VIRGINIA ARRHYTHMIA CONSULTANTS

Helping you get your rhythm back

Name: _____Date of birth: _____

Permission to Discuss PHI: I authorize Virginia Arrhythmia Consultants PLLC and its agents to release my protected health information to the following individuals:

Name	Relationship	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Consent to Treatment: I understand that as part of my healthcare, Virginia Arrhythmia Consultants PLLC originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care and treatment. I also understand this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many health professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

With this consent, Virginia Arrhythmia Consultants PLLC may e-mail and text me appointment reminders and patient statements. By signing this form, I am consenting to Virginia Arrhythmia Consultants PLLC's use and disclosure of my PHI to carry out my treatment, payment, and operations activities. I may revoke my consent in writing except to the extent that Virginia Arrhythmia Consultants PLLC has already made disclosures in reliance upon my prior consent. **If I do not sign this consent, Virginia Arrhythmia Consultants PLLC may decline to provide treatment to me.**

Insurance Authorization: I authorize the release of any medical information to any insurance company, Medigap Insurance, third party administrator, or other payer that is necessary to process the claim and request payment of benefits either to myself or to Virginia Arrhythmia Consultants PLLC. I authorize Virginia Arrhythmia Consultants PLLC and its agents to release medical information contained in my medical record to any insurance companies, federal programs or state programs with which I am insured or who are responsible for payment of my claim. If applicable, I certify that the information given by me in applying for payment under Title XVIII or XIX of the Social Security Act is correct. I request that payment of

authorized benefits be made on my behalf for any services furnished to me by or in Virginia Arrhythmia Consultants PLLC including physician services. I understand that I am financially responsible for all charges, whether or not covered by insurance.

Assignment of Benefits: In consideration for healthcare and subsequent services provided to me by Virginia Arrhythmia Consultants PLLC, I hereby assign to Virginia Arrhythmia Consultants PLLC and any holder of medical or other information about me, and their agents, any and all rights, benefits, and claims I may have under any policy of insurance and the proceeds from any claim that I may have for injuries. Such assignment hereby authorizes direct payment to Virginia Arrhythmia Consultants PLLC under and/or from any such policy of insurance or proceeds. I certify that I have reviewed this document in full, understand its terms, and have had the opportunity to ask questions regarding its contents. I understand that this document is valid and remains in effect unless revoked in writing by me.

PRINT PATIENT NAME: _____ _____ _____

PATIENT SIGNATURE _____DATE _____

PARENT/GUARDIAN NAME (PRINT) _____
(If Patient is a minor, under age 18)

PARENT/GUARDIAN SIGNATURE _____DATE _____