FINANCIAL RESPONSIBILITY AND AUTHORIZATION
TO DISCLOSE PROTECTED HEALTH INFORMATION

In consideration of the services to be rendered to the patient, the undersigned (as the patient, the patient's legal representative, parent, guardian, spouse, guarantor, or agent individually promises and agrees to pay the patient's account at the rates and terms stated in the Center's price list (known as the "Charge Master") effective on the date of service, which rates are hereby expressly incorporated by reference as the price terms of this Agreement to pay the patient's account. Some special items will be priced separately if there is no price listed on the Charge Master, or the charge is listed as zero. In the event that the Center has to engage an attorney or collection agency to collect any unpaid balances that arise from the treatment consented to and services provided herein, the undersigned agrees to pay the reasonable attorney's fees and collection expenses, including, without limitation, collection agency expenses, incurred by the Center.

An estimate of the anticipated charges for services to be provided to the patient is available upon request from the Center. Estimates may vary significantly from the final charges based on a variety of factors, including, but not limited to, the course of treatment, intensity of care, physician practices, and the necessity of providing additional goods and services.

In consideration of facility, medical and/or anesthesia services rendered to me or my dependants, I hereby assign and transfer any benefits due me under an insurance policy in so far as they are necessary to cover the expenses. If I maintain an insurance policy, then I, as the policy holder, do hereby authorize the payment of any benefits due me or my dependents under such policy in accordance with this assignment.

The insurance information that has been supplied to this facility is _____ and this center { ❑ is / ❑ is not } a participating provider of services with your insurance plan. Furthermore, the physician or other healthcare provider(s) who may provide you service today may not be participating providers with your insurance plan.

You will receive separate bills from the treating and consulting physicians who have provided services to you at the Center.

I authorize the release of medical, protected health and insurance information to the admitting physician, emergency physician, consulting physician, and institutions performing special tests or providing special equipment or supplies. I further request payment of Medicare or other insurance benefits be made to these physicians for professional services rendered while I, or one of my dependents was a patient at the Center. Initial: _____

The Center may use or disclose information about you to bill or receive payment for medical treatment or services and/or supplies provided to you to which you consent to by your signature below. These disclosures include, but are not limited to, releasing information:

1) to your health plan to obtain prior approval or to determine whether your plan will cover the treatment or services; and
2) to individuals or entities involved in collecting amounts owed to us.

I have received this Center's Notice of Privacy Practices. I understand that if I have any questions or complaints I may contact the Center's Facility Privacy Official. Initial: _____

Signature _____

Patient Date Witness Time

If the patient is unable to sign, complete the following:

❑ Patient is unable to sign because _____

_____

_____

Patient Parent Legally Designated Representative

Relationship to Patient if Patient does not sign_____

I give permission for my protected health information to be disclosed for purposes of communicating results, findings care decisions, and billing & financial to the family members and others listed below:

Name _____ Name _____

Name _____

_____

Signature of Patient

WHITE = Chart CANARY = Patient or Guardian

SOUTH TEXAS
Cardiovascular
& Rhythm Center

IH 10 Heart Plaza
6800 IH-10 W, Ste 120
San Antonio, TX 78201

Tel 210.732.0200
Fax 210.732.0600

PATIENT IDENTIFICATION:

AUTORIZACIÓN PARA INSPECCIONAR Y LIBERAR INFORMACIÓN DE SALUD PROTEGIDA

NOMBRE DEL PACIENTE: _____ FECHA DE NACIMIENTO: _____

DIRECCIÓN: _____ TELÉFONO: (_____) _____

_____

1. Por este medio, yo autoriza al South Texas Cardiovascular & Rhythm Center a que cuando sea médicamente necesario:

   Revelar/liberar la información de salud especificada:

   PARA: _____
   _____
   _____
   _____
   _____

   Recibir la información de salud especificada:

   DE: _____
   _____
   _____
   _____
   _____

2. La siguiente información de salud que se revelará se mantiene en la serie de registros designada: (especifique la información exacta que será revelada, incluyendo las fechas del servicio):

   ❑ Registro Médico Completo
   (O los registros marcados abajo)

   Fecha del servicio _____

   ❑ Resumen del Alta
   ❑ Historial & Examen Físico
   ❑ Reportes de Consultas
   ❑ Notas del Progreso
   ❑ Reporte del Procedimiento
   ❑ Notas de la Enfermería
   ❑ Reporte de Patología
   ❑ Diagramas Cardiacos
   ❑ Pruebas de Laboratorio
   ❑ Reportes de Radiología
   ❑ Ordenes de los Médicos
   ❑ OTROS (especifique): _____
   _____
   ❑ Diagnóstico Películas/Digital Imágenes (especifique): _____
   ❑ Facturación Registros (especifique): _____

3. Para propósito de: ❑ Revisión de Resultados ❑ Control de Calidad ❑ Otro

4. Entiendo que ésta información podría incluir información relacionada a pruebas de laboratorio específicas de infección VIH (Virus de Inmunodeficiencia Adquirida, los agentes causantes del SIDA) o el diagnóstico de Síndrome de Inmunodeficiencia Adquirida (SIDA) o condiciones relacionadas al SIDA; tratamientos por abuso de drogas o alcohol, salud mental o de comportamiento o atención siquiátrica, excluyendo notas de psicoterapia.

5. Esta autorización se da libremente con el entendimiento de que:

   a) Yo podría revocar esta autorización en cualquier momento, excepto aquella información que ya fue liberada.
   b) La revocación debe ser por escrito y existe un formulario disponible del departamento de registro médico.
   c) Esta autorización expira 180 días después de la fecha de la firma, a menos que se especifique lo contrario; expira _____ .
   d) Una fotocopia o fax de esta autorización es tan válida como el original.
   e) La información usada o revelada en conformidad con esta autorización podría ser sujeta a volverse a revelar por el recipiente y ya no está protegida.

_____ _____
Firma del Paciente Firma del Representante del Paciente

_____ _____
Fecha Nombre del Representante Printed Name

_____ _____
Relación con el Paciente Fecha

SOUTH TEXAS
Cardiovascular
& Rhythm Center

IH 10 Heart Plaza
6800 IH-10 W, Ste 120
San Antonio, TX 78201

Tel 210.732.0200
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PATIENT IDENTIFICATION: