

PATIENT'S AGREEMENT

(PLEASE READ CAREFULLY)

1. **I CONSENT TO CARE AND TREATMENT**

I consent to examination, treatment, and testing as advised by the physicians and staff of South Charleston Cardiology Associates, LLC (South Charleston Cardiology Associates). In addition, I consent to the use or sharing of my protected health information by South Charleston Cardiology Associates to diagnose and treat me, to obtain payment for my bills, and to conduct its health care operations and business.

2. **I HAVE RECEIVED THE NOTICE OF PRIVACY PRACTICES**

I have received the South Charleston Cardiology Associates' Notice of Privacy Practices, which tells how my health information may be used and shared. I understand that South Charleston Cardiology Associates reserves the right to revise the notice at anytime and that I can always get the current copy by asking for it.

3. **I AGREE THAT PAYMENTS CAN BE MADE DIRECTLY TO SOUTH CHARLESTON CARDIOLOGY ASSOCIATES**

I allow South Charleston Cardiology Associates to directly bill and collect payment from my insurance company, Medicare, Medicaid, or other person or entity that pays my medical bills. I assign my right to receive payment of any insurance to South Charleston Cardiology Associates, including Medicare, Medicaid, or other benefits payable from any source. I certify that all information given by me in applying for payment by any third party is true and accurate. Some insurance companies will not pay for services unless they authorize the service in advance, sometimes call "pre-certification." I understand that it is my responsibility and I will get authorization or pre-certification from my insurance company if it is required by my health insurance policy.

4. **I AGREE TO PAY FOR THE COST OF CARE AND TREATMENT**

I accept full responsibility for the cost of all services that South Charleston Cardiology Associates provides me. I promise to personally pay all expenses and charges that are not paid by my insurance company or anyone else. I will pay the collection costs, including court costs, if South Charleston Cardiology Associates must sue me to collect my unpaid bill.

5. **I CAN CANCEL THIS AGREEMENT**

I understand that I can revoke this agreement in writing. This can be done at any time by delivering to South Charleston Cardiology Associates a written statement of revocation, except to the extent that South Charleston Cardiology Associates has relied on this consent, agreement, and authorization. I will be financially responsible for any medical services provided before the date of such revocation.

*If you have any questions about this document,
please ask someone at the front desk for assistance.*

I HAVE READ AND UNDERSTAND WHAT I AM AGREEING TO. (*Upon signing, the responsible party assumes all liability for the consents, authorizations, and financial responsibility discussed above.*)

Date

Signature of Patient

Date

Signature of Patient's Legal Representative or
Agent (if other than patient)

STATEMENT OF PATIENT'S LEGAL REPRESENTATIVE OR AGENT

I give the consents and authorizations made above on behalf of the patient and I have the authority to do so. The patient did not sign because he or she is (check one):

- A minor (under 18 years of age)
- Mentally or physically unable to understand or sign
- Other (describe):

I am authorized to sign for the patient because: (for example, being a parent or having medical power of attorney)
