UNIVERSITY CARDIOLOGY

One Time Authorization Form

Patient's Name_____ **Date** _____
(Please Print)

Assumption of Responsibility: I agree that in consideration of services to be rendered, I obligate myself, assume financial responsibility and agree to pay upon demand to above named PROVIDER all charges for such services and incidentals incurred. Should the account be referred to an attorney for collection, I shall pay reasonable attorney fees and collection expenses. Even though insurance may be filed, I understand that all bills are payable upon receipt and that I and not the insurance company, am responsible for the payment of all services.

Initial: _____

Responsibility for Co-pay Amounts: I agree to be fully responsible for paying co-pays of set amounts at the time of physicians visit. Further, I understand that if my co-pay is a percentage, I will be responsible for payment immediately after insurance benefits have paid. This meaning that any bill received once insurance is paid, will be due upon receipt.

Initial: _____

Assumption of Referrals: I understand that if I have insurance coverage, which requires a referral from a Primary Care Physician, it must be received in order to receive the maximum benefits from the insurance company. I further understand that it is my responsibility to obtain a hardcopy referral from my Primary Care Physician. I will be given the opportunity by the above said provider to obtain a referral or reschedule my appointment. I understand that if I refuse that I am taking full responsibility for payment.

Initial: _____

Assignment of Insurance Benefits: I hereby assign direct payment of any hospital insurance benefits, medical insurance benefits including Medicare, Medigap, major medical benefits, insurance disability benefits, or injury benefits payable because of liability of a third party or organization, and so forth, payable to or for the above said patient until account is paid in full.

Signature:_____ **Date:**_____

Acknowledgement of Receipt of Privacy Notice: I acknowledge receiving today a copy of the PROVIDER'S notice of privacy policies. I consent to the PROVIDER'S use of protected health information as described in the notice for treatment, payment, or health care operations. I understand that I must provide a separate authorization before any other disclosures may be made.

Signature:_____ **Date:**_____

Authorization for release: By signing below I am authorizing the practice to leave messages, including appointment reminders and my Protected Health Information, for me by e-mail, home and/ or cell phone voice mail at the numbers listed below:

Home Phone:_____ **Cell:**_____ **Email** _____

I also authorize the practice to disclose my PHI to the following individuals:

☐ spouse ☐ parents ☐ children ☐ clergy ☐ other (list names)_____

I understand my rights and how to revoke this permission as described in the Notice of Privacy Practices given to me by the practice.

Signature:_____ **Date:**_____

Request for restrictions: I request that my protected health information not be disclosed to the following:

_____

Signature:_____ **Date:**_____