

## Cardiac Care Consultants

### Assignment of Benefits/Authorization to Release Medical Information/Financial Responsibility

I hereby assign and authorize direct payment to Cardiac Care Consultants of all insurance or other benefits otherwise payable to me for medical services provided by any member of this group practice. To the extent necessary to determine liability and to obtain payment, I hereby authorize CCC to release portions of my record, including my medical record, to any person, organization or agency which may be liable for reimbursement of medical services provided to me. I understand that I am financially responsible for charges not covered by my insurance plan. Should my account become delinquent and referred to an attorney or collection agency for collection, I understand that I will be charged for all attorney fees and collection expenses and may also be charged interest at the maximum rate allowed by law.

Print Name: \_\_\_\_\_

Date: \_\_\_\_\_

Signature: \_\_\_\_\_

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#### For Office Use Only

We attempted to obtain written acknowledgement of receipt of our policies and assignment of benefits, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- Other (please specify): \_\_\_\_\_