Northwest Cardio-Vascular Associates, S.C.

MEDICAL INFORMATION WAIVER

In an effort to provide you with timely information regarding your health care, we are asking that you complete this waiver.

- ❑ Phone calls to patients regarding test results & medical information are made between the hours of **9:00 am to 5:00 pm**. Please supply us with a number where you can be reached during this time.

  ________________ ☐ Home ________________ ☐ Work ________________ ☐ Cell

- ❑ If you are unavailable when we call you, may we leave medical information with another person and/or do you authorize any other person to call regarding your medical information?
  ☐ Yes ☐ No

  If Yes, with whom? ______________________________ Phone# ____________________

- ❑ If you are not available at the time we try to call you, may we leave medical information on an answering machine or voice mail? ☐ Yes ☐ No

(If your answering machine does **not** identify your last name or phone number, we will **not** leave medical information.)

DEMOGRAPHIC INFORMATION

Patient's Home Address ____

Street City State Zip Code

INSURANCE AUTHORIZATION

I hereby authorize Northwest Cardio-Vascular Associates, S.C. to release to my insurance company, third party insurance or their medical review companies, all medical information necessary to secure payment of medical services.

I hereby authorize payment of all medical/surgical insurance benefits, including Medicare B, to which I/patient am or may be entitled, be paid directly to Northwest Cardio-Vascular Associates, S.C. I understand that I/patient will be fully responsible for payment of any and all charges not covered by medical insurance, co-pays, deductibles and unauthorized managed care treatments.

ACKNOWLEDGEMENT OF TERMS

Payment for services may be made by credit card, approved check, or cash. Returned checks will be issued a $25.00 return fee. Balances past due may be subject to finance charges of 1.5% per month. All collection fees will be charged to your account in the event of nonpayment.

I have read, understand its content, and agree to abide by the terms set forth in this document.

Patient's Signature or
Parent/Legal Guardian: ________________________________ Relationship
To Patient: ________________

Insured's Signature (if required): ________________________ Date Signed: ________________

PRIVACY POLICY

I HAVE BEEN NOTIFIED OF THE PRIVACY POLICY FOR THIS PRACTICE WHICH IS AVAILABLE AT THE FRONT DESK.

________________________ ________________________ ____________

Name (please print) Signature Date