PATIENT AUTHORIZATION AND FINANCIAL RESPONSIBILITY FORM

Consent for Treatment

I voluntarily consent to the rendering of medical care by the physicians and medical staff of HeartWell LLP. This may include examination, treatments, administration of anesthetics and performance of diagnostic and/or surgical procedures deemed necessary for the diagnosis and treatment of my medical condition. _____***(Initial)***

Guaranty of Payment

I understand I am financially responsible for payment to HeartWell LLP for any charges not covered or allowed by my insurance company and all applicable out-of-pocket expenses including deductibles, co-insurance and co-payments. I understand these payments are due at the time of the visit. I further understand and agree that if my account is placed for collections due to non-payment, I will be responsible for paying the balance owed to HeartWell LLP plus any attorney and/or collection agency fees if applicable. _____***(Initial)***

Medicare and Medicaid Assignment of Benefits

I certify the information given by me in applying for payments under Title XVII and/or Title XIX of the Social Security Act are correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediary carriers, any information needed for this or a related Medicare or Medicaid claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician(s) services. I understand I am fully responsible for my health insurance deductibles and co-insurance. I authorize any holder of medical information about me to release to the Health Care Financing Administration (HCFA) and its agents any information needed to determine benefits or the benefits for related services. _____***(Initial)***

Assignment of Insurance Benefits

I authorize my insurance company to make payments on my behalf of any and all individual group benefits directly to HeartWell LLP for medical services provided to me. _____***(Initial)***

I, _____ (Print Name) acknowledge that I have read and understand each of the above provisions appearing on this form, I consent to these provisions individually and collectively.

I have a Living Will/Advanced Directives _____**Yes** _____**No**

_____ _____

PATIENT OR LEGAL GUARDIAN SIGNATURE **WITNESS**

_____

DATE