Heart Of Texas Cardiology, P.A.

2911 Medical Arts Street, Bldg.. 10
Austin, Texas 78705
512-474-5551

David Hayes, M.D.

David Garza, M.D.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS (Please Print)

Patient Name: _____

Date of Birth: _____ SSN: _____

Home Address: _____

Mailing Address: _____

Home Phone #: _____ Work Phone#: _____X_____

All of the following information must be provided in order for us to process your request.

Records Released **From**: (previous physician)

_____
Physician or Clinic Name

_____
Address

_____
City, State, Zip

_____
Phone Number

_____
Fax Number

Records **Sent To:**

Heart of Texas Cardiology, P.A.
2911 Medical Arts Street, Bldg. 10
Austin, Texas 78705
Phone: 512-474-5551
Fax: 512-474-7324

Please release the following for date(s) of treatment from: _____ to: _____

- ☐ History & Physical
- ☐ Treadmill Reports
- ☐ Echo
- ☐ Laboratory Reports
- ☐ Nuclear Reports
- ☐ Holter Reports
- ☐ EKG (s)
- ☐ Hospital/Operative Report(s)
- ☐ Other (please specify) _____

PURPOSE OR NEED FOR DISCLOSURE:

- ☐ Primary Care Physician
- ☐ Consultation
- ☐ Disability Determination
- ☐ Transfer of Care
- ☐ Insurance
- ☐ Payment of Claim
- ☐ Other (please specify) _____

I hereby authorize the release of my medical records, including all results and tests that may include the following data: drug, alcohol, and psychiatric treatment to party noted above. I understand that I may revoke this authorization at any time except to the extent that the action has been taken in reliance on it. This authorization will expire in one year from the date of my signature or as otherwise specified by date, or events of conditions as follow: _____

_____ _____
Signature of Patient Date

_____ _____
Signature of Witness Date

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Financial Policy

PAYMENT IS REQUIRED AT TIME OF SERVICE, FOR YOUR CONVENIENCE.
WE ACCEPT CASH, CHECKS, VISA AND MASTERCARD.

Payment: All patient responsibilities are due at the time of service, you are required to pay your deductibles, co-pays, and co-insurance at the time services are rendered. If you are unable to meet your obligations, it is our office policy to reschedule your appointment. _____initial

Insurance: As a courtesy we file medical claims to your insurance company(s). Please realize that your insurance policy is a contract between you and your insurance company and that it is your responsibility to understand the benefits provided to you through your plan. Some, or perhaps all, of the services provided may be "non-covered benefits" by your insurance company and not considered reasonable and necessary by your insurance plan. If this occurs you will be responsible for all fees incurred. We required that you pay co-pays and deductible at time of service, we will do our best to provide you with the accurate amount(s) due based on verification of your insurance coverage. *In some instances your insurance may pay differently than originally anticipated, this could ultimately cause an additional balance due on your behalf or a refund.* Please make sure we have the most accurate insurance information on file. Let the office know if there has been **any** change in your plan(s).

Assignment of Benefits: You may choose to have your insurance company mail payment directly to this office. Our **Accepting Assignment Does Not mean that we accept Insurance Payment As Payment In Full.** Any remaining balance after your insurance company pays is your responsibility. Note: Medicare pays 80% of approved fees. You are responsible for your deductible and remaining 20%. Also, please DO NOT ASSUME THAT WE HAVE YOUR SUPPLEMENTAL INSURANCE INFORMATION. It is your responsibility to provide that information to us.

Deductible: All charges applied to your deductible are your responsibility. If you choose to see one of our doctors "out of network", you may be subject to a higher deductible. Please contact your insurance company regarding your deductible and out of network coverage.

Statements: We mail statements on a monthly cycle. Payment is due upon receipt. Failure to respond to our statements may result in your account be handled by our collection department, an independent collection agency, or an attorney. If you feel that you have received a statement in error, call the office immediately. For an explanation of how your insurance company handled a claim, please refer to the Explanation of Benefits (EOB) which your insurance company is obligated to provide to you.

If you have any questions, please ask.

I have read the above Financial Policy. I understand and agree to this Financial Policy.

Signature of Patient or Responsible Party Date

I authorize my insurance company to pay benefits directly to Heart of Texas Cardiology, P.A.

Signature of Patient or Responsible Party Date