MEMORIAL CITY CARDIOLOGY ASSOCIATES
KATY CARDIOLOGY ASSOCIATES

1331 W Grand Parkway N, Suite 130
Katy, TX 77493
281-392-3401

10496 Katy Freeway, Ste 130
Houston, TX 77043
713-464-2928

18400 Katy Freeway, Suite 600
Houston, TX 77094
713-464-2928

ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES AND DISCLOSURE OF OWNERSHIP

Please carefully review the information contained in this notice. This is furnished to all patients of Memorial City Cardiology Associates and Katy Cardiology Associates.

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

• _____ ___/___/_____ _____
Signature of Patient or Personal Representative **Date** **Printed Name**

RELEASE OF INFORMATION

I authorize Memorial City Cardiology Associates and Katy Cardiology Associates to release my private healthcare information **to the following family members if needed:**

_____ _____
Printed Name **Printed Name**

_____ _____
Printed Name **Printed Name**

CONSENT FOR TREATMENT

I consent for medical services and treatment from the physician and staff of Memorial City Cardiology Associates and Katy Cardiology Associates.

• _____ ___/___/_____
Signature of Patient or Personal Representative **Date**

ASSIGNMENT OF BENEFITS AND PAYMENT POLICY

I authorize payment of medical benefits from my insurance carrier to the physicians of Memorial City Cardiology Associates and Katy Cardiology Associates. I understand if I do not assign benefits, I will be responsible to for services in full at the time services are rendered. Co-payments, co-insurance, or deductibles require payment at the time of service. If you have insurance coverage with a managed care plan, it is your responsibility to ensure we are a contracted physician. We refer lab work to numerous laboratories. It is your responsibility to ensure they are a contracted lab on your plan. If your insurance requires a referral to see a specialist, it is your responsibility to make sure there is a current referral on file with our office. I have read and understand the above policy and also understand I am responsible for timely payment of my account.

• _____ ___/___/_____
Signature of Patient or Personal Representative **Date**

You should be aware that your physician may have various affiliations or ownership interests in the below facilities. You are hereby advised that if you wish, you have the right to use a different healthcare facility which we can provide you a list of at your request. You will not be treated differently by your physician if you choose another healthcare facility.

Advanced Cardiovascular Center at Methodist West Houston Hospital

Katy Sleep and Wellness Center

Memorial Hermann Katy Rehab Hospital