Clarkson Heart CENTER

Conditions Of Treatment

Patient Label

1. **CONSENT TO TREATMENT**
As a patient of Clarkson Heart Center, I agree, request, and authorize physicians, their assistants, or designees, and/or allied health professionals to administer such treatment to the patient as necessary. Necessary treatment includes, but is not limited to services, care, diagnostic procedures, medical treatments, pathology services and radiology serves as the health care provider(s) deems reasonable and necessary. I acknowledge that no guarantees have been made to me as to the results of diagnosis, treatments, tests or examinations.

2. **ASSIGNMENT OF INSURANCE BENEFITS**
I assign the clinic, providing services in the connection with the episodes of treatment to which this form applies, subject to acceptance, all right, title and interest and to benefits payable, and authorize direct payment to Clarkson Heart Center of all my health insurance benefits. I agree to pay for charges not paid pursuant to this assignment. I agree that I am responsible for obtaining any prior authorizations or utilization review approvals required by my insurance company.

3. **FINANCIAL AGREEMENT**
I understand and agree, by signing as the patient and /or responsible party, that in consideration for the services to be rendered to the patient, I obligate myself and/or the patient to pay the accounts of the clinic rendering services in connection with these episodes of care, in accordance with the billing rates and established policies of the Clarkson Heart Center. The amount of the patient's charges may differ from what other patients are obligate to pay based upon each patient's private insurance coverage, Medicare/Medicaid coverage, or lack of any such coverage. I may request financial counseling and will be provided with information about charity care programs, for which the patient may qualify.

4. **MEDICARE PATIENT'S CERTIFICATION**
Patient Certification, Authorization to Release Information and Payment Request: **a.** I certify that the information given in applying for payment under Title XVIII of the Social Security Act is correct. **b.** I authorize release to the Centers for Medicare and Medicaid Services or its intermediaries any information needed for this or a related Medicare claim and request the payment of authorized benefits be made on my behalf. **c.** I authorize any of the physicians to submit a claim to Medicare with the understanding that I will be responsible for the entire unreimbursed balance of the claim to the extent permitted by law. **d.** I certify that I have read the Conditions of Treatment (COT) form in its entirety and understand that other items and/or services may affect reimbursement under the Medicare program.
e. I **(a)** HAVE **(b)** HAVE NOT been in a hospital or nursing home within the past 60 days.

If (a) circled given name of Hospital or Home:_____
And Length of Stay:_____

5. **RELEASE OR RESPONSIBILITY FOR PERSONAL PROPERTY**
I accept full responsibility for all property kept in my possession

6. **NOTICE OF PRIVACY PRACTICES**
X _____ The Notice of Privacy Practices has been made available to me.

7. **RELEASE OF INFORMATION**
I hereby authorize Clarkson Heart Center to release my protected health information to the following person(s).
****FAMILY MEMBER, FRIEND OR ANYONE BESIDES YOURSELF YOU WOULD LIKE TO HAVE ACCESS TO YOUR ACCOUNT****

Name of Recipient:_____ Relationship to patient:_____

8. **I ACKNOWLEDGE RECEIPT OF THE CLARKSON HEART CENTER PATIENT RIGHTS & RESPONSIBILITIES**
The undersigned certifies that he/she has read the foregoing, has received a copy of this document, and as the patient, or as duly authorized signer on behalf of patient, to execute the above and accept its terms.

X _____ **Date of signing** _____
Signature of Patient

X _____ **Time of signing** _____
Signature of Patient's Representative

_____ **Witness** _____
Representative's Relationship to Patient

If patient is unable to sign, state reason: _____

Copy to the patient