David M. Stieber, MD Interventional & Consultative Cardiology

CONSENT FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing below, you agree to the use and disclosure of your protected health information by David M. Stieber, M.D., our staff and other business associates for treatment, payment and healthcare operations. You have the right to request that we restrict our uses or disclosures of your protected health information, which we are otherwise permitted to make, for treatment, payment and healthcare operations, although we are not required to agree to these restrictions. However, if we agree to these restrictions, they are binding on us. You have the right to revoke consent in writing, except to the extent that we have taken action in reliance on the consent.

ASSIGNMENT OF INSURANCE BENEFITS: Patients with insurance please read and sign. I hereby assign payment for all medical benefits including major medical benefits to which I am entitled from private insurance and any other health plans to: Dr. David M. Stieber. This assignment will remain in effect until revoked by me. A photocopy of this assignment is to be considered valid as an original. I understand I am financially responsible for all charges that are left unpaid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment. *I understand that if a prior authorization needs to be obtained by my insurance company for diagnostic testing ordered by the provider, it is my responsibility to contact my insurance company. If a prior authorization is necessary I will inform the office staff of this so a prior authorization can and will be obtained.*

PERMISSION FOR MEDICAL PROCEDURE: By signing below I authorize Dr. David M. Stieber to provide me with diagnostic imaging services as requested by my health care provider. I have read, understood and agreed that I am ultimately responsible for all professional and/or technical fees.

RECEIVED BILLING POLICIES: By signing below I agree that, I have received a copy of the Billing Policies and understand that I am obligated to the policies that fit my situation.

AGREED and ACKNOWLEDGED

Signature_____ Date_____

REVOCATION

Signature_____Date_____