



## HIPAA Notice / Consent Form

**Authorization for Treatment:** The person named below (hereinafter called “Patient”). Consents that Hudson Valley Cardiovascular Associates, PC (hereinafter called the “Group”), its health care providers, clinical and technical employees and consulting physicians or any assistants, whom they may call to their aid, may administer any treatment deemed advisable in the care and treatment of the patient. Patient also consents to all procedures, that whether for diagnosis or treatment prior to or during the procedure, may be deemed advisable in their care and treatment. Patient further understands that no guarantee of assurance has been made as to the results that may be obtained.

**Assignment of Benefits:** The patient and/or insured requests that payment of any existing insurance benefits are made on their behalf to all providers of service during this encounter. The patient understands that it is necessary for the Group to release certain medical information in order to receive payment of its debt from the third party insurers or governmental “providers”.

**Terms of Financial Agreement:** The patient agrees to pay all charges made by the Group or other service providers for services rendered to the patient. Any portion of the bill not covered by insurance or other benefit is due in full at the time of services unless prior arrangements have been made. Patient understands that insurance is a contract between the subscriber and the insurance company and that the Group will bill the insurance carrier as a courtesy to the patient. All required authorizations, pre-certifications, and/or referral forms are the responsibility of the patient.

### HIPAA Acknowledgement / Consent Notice Written Authorization:

I acknowledge receipt of Hudson Valley Cardiovascular Associates, PC (HVCVA) Notice of Privacy Practices. I give consent to Hudson Valley Cardiovascular Associates, PC (HVCVA) to obtain or disclose my protected health information for the purpose of treatment, payment or health care operations. I give my consent to HVCVA to leave messages about my appointments or test results at my home on my answer machine or with another party as designated by myself. Should I choose to change my authorization I will contact HVCVA by writing.

Patient Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

Designated Party / Print Name: \_\_\_\_\_

Date: \_\_\_\_\_