An Affiliate of Osceola Regional Medical Center
720 W. Oak Street Suite 360, Kissimmee, FL 34741
Phone: (407) 846-0090 ● Fax: (407) 846-0072

HCA PHYSICIAN SERVICES • PATIENT CONSENT FORM

(Please Read and Sign)

I, the undersigned, hereby consent to the following Treatment:

- Administration and performance of all treatments
- Administration of any needed anesthetics
- Performance of such procedures as may be deemed necessary or advisable in the treatment of this patient
- Use of prescribed medication
- 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 the attending physician or their assigned designees

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

I intend this consent to be 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 Cardiac Associates may include consent at satellite offices under common ownership.

I, the undersigned, acknowledge that Cardiac Surgical Associates will use and disclose my information for the purposes of treatment, payment, and healthcare operation as described in the Notice of Privacy Practices.

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

MEDICARE PATIENTS: I authorize to release medical information about me to the Social Security Administration or its Intermediates for my Medicare claims. I assign the benefits payable for services to Cardiac Surgical Associates.

I acknowledge that I have been given the Cardiac Surgical Associates Notice of Privacy Practices. I understand that if I have questions or complaints that I should contact the Privacy Official. **Patient Initial** _______

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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PATIENT CONSENT FOR FINANCIAL COMMUNICATIONS

Patient Name: ______________________________________ Date of Birth: __________________________

Financial Agreement

- I acknowledge, that as a courtesy, Cardiac Surgical Services may bill my insurance company for services provided to me.
- I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any co-payment, co-insurance, and/or deductible, or charges not covered by insurance.
- I understand there is a fee for returned checks.

Third Party Collection
I acknowledge that Cardiac Surgical Associates may use the services of a third-party business associate or affiliated entity as an extended business office ("EBO Servicer") for medical account billing and servicing.

Assignment of Benefits. I hereby assign to Cardiac Surgical Associates any insurance or other third-party benefits available for health care services provided to me. I understand Cardiac Surgical Associates has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to Cardiac Surgical Associates, I agree to forward all health insurance or third party payments that I receive for services rendered to me immediately upon receipt.

Medicare Patient Certification and Assignment of Benefit. I certify that any information I provide, if any, in applying for payment under Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to Cardiac Surgical Associates by the Medicare or Medicaid program.

Consent to Telephone Calls for Financial Communications. I agree that, in order for Cardiac Surgical Associates, or Extended Business Office (EBO) Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that Cardiac Surgical Associates or EBO Servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or Cardiac Surgical Associates or EBO Servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using prerecorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

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

Patient/Patient representative signature: ____ Date: ______________

If you are not the patient, please identify your relationship to the patient. Circle or mark relationship(s) from list below:

Spouse	Guarantor
Parent	Healthcare Power of Attorney
Legal Guardian	Other (please specify) ____