



**OFFICE POLICY ON PAYMENT:**

This provider does not contract with any insurance companies, but most health insurance companies do cover our services at the out-of-network rate. It is our policy to require payment of all charges at the time service is provided. It is the patient's full responsibility to submit his/her claims to their insurance carrier. At the time of service, this office will provide the patient with a billing statement including appropriate service and diagnostic codes. As a courtesy we will submit a copy to the insurance company if desired. It is the patient's responsibility to submit any additional information if needed.

I understand that Heart Attack Prevention Strategies, PC does not participate with insurance and is an out of network physician requiring payment is due at the time of service.

- Yes, I would like for the claim to be sent to my insurance company on my behalf.
- No, I do NOT want the claim sent to my insurance company on my behalf.

**CANCELLATION POLICY:**

Out of courtesy to our other patients and our physician, we require 72 hours notice to cancel or reschedule an appointment. This gives us and our other patients an opportunity for an earlier appointment. *If we do not receive 72 hours notice there is a no-show/cancellation charge of \$225.00*

**AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS:**

I authorize Heart Attack Prevention Strategies, P.C. to release my medical information including, but not limited to, billing, diagnosis, x-ray, test results, reports and records pertaining to any treatment or examination rendered to me. I understand that this medical information may be used for the following purposes: diagnostic, insurance, legal and when my physician deems it necessary, in order to ensure the best medical care on my behalf. I understand I can revoke this authorization at any time.

**CONSENT TO TREATMENT:**

I (the patient/parent/guardian/legal representative of the patient acting on the patient's behalf) give permission for medical treatment, including radiological, ultrasound and laboratory procedures, to be performed by the physicians and staff of Heart Attack Prevention Strategies, P.C. This consent is valid from this date forward.

I understand that while Heart Attack Prevention Strategies, P.C. strives to prevent the onset of diabetes, stroke or heart attacks, the clinic and staff makes no guarantees.

**Relationship to Patient (please circle):** Self    Child    Dependent    Other \_\_\_\_\_

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Printed Name

Signature

Date

*Heart Attack Prevention Strategies, P.C.*  
Appreciates the opportunity to serve you.