

Insurance 2 _____

SS# _____ Policy # _____ Group # _____

F or and in consideration of the services rendered by THE HEART INSTITUTE OF EAST TEXAS, I agree to pay said provider of services for all services rendered. I understand that I am responsible for all health insurance deductible, copayment and coinsurance charges not covered by my insurance policy and charges not covered as a result of any law settlements or judgments obtained on my behalf. Additionally, I understand that I will be responsible for charges not covered by my insurance policy, to include, charges for services deemed experimental, investigational and/or not medically necessary as determined by my insurance company. In consideration of services rendered, I hereby transfer and assign THE HEART INSTITUTE OF EAST TEXAS all rights, title and interest in any payment due me for services described herein as provided in the above mentioned policies of insurance/settlements or judgments. I hereby consent to the release of information necessary to process claims with my insurance policy. I understand that the specific information to be released may include, but is not limited to history, diagnosis, treatment of drug or alcohol abuse, mental illness, or communicable diseases, including HIV and AIDS . I also understand that this authorization may be revoked by the person giving authorization by written and dated notice, except to the extent that disclosure of information that has been made prior to the receipt of the revocation. I have read and understand this consent and I have signed it voluntarily and of my own free will.

Signed _____ Date _____

Patient Name (Please Print) _____

Witness Signature _____ Date _____
