LAWNWOOD CARDIOVASCULAR SURGERY, LLC

Patient General Consent to Treat

I, the undersigned, hereby consent to the following;

- Administration and performance of general treatments
- Use of prescribed medications
- Performance of diagnostic procedures/tests and cultures
- Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of my physician or their assigned designees.

I fully understand that this consent is given in advance of any specific diagnosis or treatment.

I intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

I understand that LAWNWOOD CARDIOVASCULAR SURGERY, LLC may include consent at other satellite offices under common ownership.

A photocopy of this consent shall be considered as valid as the original.

MEDICARE PATIENTS: I authorize LAWNWOOD CARDIOVASCULAR SURGERY, LLC to release medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to LAWNWOOD CARDIOVASCULAR SURGERY, LLC.

I acknowledge that I have been given LAWNWOOD CARDIOVASCUALR SURGERY, LLC'S Notice of Privacy Practices. I understand that if I have questions or complaints that I should contact the Privacy Official. Patient Initial_____

I, the undersigned, authorize LAWNWOOD CARDIOVASCUALR SURGERY, LLC to use and disclose my information for the purposes of treatment, payment, and healthcare operations as described in the Notice of Privacy Practices.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____ _____

Patient (or responsible party) Signature Date

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FINANCIAL POLICY

As your physician, we are committed to giving you the best possible medical care. To achieve this goal, we need your assistance and understanding of our payment policy.

We ask that all services be paid at time of service. If you have insurance, please present your insurance card for verification. If your insurance changes, please notify us immediately. We will be happy to bill your insurance company for services provided. Any balance outstanding following payment from the insurance, will be billed to you.

FINANCIAL AGREEMENT: We will be glad to discuss your proposed treatment and the cost of those services. If you have questions if your insurance will cover a medical service, we will try to help with that. HOWEVER, please be aware that your insurance is a contract between you, your employer (if applicable) and the insurance company. We are not a party to your contract. Unfortunately, not all services are a covered benefit in all contracts so we advise to verify covered services with your insurance company.

We must emphasize that as your physicians, our relationship and concern is with you and your health, not with your insurance company. ALL CHARGES FOR SERVICES ARE YOUR RESPONSIBILITY AT THE TIME OF THE SERVICE UNLESS ARRANGEMENTS HAVE BEEN MADE TO BILL YOUR INSURANCE COMPANY.
On any balance on your account after **90 days**, collection action will be taken unless other arrangements have been made between you and this office.

I HAVE UNDERSTOOD AND AGREED TO THE FINANCIAL POLICY FOR LAWNWOOD CARDIOVASCULAR SURGERY (DBA) FLORIDA HEART AND VASCULAR CARE.

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Patient (or responsible party) Signature Date