RELEASE RECORD

Medicare Benefits to Provider, Physicians and Patient
I certify that the information given by me in applying for payment under file XVIII of the social security act is correct. I authorize any holder of medical information or other information or other information about me to release to the social security administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that the payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services and authorize such physician or organization to submit a claim to Medicare for payment.

Authorization for Medical and Diagnostic Treatment
I, the undersigned, as the patient or his/her authorized representative, hereby authorize Cardiovascular Interventions, P.A., and/or Pradip Jamnadas, M.D., their/his employees and agents, to treat the condition(s) which appear indicated by the admission complaints and findings. I will be informed of the modes of treatment, risks involved, and the nature of the procedure(s) to be done. No guarantee has been made that my present condition will be cured.

Release of Medical Records
Release of medical records and medical information; I, the undersigned, as the patient or his/her authorized representative, hereby authorize Cardiovascular Interventions, P.A. and/or its representative(s) to release to my insurance company(ies) or other appropriate agency(ies) that information which is necessary to validate this claim.

Assignment of Insurance and Financial Responsibility
Assignment of insurance and financial responsibility; I hereby authorize payment to Cardiovascular Interventions, P.A. for benefits otherwise payable to me, including major medical insurance. I understand that I am financially responsible for all charges incurred during this treatment program, whether or not paid by said insurance. It is my responsibility to pay any deductible(s) amount or any other balance not paid by my insurance in 45 days.

I Agree …
I agree to pay Cardiovascular Interventions, P.A. any monies owed it a referral form authorizing the visit is not brought in at the time of the visit or within ten days after the visit.

The Undersigned …
The undersigned has read and understands the above statements and willingly and voluntarily agrees, whether as the patient or his/her authorized representative, to release Cardiovascular Interventions, P.A. or its employees, from any and all liability which may arise from this action, whether or not foreseen at present.

____ Date: __________________
Signature of Patient or Responsible Party

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Patient’s name (printed)