Practice Consents

Financial Responsibility:
I understand that I am financially responsible for the charges incurred. I hereby authorize my insurance benefits to be paid directly to the physician and I understand that I am responsible for any unpaid balance.

Assignment of Benefits:

The undersigned hereby authorize the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claim for benefits for services that will be bound by this signature as though the undersigned had personally signed the claim.

Consent to Treat:
I authorize and direct Vital Heart & Vein to perform upon me injections, draw blood, and/or any other procedure or treatments the doctor may make in their best judgment determine advisable for my well-being.

Acknowledgment of Receipt of Notice of Privacy Practices:
I acknowledge that I have received a copy of the Notice of Privacy Practices for Vital Heart and Vein. We reserve the right to modify the privacy practices outlined in the notice.

Text and Email Consent:
I consent to communicating with Vital Heart and Vein via text message and email unless otherwise noted. I agree to receive text messages and emails from Vital Heart and Vein for communication regarding appointments, reminders, and basic medical updates, while acknowledging the potential risks associated with electronic communication of sensitive medical information.

No Show and Late Cancellation Policy:
For office visits, please notify our office at least 24 hours in advance to cancel or reschedule appointment. On your second no-show or late cancellation, you may be subject to a cancellation fee.

For testing appointments, the required cancellation period is 24 hours in advance. Any no-show or late cancellation will result in a cancellation fee. See below:

Echo/Ultrasound Scan/PET	**$75**
Nuclear Stress Test	**$150**

_____ _____
Patient/Responsible Party Signature Date

_____ Self
Patient/Responsible Party Name Relationship

Prescription History Consent

I voluntarily consent to provide Vital Heart and Vein access to and use of my prescription medication history from other healthcare providers or third party pharmacy benefit payers for treatment purposes. I understand that my prescription history (which includes but is not limited to prescriptions, labs, and other health care drug historical information) from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions dating back for several years.

I acknowledge that Vital Heart and Vein may use health information exchange systems to electronically transmit, receive and/or access my prescription history.

I understand that this **Prescription History Consent** will be valid and remain in effect as long as I attend or receive services from Vital Heart and Vein, unless revoked by me in writing with such written notice provided to each practice site I attend or from which I receive services.

I certify that I have read this form or it has been read to me.

_____ _____

Patient/Responsible Party Signature Date

_____ Self

Patient/Responsible Party Name Relationship