Valley Heart Associates
KLEE & STEVENSON

PATIENT NAME: _____

DOB: _____ DATE: _____

Please use blue/black ink

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Valley Heart Associates follows the guidelines as stated in our Notice of Privacy Practices. Please acknowledge by signing below that you have been provided a copy of Valley Heart Associates *Notice of Privacy Practices*.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I authorize the release of photocopies of the following medical records and/or x-ray films in the possession or control of Valley Heart Associates, its employees and/or agents. FOR THE PURPOSE HEREOF, "MEDICAL RECORDS" and "X-RAY FILMS" SHALL INCLUDE ALL CONFIDENTIAL HIV-RELATED INFORMATION (AS DEFINED IN A.R.S. SECTION 36-661), CONFIDENTIAL COMMUNICABLE DISEASE RELATED INFORMATION (AS DEFINED IN A.R.S. SECTION 36-661), CONFIDENTIAL ALCOHOL OR DRUG ABUSE RELATED INFORMATION (AS DEFINED IN 42 (FR SECTION 2.1 ET SEQ), AND CONFIDENTIAL MENTAL HEALTH DIAGNOSIS/TREATMENT INFORMATION.

I authorize release of medical information to the entities indicated below. I understand that confidentiality cannot be guaranteed.

Physicians:
Family Members (please list name and relationship):
Can we contact you using the following personal electronic devices? Voicemail or Answering Machine: YES NO Fax: YES NO (if yes, fax number) _____ Email: YES NO (if yes, address) _____

ASSIGNMENT OF BENEFITS/FINANCIAL AGREEMENT

I authorize release of all medical information that is pertinent to my medical care and necessary to process my insurance claims. I assign all medical and/or surgical benefits including major medical benefits to which I am entitled to Valley Heart Associates. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

I understand that I am financially responsible for all charges. In the unfortunate event that an account is given to a collection agency or to an attorney, for collection, then the patient/responsible party shall pay to Valley Heart Associates all costs of collection, including reasonable attorney's fees and court costs, in addition to other amounts due Valley Heart Associates. I have read this information and agree with this policy.

I have read and understand the PRIVACY PRACTICES, AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS and ASSIGNMENT OF BENEFITS/FINANICAL AGREEMENT contained herein.

Patient Signature: _____ **Date:**_____

Financial Policy and Patient Responsibility

We are committed to providing our patients with the highest quality care. We thank you for taking the time to read and understand our policy.

Please be aware that due to current federal regulations, we are obligated to collect all applicable co-payments, co-insurance, and deductibles for all services. To assist you in understanding your financial responsibilities, please refer to the following:

PATIENT RESPONSIBILITY

- Know your insurance policy: Patient should be aware of your benefits coverage including which physicians are contracted with your plan, covered and non-covered benefits, authorization requirements, and cost share information such as deductibles, co-insurance, and co-pays. If you are not familiar with your plan coverage, we recommend you contact your carrier directly.
- Your current insurance card is required at the time of each visit at check in. It must be on file for us to bill your insurance. If we do not have your card on file, you will be treated as a self pay patient, and our fee is expected at the time of service. When the card is furnished, we will file your insurance and reimburse you after your claim has been paid.
- Our insurance contracts require us to collect co-pays and co-insurance at the time of service.
- Deductible and co-insurance amounts not covered by their supplemental insurance plans are patient responsibility.
- A sixty (60) day period, from the billing date, will be extended for pending insurance payments, after which the patient may be held responsible for the balance.
- We require a twenty-four (24) hour notice for appointment or testing cancellations.
    - There is a $200 fee for any Nuclear testing appointment missed.
    - There is a $150 fee for any Echocardiogram, Carotid, ABI or other ultrasound appointment missed.
    - There is a $50 fee for any appointment missed with a doctor or nurse practitioner.
- There is a $35 charge for the completion of each form that you may require. (medical records, life insurance, disability, FMLA) We require a minimum of 5 days to complete these forms. Payment is expected at the time the service is requested. We will notify you when the form is completed.
- There is a NSF (non sufficient funds) fee of $25 plus the fee the bank charges.

PATIENT POLICY AKNOWLEDGEMENT:

I have read and understand the about financial policy. I understand that, regardless of my insurance claim, status or absence of insurance coverage, I am ultimately responsible for the balance on my account for any services rendered. I understand that payments may be made with cash, check, or credit card.

Patient Name (Please Print) _____ **Signature** _____

Date of Birth _____ **Today's Date** _____

Request for Release of Medical Records

I authorize the release of the following medical record photocopies and/or x-ray film copies, ***to or from*** the facility/facilities referenced below (to include the named facility, its employees and/or agents):

FOR THE PURPOSES HEREOF, "MEDICAL RECORDS" AND "X-RAY FILMS" SHALL INCLUDE ALL CONFIDENTIAL HIV-RELATED INFORMATION and/or CONFIDENTIAL COMMUNICABLE DISEASES-RELATED INFORMATION (AS DEFINED IN A.R.S. SECTION 36-661), CONFIDENTIAL ALCOHOL OR DRUG ABUSE RELATED INFORMATION (AS DEFINED IN 42 CFR SECTION 2.1 **ET SEQ**.), AND CONFIDENTIAL MENTAL HEALTH DIAGNOSIS/TREATMENT INFORMATION.

Get Records FROM:	**Send Records TO:**
RECORDS REQUESTED:	

Valley Heart Associates
2075 West Pecos Road
Suite 1
Phone: (480) 656-5711
Fax: (480) 656-5622

Patient's Signature: _____

Patient's Name: _____

Patient's DOB: _____