Heart Rhythm Clinic

Patient Name: _____

Emergency Information (Please Provide information on nearest relative not your spouse).

Name: _____ Relationship: _____
Home Address: _____ City: _____
State: _____ Zip code: _____ Phone: ( ) _____

Signature (The above information is true and correct to the best of my knowledge).
X _____ Date: _____
Signature of Patient or Responsible Party

Release and Assignment

I hearby authorize **Heart Rhythm Clinic** to furnish my attorney and/or insurance company any information including the diagnosis and the records of any treatment or examination rendered to me/my child during the period of such medical or surgical care. I also authorize payment to the above office the amount due to me for any medical services rendered. I understand I am financially responsible for any charges **NOT** covered by my insurance company.

Signature
X _____ Date: _____

Medicare Assignment

I request that payment of authorized Medicare benefits be made to the practicing physicians of **Heart Rhythm Clinic** for any services furnished to me by those physicians/suppliers.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim.

In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance and non-covered services.

Signature
X _____ Date: _____