I authorize my medications to be electronically downloaded to The Heart Center Cardiology, PC.

Patient or Responsible Party Signature: _____ Date: _____

RELEASE OF INFORMATION: I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment to the medical benefits to The Heart Center Cardiology, PC.

Patient or Responsible Party Signature: _____ Date: _____

PERSONAL HEALTH INFORMATION:I understand that The Heart Center Cardiology, PC will access my records directly from East Alabama Medical Center. I authorize The Heart Center Cardiology, PC to discuss any aspect of my care with the following designated people:

Name	Relationship	Contact Number

Patient or Responsible Party Signature: _____ Date: _____

PRIVACY NOTICE: Please sign below stating you are in receipt of The Heart Center Cardiology, PC privacy notice. The privacy notice is displayed in our lobby area. If you would like a printed copy, please see the front desk.

I, Hereby Acknowledge the receipt of this Privacy Notice.

Patient or Responsible Party Signature: _____ Date: _____

PAYMENT POLICY: Payment for all services will be due at the time services are rendered. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf; however, **YOU are ultimately responsible for the entire bill**. Please be aware of the following:

- **ALL charges are YOUR responsibility regardless if your insurance company pays or not.**
- **Insurance referrals are YOUR responsibility to obtain prior to your appointment. If it is not obtained, you will be responsible for ALL charges.**
- Your insurance is a contract between YOU and YOUR insurance company. We will not become involved in any disputes you have with YOUR insurance company. As your medical provider, we supply only factual information to facilitate claim processing.
- Fees for service such as unpaid balances, deductibles, and co-pays are due at time of service.
- ALL return checks AND unpaid balances WILL be subject to collection placement and fees.
- If you do not cancel your appointment 24 hours before-a $25 no show fee will be charged to you.
- We encourage you to communicate any financial problems that may affect your timely payment to us so that we may assist you in keeping your account in good standing.

I agree and understand The Heart Center Cardiology, PC payment policy. I also agree and understand that if I fail to make any of the payments for which I am responsible in a timely manner, after such default and upon referral to a collection agency or attorney by The Heart Center Cardiology, PC, I will be responsible for all costs of collecting monies owed, including collection agency fees.

Patient or Responsible Party Signature: _____ Date: _____

Assignment of Benefits: I/We, the undersigned authorized benefits from Medicare, Medicaid and all Commercial insurance companies be made on my behalf to The Heart Center Cardiology, PC for any services furnished to me.

Patient or Responsible Party Signature _____ Date: _____