Sunnyvale Cardiology

PATIENT NAME:

_____

DATE OF BIRTH: _____ SOCIAL SECURITY #: _____

ADDRESS: _____

CITY, STATE, ZIP: _____

HOME PHONE #: _____CELL/WORK PHONE #: _____

EMAIL ADDRESS: _____

EMERGENCY CONTACT: _____

RELATIONSHIP: _____

EMERGENCY CONTACT PHONE NUMBER:

_____

PRIMARY CARE PHYSICIAN NAME AND NUMBER:

_____

PHARMACY NAME AND NUMBER:

_____

INSURANCE COMPANY:

_____

PATIENT SIGNATURE: _____ DATE: _____

Sunnyvale Cardiology

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

PATIENTS NAME: _____

DATE OF BIRTH: _____SOCIAL SECURITY #: _____

I AUTHORIZE AND REQUEST: _____

PHONE NUMBER: _____ FAX NUMBER: _____

TO RELEASE MY PROTECTED HEALTHCARE INFORMATION TO:

SUNNYVALE CARDIOLOGY

182 S. COLLINS ROAD SUITE 800

SUNNYVALE, TEXAS 75182

PHONE NUMBER: 214-206-3695 / FAX NUMBER: 866-313-9413

THIS AUTHORIZATION AND REQUEST APPLIES TO HEALTHCARE INFORMATION RELATING TO THE FOLLOWING TREATMENT, CONDITION, OR DATES:

PATIENT SIGNATURE: _____ DATE: _____

Sunnyvale Cardiology

FINANCIAL RESPONSIBILITY

I _____, understand Sunnyvale Cardiology accepts my Insurance Plan and the assignment of benefits as a courtesy to their patients. I further understand that I (not the insurance company) have primary responsibility for the full payment of services rendered. **There will be a $40 MISSED APPOINTMENT FEE and a $250 LATE CANCELLATION/ MISSED APPOINTMENT FEE FOR ALL SCHEDULED NUCLEAR TESTING**. We do require you to give our office a 24/48-hour notice if you are not able to make your scheduled appointment. By signing or not signing this document and having services rendered, I fully accept and agree to meet my financial obligations to your office for all denied Insurance claims and services rendered by Sunnyvale Cardiology.

_____ _____

Patient (Responsible Party) Date

Sunnyvale Cardiology

HIPAA Privacy and Release of Information Authorization

I _____ **hereby authorize Sunnyvale Cardiology and its affiliates, its employees and agents, to use and disclose protected health information** (e.g., information relating to the diagnosis, treatment, claims payment and health care services provided or to be provided to me and which identifies my name, address, social security number, Member ID number) **for the purpose of helping me to resolve Insurance claims and health benefit coverage issues.**

I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws. I understand that I have a right to revoke this authorization by providing written notice. However, this authorization may not be revoked if, its employees or agents have acted on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization. I have been advised of this practices Release of Billing Information policy, Assignment of Benefits Policy and grant the practice Medication History Authority.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for a coverage of services.

If applicable, Legal Representatives sign below

By signing this form, I represent that I am the legal representative of the above-named patient and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Patients behalf with respect to this authorization.

_____ _____

Patient / Legal Representative Printed Name Date

_____

Patient / Legal Representative Signature

Sunnyvale Cardiology

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

I authorize Sunnyvale Cardiology to use or disclose my health information to the recipient(s) that I have identified below.

Name: _____ Relationship: _____
Phone#: _____

Name: _____ Relationship: _____
Phone#: _____

Name: _____ Relationship: _____
Phone#: _____

Information to be disclosed: I authorize the release of the following health information

____ All of my health information, including information relating to any medical history, mental or physical condition and any treatment received by Sunnyvale Cardiology.

____ Only the following records or health information may be released:

_____

I understand that at any time I have the right to revoke this authorization by providing written notice directly to Sunnyvale Cardiology.

_____ _____

Patient Signature Date