Cardiology Associates of West Alabama
4401 Watermelon Road
Northport, AL 35473

AGREEMENT TO PAY

The Patient and Responsible Party listed below agree to pay all amounts and charges submitted by Cardiology Associates of West Alabama (referred to as physician) for services rendered by himself or any of his other employees or contractors, during the course of treatment for the Patient, including hospitalization, unless the physician or contractors, are otherwise obligated to accept payment solely from a third-party. The Patient and the Responsible Party understand and agree that they are financially responsible to the physician even though there may be insurance or third-party coverage and agree to pay all costs of collection, including a reasonable attorney's fee. The Patient and Responsible Party acknowledge their understanding that payment is due in full upon receipt of invoice statement. The Patient and the Responsible Party agree that their obligations to make payments are joint and severable and that the physician may pursue either or both parties for payment, and that they, and not any insurance company, are solely responsible for the entire bill, even though the cost of this medical care may exceed the amount reimbursed by third-party insurers of payers.

RESPONSIBILITY FOR NON-COVERED SERVICES

The Physician may determine that there are certain routine services that are necessary for the maintenance of good health and standard medical care that are not covered by your Blue Cross/PMD contract, other insurance contract, HMO or other third party insurance coverage. Charges not covered may include services rejected as not medically necessary, denied as non-covered services, and/or any annual deductibles or co-pays. Patients and Responsible Party agree to be fully responsible for all charges by the physician for such non-covered charges in the amounts set forth on the fee schedule, which is available upon request. The Physician will order only tests that are deemed medically necessary in the Physicians opinion and any questions regarding whether a certain service is covered by your carrier. Patient and Responsible Party acknowledge their understanding of this non-covered service policy of the Physician.

AUTHORIZATIONS

Patient and Responsible Party understand that the following authorizations are to be used by the Physician to effect the collection of benefits on Patient's behalf. Their authorizations become effective on the date of the first service rendered, and remain in effect until specifically revoked in writing by Patient and Responsible Party. Copies of this Agreement will be as valid as the original.

(a) **RELEASE OF INFORMATION**: The Patient and Responsible Party authorize the release and disclosure of all medical information related to Patient's treatment and care, to any entity, which is, or may be liable, for Physicians charges, or to any Professional Review Organization or utilization review organization associated therewith. The Patient and Responsible Party authorize the release and disclosure of all or any part of Patient's medical records to any other health care provider who may be of assistance, in the opinion of the Physician in providing medical care and treatment for the Patient, and/or for assisting in any reimbursement or benefits to which Patient may be entitled.

(b) **ASSIGNMENT OF BENEFITS**: The Patient and Responsible party authorize and requests that payment of any authorized insurance benefits be made either to Patient, or on a Patient's behalf, to the Physician for the services furnished the Patient by the Physician. This authorization allows the Physician to file "assigned" claims only for the purpose of having benefits paid to the Physician and does not imply that the Physician accepts insurance as payment in full, unless the Physician has a contractual agreement with the Patient's carrier or is otherwise legally obligated to accept less than the actual charges. The signatures below are deemed sufficient for all insurance forms on a continuing basis.

(c) **FOR TREATMENT**: The Patient and Responsible Party authorize the Physician to perform any procedure, which may be deemed necessary in the judgment of the attending Physician in the diagnosis and treatment of Patient's condition. The Patient and Responsible Party consent to the administration of such drug(s) as may be considered necessary or advisable for treatment of Patient, with the exception of _____.

(d) **COMMUNICATIONS REGARDING MY ACCOUNTS**: Until my accounts are finally settled, I give my direct consent to receive communications regarding my accounts from any servicers and any collectors of my accounts, through various means such as 1) any cell, landlines, or text number that I provide, 2) any email address that I provide, 3) any auto dialer system, 4) voicemail messages and other forms of communications.

_____ _____

DATE **PATIENT**

_____ _____

DATE **RESPONSIBLE PARTY**

This authorization is effective for two (2) years unless otherwise specified from this date _____.