Consent for Treatment

I hereby consent to examination and treatment by Kentucky Cardiology, PLLC including diagnostic and/or therapeutic procedures ordered by the physician.

Assignment of Benefits

I authorize direct payment of benefits provided under any health care plan or medical expenses policy due to me or payable on my behalf to Kentucky Cardiology. I further authorize release of information required by any third-party payor regarding this claim. I permit a copy of this authorization to be used in place of the original. I acknowledge that any or all of the expenses not paid by my third-party payor, as defined under my plan benefit contract, are my responsibility.

Applicable to Medicare Patients: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or any other information about me to release to the Social Security Administration and/or to the Medicare Program or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf.

Financial Policy

I acknowledge that I have received a copy of and will abide by Kentucky Cardiology's Financial Policy.

Privacy Practice Acknowledgement

I acknowledge that I have received a copy of the "Notice of Privacy Practice" which provides a detailed description of the uses and disclosures allowed, as well as other rights I have regarding my protected health information.

I hereby give consent to Kentucky Cardiology, PLLC to use and disclose my protected health information as detailed in the "Notice of Privacy Practices." I understand this information may contain records on chemical dependency, substance abuse and sexually transmitted diseases. I have the right to request restriction on how my information is used and disclosed. I have the right to revoke consent in writing (except to extent already acted upon).

Appointment Reminders

Kentucky Cardiology makes every effort to remind patients of their appointments. We intend to notify you of appointments by mail via post card that will contain your name, address, and appointment date and time. We may also notify by automated phone message that will contain your first name as well as appointment date and time. By signing this document you are giving consent to these types of appointment reminders. Please let one of our associates know if you do not wish to be notified of your appointments in either of these manners.

I acknowledge that it is my responsibility for the sake of my health to be compliant with my appointments at Kentucky Cardiology and with my cardiologist's instructions and treatment plan. Kentucky Cardiology makes a good faith effort to follow-up with me on missed appointments but it is my responsibility to have concern for my own health and well-being.

Mobile Phone and Email Communication

I hereby give consent for Kentucky Cardiology, PLLC to contact me by mobile phone and email address.

_____ _____

Date Signature of Patient or Person Authorized to Consent

Release of Financial Information:

Although we make every attempt to keep your financial information secure, we must disclose that as part of billing process we may discuss your account information with a caller who can provide us with your name, date of birth, social security number and account number. Please indicate if you agree to this policy. Please circle YES or NO

_____ _____

Date Signature of Patient or Person Authorized to Consent

Note: This authorization is not valid unless signed and dated, and will remain in effect until you notify us otherwise.

Revised 6/30/14