NORTH SHORE CARDIOLOGY CONSULTANTS "NSCC"
NORTH SHORE VEIN CENTRE "NSVC"

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AGREEMENTS & AUTHORIZATIONS

CONSENT FOR TREATMENT

I hereby authorize and consent to treatment provided by "***NSCC/NSVC"***, its employees or designees and authorize medical services, diagnostic procedures and medication as deemed necessary or advisable by my caregiver(s). An additional signed informed consent may be required for specific testing and/or procedures. (______) Patient's Initials

FINANCIAL POLICY

- **Self-Pay Patients**: Payment in full is due at the time of service.
- **Medicare Patients**: ***"NSCC/NSVC"*** is a participating provider with Medicare and accepts Medicare assignment. I acknowledge that I am responsible for any amounts applied toward my yearly deductible, 20% co-insurance or services denied as "not covered" or "not deemed medically necessary". My secondary/supplemental policy is billed as a courtesy and any remaining balance is my financial responsibility. I request that payment of authorized benefits be made on my behalf directly to ***"NSCC/NSVC".***
- **PPO, HMO, Other Insurance:** Co-payments are due at the time of service. If my plan requires referrals or pre-authorization prior to a visit with a specialist, testing or procedure, it is my responsibility to obtain the referral from my PCP (Primary Care Physician). In most cases, referrals will not be authorized after services have been rendered. I authorize payment to be made directly to "***NSCC/NSVC"*** for insurance benefits payable to me. I understand that I am financially responsible to "***NSCC/NSVC"*** for any covered or non-covered services, as defined by my insurer, which are not paid by my insurer. It is my responsibility to understand and verify my benefits and ***"NSCC/NSVC's"*** participating provider status with my insurance carrier.
- **All Patients:** I also agree that if I cancel an appointment (with less than 24 hours' notice) or miss an appointment, I will pay the missed appointment fee of $30.00 (office visit) and/or $100 (tests/procedures).
- **All Patients:** I understand that if my account balance is not paid within 30 days of billing I will incur a rebilling fee of $20. Additionally, the account shall bear interest at the rate of 1.5% per month (18% annually). If the overdue account is referred to a collection agency, a collection fee, not to exceed 33.3% of the overdue balance, may be added to the amount due and I am financially responsible for the added collection fee and any reasonable attorney's fees and other costs incurred for collection. NSF checks will incur a fee of $25.
- **All Patients:** I am aware that there will be a $20 charge incurred for the completion of forms including but not limited to: disability, FMLA, short/long term claims etc.
- **All Patients:** I will notify ***"NSCC/NSVC"*** within 30 days of any change to my insurance plan.

(______) Patient's Initials

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I authorize ***"NSCC/NSVC"*** to release information required in the processing of claims for services rendered and/or for the purposes of treatment, payment and operations of the practice. I authorize physician and/or physicians' staff to release clinical information related to HIV (AIDS) & Genetic testing and/or psychiatric care rendered to me only if such request is accompanied by my signed consent. I authorize other requests for clinical information including but not limited to life or disability policies only if such request is accompanied by my signed consent. (______) Patient's Initials

NOTICE OF PRIVACY PRACTICES – "NPP"

I acknowledge receipt of or have read a copy of the "***NSCC/NSVC"*** Notice of Privacy Practices. The ***NPP*** discloses my right to view and/or copy my records, limit disclosure of my health information and details how the practice may use and disclose my confidential information. I understand that "***NSCC/NSVC"*** has reserved the right to change their privacy practices that are described in the Notice. (______) Patient's Initials

PATIENT ACKNOWLEDGEMENT

I have read the Agreement and Authorization form and understand its contents and have had an opportunity to discuss its contents. This consent shall remain in effect until I choose to revoke it in writing. (______) Patient's Initials

Patient Name (Please Print)	Patient Signature	DOB	Date
Patient Representative (Please Print)	Signature of Patient Representative		Date
Reason Patient unable to sign	Relationship of Patient Representative to the Patient (Please Print)		