Cherry Creek Heart

PUT YOUR HEART IN OUR HANDS

HIPAA Privacy and Release of Information Authorization

I, _____hereby authorize HEARTISTIC COLORADO LLC and its affiliates, its employees and agents, to use and disclose protected health information (e.g., information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, Member ID number) for the purpose of helping me to resolve claims and health benefit coverage issues.

I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws.

I understand that I have a right to revoke this authorization by providing written notice. However, this authorization may not be revoked if, its employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services.

I have been advised of this practice's Privacy Practices, Release of Billing Information policy, Assignment of Benefits policy, and grant the practice Medication History Authority.

I understand that I may be asked to leave the practice at any time for violating patient code of conduct or being disrespectful to physicians or clinic staff. If asked to leave the practice, Cherry Creek Heart will provide 30 days of emergency coverage to help with the transition.

If applicable, Legal Representatives sign below:

By signing this form, I represent that I am the legal representative of the Member identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Member's behalf with respect to this authorization form.

For correspondence via SMS

No mobile information will be shared with third parties/affiliates for marketing/promotional purposes. All the above categories exclude text messaging originator opt-in data and consent; this information will not be shared with any third parties.

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Financial Disclosure

I understand that it is my personal responsibility to verify my insurance benefits before any services are received and it is not the responsibility of Cherry Creek Heart or its office members. If there are any services that are not covered under my plan due to plan provisions within my policy, they will be my financial responsibility. I also understand that it is ultimately my responsibility to contact my insurance carrier if I have questions regarding my plan provisions. Due to these provisions, I might be liable for a deductible, co-pay, and co-insurance depending upon my plan provisions. I understand that a credit card, debit card, or health savings account card will need to be kept on file. Any copays are due at the time of service and I authorize Cherry Creek Heart to hold and charge my credit on file for any balances due on my account.

I also understand that if there is a change in my insurance policy, it is my responsibility to notify the Cherry Creek Heart office to update my file before my next visit. If I fail to do this, I may be responsible for the full fee of the visit. When I receive my statement from the Cherry Creek Heart billing office, I will make arrangements to pay my balance in full within 30 days. If I cannot pay my balance in full, I will contact the Cherry Creek Heart collections department to make suitable payment arrangements. I will also be responsible for medical record printing charges of $0.15 per page, a <48h notice cancellation of appointment fee (excluding weekends and holidays) of $100, and any other services that the office provides that are not billed through insurance. If I am more than 15 minutes late to my appointment it is up to the provider's discretion if the no-show fee of $150 will be charged. Please note that the cancellation fee is charged no matter the circumstance and it is up to the practice's discretion to waive the fee as deemed appropriate. If I am unable to pay my bills on time, Cherry Creek Heart has the right to send my account to 'Collections' with a 25% collection fee.

I take full financial responsibility for the payment of all outstanding balances for services provided by Cherry Creek Heart.