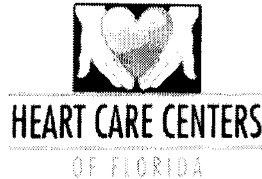

General Consent to Treat/Patient Authorization/

Acknowledgement of Benefits Release

The following are the conditions for services provided by Heart Care Centers of Florida for the patient whose name appears at the bottom of this page.

Consent for Medical Treatment

I/we voluntarily consent to medical treatment and diagnostic procedures provided by Heart Care Centers of Florida and its associated physicians, clinicians and other personnel. I/we consent to the testing for infectious diseases, such as, but not limited to Syphilis, AIDS, Hepatitis and testing for drugs if deemed advisable by my physician. I/we am/are aware that the practice of medicine and surgery is not an exact science and I/we acknowledge that no guarantees have been made as to the result of treatments or examinations.

Authorization for Release of Information

The practice and physicians are authorized to release any medical information required in the processing of applications or submission of information for financial coverage, discharge planning and further medical treatment, to disclose to my employer (if seen for work related exam or injury) insurance and/or any third party payer all medical information, test results and findings made during the course of this examination and/or treatment. To include information referring to psychiatric care, sexual assault or tests for infectious diseases including AIDS/HIV for services provided during this visit. I/we also agree to the release of medical or other information about me to government federal or state regulatory agencies as required by law.

Assignment of Insurance Benefits

I/we guarantee payment of all charges made for or on account of the patient and I/we assign our rights in any insurance benefits or other funding to the physician and Heart Care Centers of Florida. I/we understand that I/we am/are responsible for any charges not covered by insurance or other forms of benefits. I/we understand that Heart Care Centers of Florida can obtain my/our credit report for review in collection of this debt. In the event that this account is placed with a collection agency or attorney for collection or collected, I/we shall pay all

collections fees and cost, including reasonable attorney's fees for Medicare beneficiaries. I/we have provided all necessary information for proper assignment of Medicare benefits.

Acknowledgement of Receipt of Notice of Privacy Practices

I/we have received a copy of the Notice of Privacy Practices. The notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the Notice maybe changed at any time.

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Patient Signature/Parent/Legal Guardian **Date**

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Witness Signature **Date**