NEVADA CARDIOLOGY ASSOCIATES
PATIENT/PRACTICE AGREEMENT

Patient Name: ___________________________

I consent to medically necessary evaluation and treatment.

I authorize direct or fax release of all medical records to my referring physician and insurance company and/ or companies.

I acknowledge my full financial responsibility for services rendered by Nevada Cardiology Associates. I understand that payment for charges incurred is due at the time of service. I agree to pay all reasonable attorney fees and collection costs, in the event I default on payment for my charges. I also understand that if I do not provide payment, when due, that I will not be allowed to continue in the practice.

I acknowledge that Nevada Cardiology Associates will bill my insurance company, as a courtesy, for services rendered. I additionally understand that my contract for services is with Nevada Cardiology Associates directly, and not the insurance company. After 90 days, or if insurance payment is denied, I understand that I will assume responsibility for all charges incurred. A service charge of 1.5% per month of the current unpaid balance may be charged on all accounts exceeding 90 days. I also understand that a fee of $25.00 will be charged to me for any returned check, or invalid credit card transaction.

I understand that it is my responsibility to provide accurate insurance information, and to immediately report any changes in my insurance coverage. I also understand that it is my responsibility to determine whether Nevada Cardiology Associates, or any other medical facilities are providers for my insurance plan.

I understand that I may have to be rescheduled if I am 10 minutes late for my appointment. Scheduled appointment times are generally adhered to, but no guarantee is implied. Unforeseen events may cause rescheduling or cancellation of your appointment. I also understand that if I need to cancel or reschedule an appointment or procedure, I must contact the office at least 24 hours prior to the appointment.

Nevada Cardiology Associates limits its scope of practice to cardiovascular diseases. Hence, it is my responsibility to pursue general health care, and cancer screening measures outside of this practice, as needed. If I do not have a primary care physician, Nevada Cardiology Associates will make recommendations, upon my request. I additionally understand that it is my responsibility to contact Nevada Cardiology Associates, regarding any necessary adjustments to my medications, based on laboratory testing. I understand that I must review my prescription drugs prior to office visits, and request any prescription refills at the time of the office visit.

I understand that I will not be allowed to continue in the practice, if I repeatedly miss appointments or procedures, or fail to follow recommended medical treatment.

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Signature   Date