CARDIOVASCULAR CLINIC of NORTH GEORGIA
CVCNG

Dr. Salman Ashfaq, MD, FACC, FSCAI
Dr. Saurabh Dhawan, MD, FACC
Dr. Syed Shirazi MD, FACC, FACP
Dr. Masih Uddin MD, FACC
Dr. Vivak Patel DO, FACC
Dr. Salil Patel MD, FACC

By signing this form, I authorize the Cardiovascular Clinic of North Georgia to obtain records from facility listed below.

Valid for one year from date of Signature

Name: _____

DOB: _____

Social Security: _____

Address: _____

Date: _____

Signature: _____

Release from:

(OFFICE USE)

Facility/ Doctor: _____

Address: _____

Phone number: _____

Fax number: _____

Please release records to:
Cardiovascular Clinic of North Georgia
Gainesville Fax: 678-928-5955

Or

Lawrenceville Fax: 770-277-3458

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Medication List

Name: _____ DOB:_____

Allergies: _____

Please include any over the counter supplements that you currently take

Name:	Dosage:

Office Locations:
1475 Jesse Jewell Pkwy. Ste. 300 Gainesville, GA 30501 | 4700 Nelson Brogdon Blvd. Ste. 200 Buford, GA 30518
5670 Old Winder Hwy Ste. 200 Braselton, GA 30517 | 638 Historic Hwy 441 N. Ste C Demorest, GA 30535
771 Old Norcross Road, Ste 305 Lawrenceville, GA 30046 | 317 Resource Parkway, Winder, GA 30680
4245 Johns Creek Parkway, Suite D Suwanee, GA 30024

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HIPAA Acknowledgement:

I understand that under the Health Insurance Portability & Accountability Act of 1996.I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow up among the multiple healthcare providers who may be involved in treatment directly or indirectly.
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physical certifications.

I have read and understand the CVCNG Notice of Privacy Practices. I understand that this practice has the rights to change its Notice of Privacy Practices and that I may contact the practice at any given time to obtain a copy.

I authorize CVCNG to release and/or obtain my records to/from other physicians for the purpose of continuity of care.

_____

Signature of patient/patient Representative Relationship Date

Financial Policy & Assignment of Benefits:

- Copayments for services are required at the time of registration. Failure to pay your copayment at the time of service may result in a billing/statement fee of $10.00. Please be advised that we are contractually obligated by your insurance carrier to collect your copayment at the time of service.
- We will process and file your insurance claims for services. The balance of your charges will be billed to you. Payment in full of the patient portion will be expected with receipt of your statement. You will receive two billing statements regarding your balance.
- Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover or which they may consider medically unnecessary and in some instances, you will be responsible for these amounts. We will make every effort to ascertain your coverage for our services before treatment and will make you aware of our findings. However, this does not guarantee payment from your insurance carrier and you may be responsible for the balance.
- For services that are not covered by insurance, the practice requires payment of 100% of total charges unless prior arrangements have been made.

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Financial Policy & Assignment of Benefits:
(Continued)

- If you do not have insurance, please ask to speak with the practice manager to review our payment options. We offer a 50% discount on your services if you pay on the same day services are rendered. If you cannot pay at the time of service, we offer a 30% discount and we will be happy to put a payment arrangement in place for you that meets our established practice policy.
- For hospital charges, we offer a 50% discount on services if paid in full upon receipt of statement. If you cannot pay upon receipt of statement, we offer a 30% discount on services and we will be happy to put a payment arrangement in place for you that meets our established practice policy.
- Returned checks are subject to a handling fee of $30.00. In the event your account must be turned over for collection, you will be billed and are responsible for all fees involved in that process.
- Cancellation policies are set forth to ensure all patients are seen in a timely manner. If for any reason you cannot keep your appointment, we ask that you cancel at least 24 hours in advance. If you are scheduled for a **test** and do not cancel at least 24 hours in advance of your appointment time, a cancellation fee of **$175.00** will be assessed to your account. If you do not cancel an **office visit** appointment with a 24 hour notice, a cancellation fee of **$25.00** will be assessed to your account.

_____

Signature of Patient/Patient Representative Relationship Date

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Authorization to Release Protected Health Information:

You have the right to request a restriction on your protected health information (PHI) at any time.

Patients may request that we release their protected health information to family, friends, or physicians. If you request this right, we are required to have a completed authorization prior to releasing your PHI.

If You wish For Someone to Have Access to Your PHI, Please Complete This Authorization Form.

I authorize the individuals below access to my PHI over the telephone. This authorization is effective until such time as you revoke or terminate this authorization.

_____ _____

Name Relation

_____ _____

Name Relation

If you do not wish to disclose information to anyone, please indicate by checking box below.

☐ Do not disclose information

If you would like for our office to release any protected health information to another physician please complete below.

_____

Physician Name & Location

_____

Physician Name & Location

Signature is acknowledgement that you have read and understand the implications of this authorization to release your protected health information to others designated above.

_____ _____

Print Name DOB

_____ _____

Signature Date