PREMIER HEART

Patient Authorization and Consent

Patient Name: _____ Date of Birth: _____

I am presenting myself for treatment at Premier Heart, LLC. I voluntarily consent to the rendering of such care, including diagnostic procedures and medical treatment by the employees and medical staff of Premier Heart, which, in their professional judgement, is necessary or beneficial. I understand that this consent applies to this and to all subsequent visits as a patient relating to the diagnosis and treatment of my medical condition(s).

I agree that my provider can check my external medication history at his/her discretion.

I hereby authorize payment directly to Premier Heart the benefits under the insurance coverage(s) identified by me which may be payable to me but not to exceed the regular charge or all services rendered. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable or provider services or authorize such provider of submit claims to the insurer for payment.

I understand that I am financially responsible for all charges not paid under this assignment. I further understand that my provider cannot know all the terms of my insurance and that if my insurance declines payment for any reason I am responsible for payment of all declined charges. I understand and agree that in the event that I fail to make payment for service rendered to me, my identifying information will be turned over to a collection agency and/or attorney and I will be responsible for all costs associated with collecting payment including but not limited to attorneys fees, court costs, and collection agency fees.

The undersigned agrees, whether she/he signs as agent or as patient, that in consideration of the services to be rendered to the patient she/he hereby individually obligates herself/himself to promptly pay the account of Premier Heart in full upon presentation of any portion denied or not covered by the patients insurance carrier. Provisional credits are subject to collections thereof by Premier Heart.

I authorize Premier Heart along with any billing service and/or their collection agency or attorney who may work on their behalf, to contact me on my cell phone and or home phone, and/or may use pre-recorded messages, artificial voice messages, automated telephone dialing devices or other computer assisted technology, or by electronic mail, text message or by any other form of electronic communications.

I authorize Premier Heart to electronically share my medical information through Health Information Exchanges for the purpose of coordinating patient care, treatment, payment, health care operations, and other authorized purposed to the extent permitted by law. I acknowledge that I have been informed of my rights to “opt out” or decline participation in Health information exchanges.

I certify that the information given by me is correct.

I certify that I have been provided with the HIPAA guidelines for confidentiality as pertain to Premier Heart and its providers. I understand that I may receive additional copies at any time upon request. I understand that staff is available to answer any questions regarding the HIPAA guidelines.

The undersigned certifies that she/he has read and understands the foregoing and is the patient or is duly authorized by the patient as the patient’s general agent to execute the above and accepts its terms.

Patient/Legal Representative Signature: _____ Date: _____

The Patient is unable to sign because:

_____

PREMIER HEART

HIPAA Notice of Privacy Practices

Acknowledgement Form

By signing below, I acknowledge that I have been provided Premier Heart's Notice of Privacy Practices, which contains a detailed description of the uses and disclosures of my health information. Additionally, I have been given an opportunity to read the Notice.

Signature:_____
Date:_____

Print Name: _____

Signature of Authorized Representative: _____

Office use only:
If unable to obtain the patients signature in acknowledgment of receipt of the HIPAA Notice of Privacy Practices, document the reason below (emergency etc)

Patient Name: _____
Date:_____

Reason: _____

PREMIER HEART

Medical Information Communication Preferences

Patient Name: _____ DOB: _____

As our patient we may need to reach you when you are not in the practice. For your privacy, please indicate your preferred method for us to communicate confidential medical information, such as labs, test results or appointments, to you and/or others involved in your care. Please note that appointment reminder "telephone calls or text" may be left at the contact number(s) or email you list below. Please list your email address to receive online healthcare information provided by Premier Heart patient secure portal or secure email.

Please indicate your communication preferences below:

By listing number(s)/or email(s) below you are giving Premier Heart permission to leave medical information pertaining to you, your dependent, or child.

Method	Area Code + Phone Number	Leave Voice Message or Email Please circle yes or no
Home Telephone		YES or NO
Mobile phone		YES or NO
Work phone		YES or NO
Email		YES or NO

Without specific permission, we will not release any medical information to anyone other than you. In some cases, you may wish for another person to have access to your medical information. Please identify those individuals and their relation to you (i.e. spouse, parent, son, daughter, partner, etc.) below if you would like medical information released to anyone other than yourself. Please check yes if a message with medical information can be left at the number you list below.

Name	Relationship (i.e. spouse, parent, son daughter, etc.)	Area Code, Phone #, extension	**OK** to leave a message
			Yes or No
			Yes or No
			Yes or No
			Yes or No
Comments:			

I assume the responsibility to inform the practice of any changes in my phone number(s) or my preferences or to revoke this specific medical information authorization at any time.

Signature of Patient or Legal Representative: _____ Date: _____

Print Signers Name: _____