Affix Patient Label Here

Advanced Heart and Vein Surgery Center
AGREEMENTS AND AUTHORIZATIONS

You are scheduled to have surgery at Advanced Heart and Vein Surgery Center.

AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION

I hereby authorize Advanced Heart and Vein Surgery Center to release to my insurance companies, employer insurance groups, health plans, Medicare, Medicaid, or any intermediaries, or physicians associated with the center and any billing or collection agents of Advanced Heart and Vein Surgery Center, any medical or financial records or other information concerning this treatment to obtain reimbursement on by behalf for the treatment and services provided to me by Advanced Heart and Vein Surgery Center.

ASSIGNMENT OF INSURANCE BENEFITS/PAYMENT GUARANTEE/COLLLECTION FEE

I herby authorize payment to be made directly to Advanced Heart and Vein Surgery Center for insurance benefits payable to me. I understand that I am financially responsible to Advanced Heart and Vein Surgery Center for any covered or non-covered services, as defined by my insurer, which are not paid by my primary or secondary insurer. I also understand that if my account balance becomes overdue and the overdue balance may be added to the amount due and that I am financially responsible for the added collection fee and any reasonable attorneys' fees and other cost incurred for collection.

PHYSICIAN OWNERSHIP DISCLOSURE

The owners of **Advanced Heart and Vein Surgery Center** are:
Dr. Behzad Molavi, Dr. Qaisar Khan, and Dr. Rajesh Sharma

NOTICE AND ACKNOWLEDGEMENT OF HIPAA & PATIENT BILL OF RIGHTS

I acknowledge that I have received a information related to the Advanced Heart and Vein Surgery Center Privacy Notice, physician ownership disclosure, 1557 notification and Patient Bill of Rights.

I verify that I was provided/offered with and consent with the following information prior to my procedure:

☐ **AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION**
☐ **ASSIGNMENT OF INSURANCE BENEFITS/PAYMENT GUARANTEE/COLLLECTION FEE**
☐ **NOTICE AND ACKNOWLEDGEMENT OF HIPAA & PATIENT BILL OF RIGHTS, PHYSICIAN OWNERSHIP AND 1557 NOTICE.**

X _____ _____

(Patient/Responsible Party's Signature) (Date)