Memorial City
10496 Katy Freeway, Ste 130
Houston, TX 77043

Katy
1331 W Grand Parkway N, Ste 130
Katy, TX 77493

Methodist West
18400 Katy Freeway, Ste 600
Houston, TX 77094

Cypress
25282 NW Freeway, Ste 250
Cypress, TX 77429

Phone: (281) 392-3401 | Fax: (281) 392-7814 | www.mc-cardiology.com

AUTHORIZATION FOR ASSIGNMENT OF BENEFITS & CONSENT FOR TREATMENT

I hereby authorize the Physicians of Memorial Katy Cardiology Associates affiliated or other providers to release any information acquired in the course of my treatment to my Insurance company, employer, or third-party payer as required for claims, quality assurance, health plan administration, or complaints /grievances. I hereby authorize Memorial Katy Cardiology or Cardiovascular Care Providers Inc aka Global Healthcare Alliance to submit claims. If the payer requires additional information during the collection process, such as medical records from Memorial Katy Cardiology Associates, I understand that the specific information to be released may include, but is not limited to, history, diagnosis, and treatment related illnesses. I authorize direct payment to the physicians of Memorial Katy Cardiology Associates or Cardiovascular Care Providers Inc. aka Global Healthcare Alliance for any rendered medical services. I understand that if any services or charges are not covered, or if Memorial Katy Cardiology Associates cannot verify eligibility, **I am responsible for all charges** incurred for services rendered. I hereby voluntarily consent to such healthcare including diagnostic procedures and treatment by my physicians and my physician's associates, assistants, and healthcare providers, as may be necessary. I understand co-payments, co-insurance, or deductibles may be required payment at the time of service. I hereby certify that I have read and understand the above policy.

●_____ _____ _____ _____

Signature of Patient/Personal Representative **Date** **Printed Name** **Date of Birth**

DISCLOSURE OF PHYSICIAN OWNERSHIP

Our Physicians at Memorial Katy Cardiology Associates have affiliations or ownership interests in the facilities listed below. You will not be treated differently by your physician if you choose to use a different facility. If desired, your physician can provide information about alternative providers. I understand the billing department will inform me of the estimated financial responsibility before any upcoming in-office or out-patient procedure. I understand that payment will be required prior to the in-office or out-patient procedure. The final amounts may differ on how my Insurance processes claims. I understand I may receive statements from Memorial Katy Cardiology physician charges for in-office or outpatient procedures and may be responsible for all or part of the remaining balance due aside from facilities listed below.

Advanced Cardiovascular Center at Methodist ● Katy Sleep and Wellness Center ● West Houston Hospital ● Memorial Katy Cardiology Vein and Vascular Center ● Memorial Hermann Katy Rehab Hospital

By signing this Disclosure of Physician Ownership, you, or your legal representative, acknowledge that you have read and understand the foregoing Notice to Patients.

●_____ _____ _____ _____

Signature of Patient/Personal Representative **Date** **Printed Name** **Date of Birth**

CONSENT FOR COMMUNICATION OF PROTECTED HEALTH INFORMATION

I authorize Memorial Katy Cardiology Associates to release my Protected Health Information **to the following person(s) or facilities** below.

_____

_____

ACKNOWLEGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES

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**

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