



*When Heart Health Counts*

CARDIOLOGY ASSOCIATES OF SOMERSET COUNTY, P.A.

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### PATIENT CONSENT FORM NOTICE OF PRIVACY PRACTICES

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- 1) Protected health information may be disclosed or used for treatment, payment or health care operations
- 2) The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- 3) The Practice reserves the right to change the Notice of Privacy Policies
- 4) The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- 5) The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- 6) The Practice may condition treatment upon the execution of this Consent

PRINT Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Patient's Signature (or Legal Representative): \_\_\_\_\_

If Legal Representative, relationship to Patient: \_\_\_\_\_

#### OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment on this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

Date:	Initials:	Reason:
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HIPPA PATIENT COMMUNICATION FORM

Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_

1) **FAMILY and FRIENDS:** It is the office policy of Cardiology Associates of Somerset County, P.A. (and related entities) not to release confidential medical information regarding your treatment to family members or friends, except for the following reasons:

- 1) parent/legal guardian
- 2) other persons authorized by the patient
- 3) as we may reasonably infer from the circumstances (e.g.: if you bring a family member into the exam room, we will assume, unless you object, that the person is entitled to receive information regarding your treatment)
- 4) in emergency situations
- 5) or as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPPA)

If you anticipate that you will need or want medical information to be provided to family members, friends, or caretakers/babysitters, please indicate that below so that we may best serve your needs. By signing below, you authorize the listed persons to receive information regarding your treatment/care or you may indicate that no additional persons may access your information.

If you wish to add/delete names at a later date, please confirm this in writing or by calling our office.

No additional persons may access my information. Please Initial: \_\_\_\_\_

The following **MAY** receive the information: (*Print name of person*)

Spouse: \_\_\_\_\_

Parent: \_\_\_\_\_

Other: \_\_\_\_\_

Other: \_\_\_\_\_

2) **ALTERNATIVE COMMUNICATIONS:** You are also entitled to specify alternative, reasonable means of communication, if you do not wish to be contacted by us in a certain manner.

**I do hereby request only the following means of contacting me:**

You may use any means available

Use this **ONLY:** \_\_\_\_\_

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

or Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Cardiology Associates of Somerset County, P.A.

**DISCLOSURE RELEASE:** I hereby give permission to release information about treatment given by Cardiology Associates to my insurance company.

I realize that I am ultimately responsible for my bill, regardless of insurance. If my insurance company requires a referral it is my responsibility to obtain it from my Primary Care Physician. All co-payments must be paid on the day of service.

\_\_\_\_\_  
Signature of patient

\_\_\_\_\_/\_\_\_\_\_  
Date

## Cardiology Associates of Somerset County, P.A.

I, \_\_\_\_\_, do hereby authorize the above named provider to file any medical appeals in regards to medical billing on my behalf. Per N.J.A.C. 8:38-8.4, a provider can act on behalf of member only with member's consent.

\_\_\_\_\_  
Signature of patient

\_\_\_\_\_/\_\_\_\_\_  
Date

## Cardiology Associates of Somerset County, P.A.

I, \_\_\_\_\_, request that payment of authorized Medicare benefits be made to Cardiology Associates of Somerset County, P.A. for any services furnished me by Cardiology Associates of Somerset County, P.A. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_/\_\_\_\_\_  
Date