EASTERN SHORE HEART CENTER
19725 SOUTH GREENO RD.
FAIRHOPE, AL. 36532

CONSENT FORM

I HEREBY give my consent for treatment and any testing procedures by Eastern Shore Heart Center's physician and/or clinical staff members. I authorize the release of my medical information to any providers involved in the direct care associated with my treatment.

FINANCIAL AUTHORIZATION

I HEREBY acknowledge that the patient or responsible party is financially responsible for payment of the account regardless of whether they do or do not have insurance. I, the undersigned, accept the fee charged as a legal and lawful debt and agree to pay said fees including any/all of collection agency fees (33.33%), attorney fees and/or court costs, if such be necessary. I waive now and forever my right of exemption under laws of the constitution of the State of Alabama, and any other State.

PRINT NAME _____ **ACCOUNT/RECORD NUMBER** _____

SIGNATURE _____ **DATE** _____

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICE – HIPAA

I HEREBY acknowledge I have been notified & my rights are displayed and available for review of the Notice of Privacy Practice.

INSURANCE AUTHORIZATION/RELEASE OF MEDICAL INFORMATION

I HEREBY authorize the release of medical information to insurance carriers necessary to process claims and hereby assign to Eastern Shore Heart Center all payments for medical services rendered. I hereby authorize and direct my insurance carrier (s), including Medicare, private insurance and any other health/medical plan, to issue payment (s) directly to Eastern Shore Heart Center, for medical services/supplies rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am personally responsible for any amount not covered by this insurance assignment.

SIGNATURE _____ DATE

EASTERN SHORE HEART CENTER

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PATIENT NAME:_____ _____
ACCOUNT /RECORD NUMBER

CONSENT TO CONTACT

I hereby AGREE, in order for us to service your account or to collect monies you may owe, remind you of appointments, Eastern Shore Heart Center and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by leaving voice messages, sending text messages or emails, using any email address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable.

I/We have read this disclosure and agree that Eastern Shore Heart Center, its employees and/or agents may contact me/us as described above.

Patient Signature Date

Printed Name of Patient_____

It patient is unable to sign, responsible party signature and relationship **Date**

FOR OFFICE USE ONLY: In lieu of patient signature, I _____ an employee of ESHC state that patient, _____, has been given our current Notice of Privacy Practices. Please initial _____if patient refused to sign.

Eastern Shore
Heart Center

Comprehensive heart care with a personal touch

Craig Peterson, MD, FACC
19725 So. Greeno Rd.
Fairhope, AL 36532
(251) 990-1930
Fax: (251) 990-1931

This is an authorization giving Eastern Shore Heart Center, Craig R. Peterson, M.D. and staff permission to have verbal or written communication with your spouse, family members and/or someone specified by you regarding your medical condition, treatment and/or financial matters concerning your treatment. Please list below individuals who may receive information by any type of communication.

I, _____, give permission to release information to the following:

PRINT NAME	RELATIONSHIP
_____	_____
_____	_____
_____	_____
_____	_____

_____ _____
Patient Signature Date

_____ _____
Witness Date