

RELEASE OF INFORMATION

1. Please list the family members or others persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operations).

2. Please list the family members or significant others, if any, whom we may inform about your medical condition **ONLY IN AN EMERGENCY:** _____

3. Please print the address of where you would like your postcards and/or correspondence from our office to be sent if other than your home. _____
4. Please print the telephone number, if any, where you want to receive your calls about your appointments, lab and x-ray results, or other health care information if other than your home phone number: ()

** I am fully aware that a cell phone is not a secure and private line.*
5. Can confidential messages (i.e. appointment reminders) be left on your telephone answering machine or voicemail? YES _____ NO _____
6. Have you received a copy of the HIPAA Privacy Notice? YES _____ NO _____
7. Do you have a Living Will or Advance Directive? YES _____ NO _____

REFERRAL INFORMATION

Name of your Family Doctor _____ Address _____

How did you find out about Southeastern Cardiovascular Consultants? Check all that apply.

_____ TV or Radio _____	_____ Word of Mouth _____
_____ Friend _____	_____ Employer _____
_____ Yellow Pages _____	_____ Hospital Emergency Room _____
_____ Family Member _____	(please specify)
NAME _____	Other _____
	(please specify)

_____ Doctor Referred You _____
NAME CITY, STATE

I authorize the release of any information to process my insurance claim and/or to other physicians who are also responsible for my care. I hereby authorize payment of medical insurance benefits to Southeastern Cardiovascular Consultants for medical services rendered to me. I am responsible for any remaining balance after insurance pays. I am in agreement that in the case of my account becoming delinquent that I am responsible for accrued interest in the amount of 1.5% of the unpaid principal balance per month, reasonable attorney fees in the amount of 25% of the unpaid principal balance and interest, court costs, and other expenses related collection procedures on my account. If I am the guarantor for a patient, I as guarantor bind myself, in solido, with the patient herein for all sums owed Southeastern Cardiovascular Consultants.

Signature of the Patient or Person Legally Responsible for the Bill.
In case of Minors, The Legal Guardian Must Sign.

Date