CARDIOVASCULAR GROUP

ANNUAL CONSENT / AUTHORIZATIONS

PATIENT NAME	DATE OF BIRTH

Consent for Treatment:

- Permission is hereby given for any medical/surgical procedures or office testing, laboratory test, administration of medication, physical test and assessments, or exam as may be deemed necessary by the physician, physician assistant, nurses, technicians or other healthcare professions as medically necessary.
- I understand I have the right to see a physician if I so choose.

_____ _____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE

Consent to Release Medical Information to a Spouse, Family Member or Significant Other:

Tell us with whom we may discuss your protected health information:

NAME	RELATIONSHIP TO PATIENT
NAME	RELATIONSHIP TO PATIENT
NAME	RELATIONSHIP TO PATIENT

☐ I do not authorize any information to be released to anyone other than myself.

I give permission for you to leave medical/appointment information for me via the following sources:

HOME PHONE	CELL PHONE
EMAIL	OTHER PHONE

Financial Responsibility:

I understand it is the responsibility of each patient to arrange for payment for the medical services received in this office.

I hereby authorize any insurance benefits to be paid to CardioVascular Group and recognize my responsibility to pay for all non-covered services.

I also authorize the release of any information necessary to process an insurance claim.

I hereby authorize CardioVascular Group, or any of its affiliates, agents, contractors or business associates, to contact me (by any telephone numbers, email addresses or other contact points provided by me or on my behalf) by the use of any automatic dialing system, by pre-recorded forms of voice/messaging systems, by electronic mail owned or used by the guarantor/responsible party, by text messages, by telephone or by cell phone for reasons related to the services I received at CardioVascular Group or payment for the services I received at CardioVascular Group including but not limited to, debt collection purposes.

_____ _____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE

_____ _____

PRINT NAME EMAIL ADDRESS