Vascular Associates, P.C. to furnish information to the insurance carriers concerning patient's illness and treatment. The undersigned, also assigns benefits to Cardio-Thoracic & Vascular Associates, P.C.

With H.M.O. coverage, The Undersigned understands the patients' responsibility to satisfy H.M.O. requirements before service is rendered and that services not authorized may become the responsibility of The UNDERSIGNED.

Release of Information and Disclosures Necessary to Support Treatment and Payment Operations

The Undersigned authorizes the release of the following data by mail, facsimile, electronic transmission, etc.

- Patient medical information to any pertinent party, in addition to any insurance companies for the processing of claims
- Medical information to other healthcare providers for treatment purposes
- Other disclosures necessary to support practice treatment and payment operations
- Consent to obtain prescription information from patient's pharmacy

I acknowledge that this release is valid until revoked by me and that photocopies may be used in lieu of the original.

I authorize the following persons to have access to my medical information and treatment:

Spouse: _____

Family: _____

Family: _____

Other: _____

Please check one:

☐ I consent to notification of tests, appointments by telephone, answering device or mail at my home address or phone number.

☐ I consent to notification of tests, appointments by telephone, answering device or mail at the alternative address and phone number listed below:

_____

_____

_____

☐ I do not consent to notification by telephone, answering device or mail.

I acknowledge that I have read this form and understand its purpose and content.

_____	_____	_____
Signature of Patient or Patient's Representative	Date	Relationship to Patient