CARDIOLOGY of ATLANTA

755 Mt. Vernon Hwy, NE
Suite 530
Atlanta, GA 30328
Ph : 404-252-7970
Fax : 404-250-0553

Consent for Medical Treatment

I, _____, consent to medical treatment as deemed medically necessary and appropriate by my Cardiology of Atlanta physician.

- Medical treatment may include, but is not limited to, performing an EKG, ordering laboratory testing, administration of medications, and other diagnostic services to assess my cardiac health as thoroughly explained to me by the physician.
- I acknowledge that no guarantee or assurance has been made to me as to the results of medical treatments or examinations.
- I understand that I have the right to be informed by my physician of the nature and purpose of any recommended treatment and/or testing, as well as any associated risks.
- This consent is not, in any way, to be considered an alternative to my physician's explanation(s) of treatment recommendations made by him.

Acknowledgment of Financial Responsibility

I, _____, acknowledge full responsibility for services rendered by Cardiology of Atlanta.

- I acknowledge that my insurance coverage is a contract between me, my employer (if applicable) and the insurance company. Cardiology of Atlanta is not a party to that contract. I agree that Cardiology of Atlanta will file my insurance for payment of services rendered as a courtesy, and that payment is not guaranteed. By providing them with my insurance information, I am authorizing assignment of benefits to Cardiology of Atlanta for payment. I understand that all deductible, co-insurance, and/or co-pay amounts are my responsibility, that payment of these obligations are due at the time of service, and that it is my obligation to make provisions to fulfill this responsibility.
- I understand that if an unpaid balance ages to a delinquent status, defined as older than 90 days, that the balance may be turned over to an outside collection agency and I will be responsible for all costs incurred for that collection effort, which includes a collection fee of 30% of the balance being placed in collections.
- I acknowledge that it is my responsibility to update any changes in my demographic information (address, phone number, marital status, insurance coverage, etc.) to ensure I remain actively engaged in all financial matters concerning my treatment at Cardiology of Atlanta.
- If I am uninsured at any time during my care at Cardiology of Atlanta, I understand that cash pay rates are available and are payable in full at the time of my appointment(s).

Patient/POA Signature: _____ DOB: _____

Printed Name: _____ Date: _____

COA Witness: _____ Date: _____