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**PATIENT INSURANCE AUTHORIZATION
&
NOTIFICATION OF BILLING POLICY**

Patient Name: _____

Patient covered by Insurance: _____ YES _____ NO

Primary Insurance Company Name: _____ Policy Holder _____

Secondary Insurance Company Name: _____ Policy Holder _____

I request that payment of authorized insurance benefits be made by my insurance company on my behalf to Cardiac Consultants, P.C. for any services furnished to me by Cardiac Consultants, P.C. I authorize any holder of hospital or medical information about me to release to the Health Care Financing Administration and its agent any information needed to determine the benefits payable for related services.

I permit a copy of this authorization to be used in place of the original.

I hereby authorize the physicians of Cardiac Consultants, P.C. or their employees to release any necessary medical information to my insurance company for the purpose of paying a claim, when requested by my health insurance company (or their agent) on record, covering me or my dependents at the time of the request.

I understand that I am responsible for payment of any services that have been provided by Cardiac Consultants P.C., including services provided in both office and hospital settings.

I understand that I will receive billing statements identifying any patient balance that is due. If a balance becomes delinquent as noted at the bottom of my billing statement, the balance will be transferred to a Collection Agency and a non-refundable processing fee of \$30 will be added at that time.

If a check is returned to Cardiac Consultants P.C. for "Not Sufficient Funds", a \$40 non-refundable charge will be added to the account balance by Cardiac Consultants.

Cardiac Consultants, P.C. is authorized to use and disclose health information about the above-named patient for treatment, payment, and healthcare operations purposes consistent with its Notice of Privacy Practices.

My signature certifies that I have provided accurate insurance company information and that I have read and understand the above important notice.

Patient Signature

Date