INSURANCE ASSIGNMENT AND RELEASE AGREEMENT

I the undersigned have insurance coverage with _____ and
Name of Insurance Carrier

And assign directly to ***Cardiology Partners / Dr.*** _____ all medical benefits if any otherwise payable to me for the services provided. **I understand that I am financially responsible for all charges including the cost of Collection Agency fees, whether my insurance company pays or not.** I hereby authorize ***Cardiology Partners*** to release all necessary information to secure payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

_____ Date: _____
Signature of Patient / Insured / Guardian

MEDICARE AUTHORIZATION

(Only for those patients who are insured by Medicare)

I request that payment of authorized Medicare benefits be made either to me or on my behalf to ***Cardiology Partners / Dr.*** _____ for any services provided to me by the physician. I authorize the release of any necessary information to the Health Care Financing Administration to determine the benefits available for the service provided by my physician. **I understand that by signing below, I am giving my physician / staff permission to request and collect payment. In addition, I am aware and authorize my physician to submit the medical and personal information necessary to collect payment.** If other health insurance is indicated in item 9 of the HCFA – 1500 form, elsewhere on other approved claim forms, or on electronically submitted claims, my signature authorizes release of the information to my insurer / agency. In Medicare assigned cases, the physician / supplier agrees to accept the charge determination of the Medicare carrier as the full charge, an the patient is responsible only for the diductibel, coinsurance (secondary insurance), and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare Carrier.

Beneficiary Signature: _____ Date: _____

Agreement

I, the patient / representative, agree not to bring a frivolous medical malpractice case or cause of action against the physician or physician's legal entity providing care. Furthermore, should a meritorious medical malpractice case of cause of action be initiated or pursued, I, the patient / representative, agree to use an expert medical witness(es) who adhere(s) to the guidelines and / or code of conduct defined by the specialty society(ies) for expert witness in the area(s) of medicine who would typically have the background and experience to opine on such a case. In consideration for this, I, the physician, agree to the same stipulation.

Patient / Guardian: _____ Date: _____