

Cardiovascular Institute of Michigan, P.C

ASSIGNMENT AND AUTHORIZATION OF BENEFITS

I acknowledge that patients who do not have insurance coverage are expected to pay at the time of services are rendered. I hereby assign all medical and/or surgical benefits to which I am entitled, including Medicare, private insurance and other plans, to Cardiovascular Institute of Michigan, P.C. I understand that I am financially responsible for payment and to obtain reimbursement, I authorize disclosure of any medical information necessary to process related claims. By signing below, I authorize insurance claims to be filed and benefits assigned. I request that payment of authorized benefits be made on my behalf to Cardiovascular Institute of Michigan, P.C. for any services rendered to me.

Signature of Patient/Parent/Patient Representative

Date

ACKNOWLEDGEMENT OF RECEIPT AND REVIEW OF PRIVACY PRACTICES – HIPAA

If you feel that we may have violated your privacy rights, please contact Cardiovascular Institute of Michigan, P.C. You may also submit a written complaint to the U. S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U. S. Department of Health and Human Services. We will not retaliate in any way if you choose to file a complaint.

I have received the notice of privacy practices and I have been provided an opportunity to review it.

Signature of Patient/Parent /Patient Representative

Date

DISCLOSURE TO FAMILY/EMERGENCY CONTACTS

I authorize Cardiovascular Institute of Michigan, P.C. to disclose my health information and to discuss my healthcare needs to those that I designate. I further authorize release of my billing information and give these individuals the ability to pick up my prescriptions and/or medications on my behalf. These individuals will be considered my emergency contacts. Without authorization, no information may be shared. I authorize Cardiovascular Institute of Michigan, P.C. to disclose my personal information with the following people:

Name: _____ Relationship: _____ Contact#: _____

Name: _____ Relationship: _____ Contact#: _____

Do you have a Durable Power of Attorney? YES NO If so, name and phone # of that person:

Name: _____ Phone#: _____

May we leave a message on your answering machine/voicemail regarding test results and/or Appointments? (circle one) **YES NO**