Heart and Vascular Care

Annual Consent/Authorizations

Patient Name:_____ **Date of Birth:**_____/_____/_____

Consent for Treatment: I consent to the rendering of medical treatment or services as considered necessary and appropriate by the physician, physician assistant, nurse practitioner or designated staff. The consent to receive medical treatment or services includes but is not limited to: initial evaluations, assessment evaluations, electrocardiogram, laboratory services or procedures, medications, patient education, and other services in which the patient will receive. I hereby authorize my physician or designated staff to perform diagnostic studies, as a recommended treatment mutually agreed upon by me and to employ such assistance as required providing proper care. Diagnostic testing and services may include but is not limited to: echocardiograms, carotid ultrasounds, exercise treadmill test, nuclear stress test, PET scans, vascular and arterial ultrasounds, event monitors and other services recommended by your physician. I am aware that there may be material risks associated with these procedures. If I have any questions or concerns regarding any procedure, I will ask my physician to provide me with additional information.

I understand I have the right to see a physician if I so choose, and have the right to see a physician prior to any prescription drug or device order being carried out by the physician assistant or nurse practitioner.

I give my consent to have the Heart and Vascular Care group obtain my prescription history from external sources.
_____**(initials)**

Consent to release Medical Information to a spouse, family member or significant other

I hereby authorize Heart and Vascular Care group to release and/or disclose any information contained in my medical record to the person(s) listed:

Name:_____Relationship to patient:_____

Name:_____Relationship to patient:_____

Name:_____Relationship to patient:_____

☐ I do **NOT** authorize any information to be released to anyone other than myself.

I give permission for you to leave medical and appointment information for me via the following source(s):

☐ Phone ☐ Text Message ☐ Email

Financial Responsibility

I understand that it is my responsibility of each patient to arrange for payment for the medical services received in this office. I hereby authorize any insurance benefits to be paid to Heart and Vascular Care, Inc group and recognize my responsibility to pay for all non-covered services rendered. I also authorize the release of any information necessary to process an insurance claim.

Signature of Patient/Legal Guardian_____ Date:_____/_____/_____

Heart and Vascular Care

Acknowledgement of Receipt of Notice of Privacy Practices

The undersigned patient or legal authorized representative of the patient acknowledges that he or she personally was offered and/or received a copy of Heart and Vascular Care, Inc. group's "Notice of Privacy Practices" on the date indicated below.

Privacy Practices are also posted in the front office near check-in for your review

Last Name: _____ First Name: _____

Date: _____/_____/_____

Signature of Patient or Legal Guardian: _____

FOR OFFICE USE ONLY

☐ Patient/Representative is unable to sign - Notice of Privacy Practices Provided

☐ Patient/Representative refused to sign - Notice of Privacy Practices Provided

☐ Other _____

Staff Name (Print):_____ Title: _____

Signature: _____ Date: _____/_____/_____