

PRINCE WILLIAM CARDIOLOGY ASSOCIATES

Privacy Practices Acknowledgement

We put our hearts into treating yours!

I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can be used to:

- conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in my treatment, directly and indirectly
- obtain payment from insurance companies
- conduct normal healthcare operations such as quality assessments

I acknowledge that I have had the opportunity to read the Notice of Privacy Practices of Prince William Cardiology Associates and have had the opportunity to ask questions about the information provided in the notice and that I may request a paper copy of the Notice. I understand that I may request in writing that you restrict how my private health information is used or disclosed. I further understand that you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

I consent to treatment by PRINCE WILLIAM CARDIOLOGY ASSOCIATES and to use and disclosure of my protected health information.

X _____
Signature of patient or patient's representative

Date

Printed name of patient or patient's representative

Relationship

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of the Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: _____ Initials: _____ Reason: _____

Insurance Assignment of Benefits Authorization

I hereby authorize Prince William Cardiology Associates (PWCA) to apply for benefits on my behalf for covered services rendered. I hereby authorize payment of medical insurance benefits to be paid directly to PWCA for services rendered. A copy of this authorization may be used in place of the original. I understand and agree that I am financially responsible for charges not paid by my insurance company. This authorization may be revoked by either me or my insurance carrier at any time in writing.

X _____
Signature of patient/parent/legal guardian

Date

I understand that if in the event my account becomes past due and all attempts to arrange payment have failed, it will be turned over for collection to another party. I understand that I will be responsible for all applicable collection or attorney's fees and any other costs expended to collect. I also understand if in the event my check is returned for insufficient funds, I will be charged a fee of \$35.00.

I also understand and agree that I can be charged \$35.00 for any missed appointments without giving 24 hours notice. I understand that I can be charged \$75.00 for missed nuclear stress testing appointments without giving 24 hours notice.

X _____
Signature of patient/parent/legal guardian

Date