Patient Consent for Use and Disclosure of Protected Health Information:
As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Effective April 14, 2003.

With my consent, Comprehensive Cardiovascular Care of The Woodlands may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Comprehensive Cardiovascular Care of The Woodlands' Notice of Privacy Practices for a more complete description of such used and disclosures.
I have the right to review the Notice of Privacy Practices prior to signing this consent. Comprehensive Cardiovascular Care of The Woodlands reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to: Comprehensive Cardiovascular Care of The Woodlands 17450 St. Luke's Way, Suite 250, The Woodlands, TX 77384.

With my consent, Comprehensive Cardiovascular Care of The Woodlands may mail or e-mail to my home or other designated location any items that assist the practice in carrying out TPO such as appointment reminders and patient statements. I have the right to request that Comprehensive Cardiovascular Care of The Woodlands restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

Financial Policy:
When making an appointment with one of our providers, it is your responsibility to make sure the physician is under contract with your insurance plan. Failure to confirm that the provider you are seeing is not in your plan may result in being out of network and may make you responsible for the charges. Please inform the receptionist at the time of making your appointment of any demographic changes (address, telephone number, insurance information, etc). There will be a delay in the event changes are given to the receptionist at the time of arrival instead of at the time of making appointment as it will be necessary to obtain insurance verification of coverage and benefits in addition to updating our records prior to being seen. Failure to notify us immediately of such changes in demographic information, financial status and/or insurance coverage may result in you being responsible for any service not covered by your insurance carrier.

As a courtesy, please arrive for your appointment at least 10 minutes prior. If more than 20 minutes late, it may be necessary to reschedule your appointment to another day in order to prevent inconveniencing other patients.

Upon arrival for each office visit, please be prepared to show the receptionist a copy of your most recent insurance card. You will be required to verify all demographic information upon check in. This will include verification of name, address, telephone numbers, and all insurance information. Failure to submit accurate information in a timely manner may result in you being responsible for balance due. Upon checking out, please be prepared to pay for current and/or previous balances on your account. Payment requested may consist of any out-of-pocket amounts associated with a current visit and/or a prior balance. For your convenience, we accept cash, check, and credit/debit cards. We will also schedule any future appointments necessary and arrange for referrals as requested by your provider. Please allow 24-48 hours for completion of most referrals.

Insurance plans may not cover after hour charges that apply to appointments at and/or after 5:00pm Monday-Friday, on Saturdays, days designated as holidays, and as an emergency work-in during regular office hours, and you will be responsible for these charges.

Appointments are scheduled for the convenience of our patients and we strive to see our patients in a timely manner when available. If appointments that you do not need are cancelled or rescheduled, this

appointment time may not be available for a patient who needs to be seen at that time. This is especially true for appointments 30 minutes or longer which are considered extended appointments. Appointments that need to be cancelled or rescheduled must be done so by the close of the previous business day and can be done so by calling the office (936)230-5006. Failure to contact our office to reschedule or cancel an extended appointment by the close of the previous business day will be subject to a charge or a minimal office visit which will be directly charged to you and is not covered by any insurance company.

We are contracted with most insurance companies for your convenience. We will obtain insurance verification prior to your appointment based on the information provided. Insurance verification does not guarantee that your insurance carrier will pay for services provided. Payment of co-insurance, deductibles, and services not covered by your insurance is required at time of service. Balances not paid within 30 days of notification of insurance denial are subject to a $15 service charge per month. We allow 45 days from the date a claim is filed by our office for the insurance company to pay. If the insurance carrier has not paid within this time, you may be responsible for the entire balance, without further notice. We will not become involved in disputes between you and your insurance company regarding coverage and/or policy benefit criteria (deductibles, non-covered services, co-insurance, coordination of benefits, pre-existing conditions or “reasonable and customary” charges, etc) other than to supply factual information when necessary.

By signing this form, I am consenting to Comprehensive Cardiovascular Care of The Woodlands use and disclosure of my PHI to carry out TPO. I May revoke my consent in writing at any time, except to the extent that the practice has already made disclosures in reliance upon my prior consent. If this consent is not signed, Comprehensive Cardiovascular Care of The Woodlands may decline to provide treatment. I have read, understood, and agree to the above HIPAA and Financial Policies. I hereby attest that I have given and agree to the above insurance information and authorize release of information necessary for insurance filing and precertification by signing this statement.

Signature: _____Date: _____