SPORTS & PERFORMANCE CARDIOLOGY

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Authorization and Consent to Treatment

Membership*:* I understand that this is a Membership based Practice. To help inform my decision to become a Member, I am aware that I can be seen for an initial consultation and, if necessary, in-office testing and one follow-up visit – all of which must be completed within 30 days and will be billed to my insurance or self-pay. After which, I understand that I must become a Member to receive any additional care from the Practice (see Membership Form).

Assignment of Benefits and Authorization to Release Medical Information: I hereby certify that the insurance information I have provided is accurate, complete and current and that I have no other insurance coverage. I assign my right to receive payment of authorized benefits under Medicare, Medicaid, and/or any of my insurance carriers to the provider or supplier of any services furnished to me by that provider or supplier. I authorize my provider to file an appeal on my behalf for any denial of payment and/or adverse benefit determination related to services and care provided. If my health insurance plan does not pay my provider directly, I agree to forward to my provider all health insurance payments which I receive for the services rendered by my provider and its health care providers. I authorize my provider or any holder of medical information about me or the patient named below to release to my health insurance plan such information needed to determine these benefits or the benefits payable for related services. I understand that if my provider does not participate in my insurance plan's network, or if I am a self-pay patient, this assignment of benefits may not apply.

Guarantee of Payment & Pre-Certification*:* In consideration of the services provided by my provider, I agree that I am responsible for all charges for services I receive that are not covered by my health insurance plan or for which I am responsible for payment under my health insurance plan. I agree to pay all charges not covered by my health insurance plan or for which I am responsible for payment under my health insurance plan. I further agree that, to the extent permitted by law, I will reimburse my provider for all costs, expenses and attorney's fees incurred by my provider to collect those charges. If my insurance has a pre-certification or authorization requirement, I understand that it is my responsibility to obtain authorization for services rendered according to the plan's provisions. I understand that my failure to do so may result in reduction or denial of benefit payments and that I will be responsible for all balances due.

Consent to Treatment: I hereby voluntarily consent to the rendering of such care and treatment as my providers, in their professional judgment, deem necessary for my health and well- being, including by a secure telehealth platform. I understand that resident physicians, medical students and/or other health professionals in-training may observe or participate in my care under proper supervision. My consent shall cover medical examinations and diagnostic testing (including testing for sexually transmitted infections and/or HIV, if separate consent is not required by law), including, but not limited to, cardiac and vascular imaging, and vaccine administration. My consent shall also cover the carrying out of the orders of my treating provider by care center staff. I acknowledge that neither my provider nor any of his or her staff have made any guarantee or promise as to the results that I will obtain.

Consent to Call, Email & Text: I understand and agree that my provider and his or her staff may contact me using automated calls, emails and/or text messaging sent to my landline and/or mobile device. These communications may notify me of preventative care, test results, treatment recommendations, outstanding balances, or any other communications from my provider. I understand that I may opt-out of receiving all such communications from my provider by notifying the office in writing. If you email us medical or billing information from a private email address, your information may not be secure in transmission. We are not responsible for the privacy or security of your PHI if you request that we send it to you in an unsecured manner.

HIPAA: I understand that my provider's Privacy Notice is available on my provider's website and that I may request a paper copy at my provider's reception desk.

I hereby acknowledge that I have received my provider's Financial Policy as well as my provider's Notice of Privacy Practices. I agree to the terms of my provider's Financial Policy and consent to my treatment by my provider. This form and my assignment of benefits applies and extends to subsequent visits and appointments.

Name: **Signature:** **Date:**