REGIONAL HEART SPECIALISTS

Patient Centered Care

PATIENT CONSENT

1. CONSENT TO DIAGNOSTIC TESTS, PROCEDURES, MEDICAL TREATMENT
   a. I voluntarily consent to care involving routine diagnostic tests, procedures and medical treatment as ordered by treating physician(s), including their assistants or designees. I consent to receive medical care by using telehealth and/or remote patient monitoring. I further consent to the interpretation of diagnostic studies from an off-site location using telehealth technologies. I also consent to testing for communicable and blood-borne infectious diseases, such as hepatitis, tuberculosis, and the human immunodeficiency virus (HIV), if a provider orders tests for diagnostic purposes or if there has been an exposure to healthcare personnel. I have been given no guarantees about the results that may be obtained from my care.

2. FINANCIAL AGREEMENT AND ASSIGNMENT OF BENEFITS
   a. I agree that I am responsible for payment of my physician office bill. Payment of any portion of my bill not covered by a third-party payor is due at the time of service unless Regional Heart Specialists has agreed to other arrangements.
   b. I agree to the assignment of all third-party payor benefits to Regional Heart Specialists and to any other healthcare provider rendering services to me. I agree to pay Regional Heart Specialists for all charges for services that are not covered or paid by any third-party payor regardless of the reason, including but not limited to a determination by any third-party payor that such services are not covered services or medically necessary. I acknowledge and agree that Regional Heart Specialists is not required to accept assignment of any third-party payor benefits, in which case, I may receive a bill from Regional Heart Specialists for the full charges. Moreover, I understand that Regional Heart Specialists may accept payment from payers with whom it does not have a contract and that any acceptance of payment does not constitute acceptance by Regional Heart Specialists of any reimbursement rates established by such third-party payors and that I may receive a bill from Reginal Heart Specialists for the difference between the rate paid by such payors and Reginal Heart Specialists charges.
      i. To the extent I am Medicare or Medicaid beneficiary, I certify that any information I provide 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 Regional Heart Specialists rendering services to me by the Medicare or Medicaid program.
   c. I hereby irrevocably appoint Regional Heart Specialists as my authorized representative to pursue any claims, penalties, and administrative and/or legal remedies on my behalf for collection against any responsible payor, employer-sponsored medical benefit plans, third-party liability carrier, or any other responsible third-party for all benefits due me for the payment of charges associated with my treatment from Regional Heart Specialists. This assignment shall not be construed as an obligation of Regional Heart Specialists to pursue any such right of recovery. I agree to take all necessary actions to assist Regional Heart Specialists in collection payment from any such third-party payor.
   d. After reasonable notice, any unpaid account may be turned over to a collection agency and/or attorney for collection. Should it be necessary for Regional Heart Specialists to pursue collection, I agree to pay all reasonable collection costs, including court costs and attorney's fees incurred by Regional Heart Specialists in collecting my account.

REGIONAL HEART SPECIALISTS

Patient Centered Care

PATIENT CONSENT

e. Pursuant to the Fair Credit Reporting Act (15 USC 1681b(a)(2)), I authorize any credit reporting agency engaged by Regional Heart Specialists to release Regional Health Specialists or any of its representatives or affiliates my consumer report. I understand that the purpose of this authorization and request is to obtain my consumer report, which may be used to determine the availability of or the need for financial assistance, charity care, or insurance coverage for me and may be used for billing and collection purposes related to payment services provided to me. I understand this authorization is valid until Regional Heart Specialists account for all services is closed.

3. NOTICE OF NONDISCRIMINATION
   a. Regional Heart Specialists services, programs, and activities are available regardless of race, color, national origin, religion, sex, disability, or any other status protected by federal, state, or local law.

4. PRIVACY NOTICE AND RIGHTS
   a. I acknowledge that I have received a copy of Regional Heart Specialists Notice of Privacy Practices or have previously received a copy of Regional Heart Specialists Notice of Privacy Practices.

5. NOTICE OF RIGHTS UNDER THE NO SURPISES ACT
   a. I have been provided a copy of Regional Heart Specialists Notice regarding my Rights and Protections Against Surprise Medical Bills and my rights to receive a Good Faith Estimate.

6. CONSENT TO WIRELESS TELEPHONE CALLS, EMAIL, AND/OR TEXT USAGE FOR HEALTHCARE COMMUNICATIONS
   a. I hereby authorize Regional Heart Specialists and all third parties, including clinical providers who have provided care to me, along with any billing services, collection agencies, attorneys, business associates making appointment and exam confirmation and reminders, third parties who perform quality surveys, or other agents who may work on their behalf (including their successors, assigns, affiliates, or agents), to contact me at any telephone number associated with my account(s), including wireless telephone numbers or other numbers that may result in charges to me. I agree that methods of contact may include using automatic telephone dialing system or other computer assisted technology.
   b. If at any time I provide an email address at which I may be contacted, I consent to receiving healthcare communication at that email from Regional Heart Specialists. I further consent to Regional Heart Specialists communicating healthcare information, such as appointment reminders, to me on my wireless telephone through text.

REGIONAL HEART SPECIALISTS

Patient Centered Care

PATIENT CONSENT

The undersigned agrees that a copy of this consent, release and assignment of benefits may be used in place of the original copy. The undersigned authorizes Regional Heart Specialists to appeal on patient's behalf any adverse coverage determinations for treatment or services rendered at Regional Heart Specialists and further authorizes Regional Heart Specialists or its designee to represent patient during any appeal process. The undersigned certified that he/she has read and agrees to this form and has received a copy.

If the patient is unable to sign, the undersigned Legal Authority certifies that the patient is a _____ and the undersigned certified that they have read and agree to this consent, release and assignment as a guardian, parent, next of kin, designated surrogate, or as a power of attorney (as noted below) and has received a copy. To the extent that the patient is unable to consent for themselves and has been appointed a legal guardian, please provide the name of the guardian, and seek the guardian's consent for treatment.

Patient Name (print): _____

Signature: _____ Date: _____

Relationship to patient: _____ Print Name: _____