Heart Rhythm Consultants P.A.

Consent For Purposes of Treatment, Payment and Health Care Operations

I consent to the use or disclosure of my protected health information by Heart Rhythm Consultants P.A., for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, or to conduct health care operations of Heart Rhythm Consultants. I understand that diagnosis or treatment of me by Heart Rhythm Consultants may be conditioned upon my consent as evidenced by my signature on this document.

My “protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is reasonable basis to believe the information may identify me.

I understand I have the right to review the Heart Rhythm Consultants*, Notice of Privacy Practices* prior to signing this document. The Heart Rhythm Consultant P A Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment, of my bills or in the performance of health care operations of Heart Rhythm Consultants PA. The Notice of Privacy Practices for Heart Rhythm Consultants PA is also provided at 3920 Bee Ridge RD Sarasota, FL / 389 Commercial CT Venice, FL / 2400 Harbor Blvd Port Charlotte, FL. This Notice of Privacy Practices also describes my rights and the duties of Heart Rhythm Consultants PA, with respect to my protected health information. Heart Rhythm Consultants P A reserves the right to change privacy practices that are described in the Notice of Privacy Practices.

I may obtain a revised Notice of Privacy Practices by requesting in writing from Heart Rhythm Consultants PA, or asking for one at my next scheduled appointment.

Financial Responsibility

I understand that insurance billing is a service provided as a courtesy and that I am at all times financially responsible to Heart Rhythm Consultants P.A. (HRC) for any charges not covered by healthcare benefits. It is my responsibility to notify HRC of any changes in my healthcare coverage. In some cases exact insurances benefits cannot be determined until the insurance company receives

the claim. I am responsible for the entire bill as determined by HRC and/or my insurance company if the submitted claims or any part of them are denied for payment. I understand that by signing this form that I am accepting financial responsibility as explained above for all payment for medical services and/or supplies received.

Assignment of Benefits

I authorize direct remittance of payment of all insurance benefits, including Medicare, if I am a Medicare beneficiary, to Heart Rhythm Consultants P. A. (HRC) for all covered medical services provided to me during all courses of treatment and care provided by HRC. I understand and agree that this Assignment of Benefits will constitute a continuing authorization, maintained on file with HRC, which will authorize and allow for direct payment to HRC of all applicable and eligible insurance benefits for all subsequent and continuing treatment provided to me by HRC.

Acknowledgement of Receipt Notice of Privacy Practices

I acknowledge that I have received a copy of Heart Rhythm Consultant's Notice of Privacy Practices, which describes how HRC will use and protect my health information. This notice describes my rights under the Health Insurance Portability and Accountability (HIPAA) and HRC's policies on use and disclosure of my protected health information.

PATIENT	**PERSONAL GUARDIAN OR REPRESENTATIVE**
Name: _____	**Name:** _____
Signature: _____	**Signature:** _____
Date:_____	**Date:**_____