

**TEMECULA VALLEY CARDIOLOGY
ACKNOWLEDGEMENT FORM**

ASSIGNMENT AND AUTHORIZATION OF BENEFITS

I acknowledge that patients who do not have insurance coverage are expected to pay charges in full at the time services are rendered. I hereby assign all medical and/or surgical benefits, to which I am entitled including Medicare, private insurance, and other plans to Temecula Valley Cardiology. I understand that I am financially responsible for all charges, co-payments, co-insurance, and deductibles. To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of any medical information necessary to process related claims. By signing below, I authorize insurance claims to be filed and benefits assigned. I request that payment of authorized benefits be made on my behalf to Temecula Valley Cardiology, for any services furnished to me.

ACKNOWLEDGEMENT OF RECEIPT AND REVIEW OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Notice of Privacy Practices for Temecula Valley Cardiology, which explains how my medical and billing information will be used and disclosed. I acknowledge that upon request I may receive a full copy of this document for me personal records at any time.

GENERAL CONSENT FOR CARE AND TREATMENT

By signing below, I am giving my consent and/or permission to Temecula Valley Cardiology to perform reasonable and necessary medical examinations, testing, and treatment. I acknowledge that I have the right to discuss the treatment plan with my physician about the purpose, potential risks and benefits of any test ordered for me. If I have any concerns regarding any test or treatment recommended by my health care provider, I am encouraged to ask questions. I voluntarily request Temecula Valley Cardiology physicians and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing, and treatment for the condition which has brought me to seek care at Temecula Valley Cardiology.

GENERAL CONSENT FOR CARE AND TREATMENT

I have read and understand the terms of the Patient Financial Policy for Temecula Valley Cardiology Medical Group, Inc. All questions have been answered to my satisfaction, therefore, I agree to the conditions of this policy.

BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE RECEIVED, READ, UNDERSTAND, AND AGREE TO ABIDE BY THE ABOVE AND THAT ALL INFORMATION IS TRUE AND CORRECT.

Signature of Patient or Patient Representative _____
Print Patient Name _____ Date of Birth _____
Date Signed _____