



cardiothoracic
surgery group

Husam H. Balkhy, M.D.
Ganesh S. Kumpati, M.D.
Robert P. McManus, M.D.
Scott A. Schlidt, M.D.
Christopher D. Stone, M.D.
Michael Swank, M.D.

Date: _____

Enclosed please find a Patient Registration form, which need be completed for the services rendered to you by Dr._____. Please complete the portions of the form, front and back, which pertain to you. Sign the form where we have highlighted.

We must have the complete mailing address for your insurance company to insure that your claims are forwarded to the correct company. If possible, please send photocopies of the front and back of your insurance cards.

We have enclosed a self-addressed stamped envelope for your convenience in returning the information to our office. If you have any questions, please do not hesitate to contact our office at (414) 271-5119.

Sincerely,

Cardiothoracic Surgery Group, S.C.

Enclosures



Husam H. Balkhy, M.D.
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Robert P. McManus, M.D.
Scott A. Schlidt, M.D.
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AUTHORIZATION FOR RELEASE OF INFORMATION INFORMED CONSENT

I, _____, DOB: _____, Social Security number: _____
(Patient's Name)

hereby request and authorize:

Three horizontal lines for patient information.

To release to:

Three horizontal lines for recipient information.

The following information:

Information in health care records including history and physical examinations, evaluation, testing and x-rays, HIV test results or documentation relating to HIV, records of care and treatment, progress and prognosis, medical, surgical, pathological, psychiatric and psychological. I understand that this includes information provided by physicians, nurses, and any other health care providers and information disclosed may include reference to or testing or treatment for alcohol/drug abuse and or emotional illness or development disorders.

Other (specify) _____

The purpose of this disclosure is for (mark one or more):

- Further care/services, Worker's Compensation, Personnel Use, Social Security Benefits, Insurance Application, Other (specify), Litigation, Payment of Health Insurance Claim

(A photocopy, fax copy or other mechanical reproduction of this form and signature is as valid as the original.)

This consent shall remain in effect until: _____

(Date, condition, or event upon which this consent will expire)

If not stipulated, I understand that this consent will expire one year from date signed and revocation must be in writing and directed to the releasor prior to release of information.

Signature of patient or legal guardian Relationship Date signed

Witness' signature _____

Please sign and date this release of medical records so that the above physicians can obtain copies of your medical records to help insure continuity of medical care. We will not request copies of your medical records unless instructed to do so by you or one of the above physicians.



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CONSENT FOR MEDICAL SERVICES

PATIENT NAME: _____
(Print)

I hereby authorize and consent to the performance of examinations, diagnostic procedures, and treatments that the physician and other Health Care providers and I agree are necessary.

This consent shall remain in effect until I choose to revoke it in writing.

SIGNED: _____ **DATE:** _____
(Patient or Parent/Guardian)

Relationship to patient: _____

**PAYMENT AGREEMENT AND AUTHORIZATION
TO RELEASE INFORMATION AND ASSIGN BENEFITS**

I assign Cardiothoracic Surgery Group, SC the medical and/or surgical benefits I am entitled from my insurance company for services provided.

I understand that the payor of my healthcare benefits may pay less than the actual bill for services. I hereby assume payment responsibility in accordance with the regular rates and terms of the clinic for all services rendered, regardless of insurance benefit levels, with the exception of Worker’s Compensation injuries, and contracted agreements with the HMO and PPO plans.

I hereby authorize the release of the following information for the purpose of processing claims for reimbursement to Cardiothoracic Surgery Group, SC:

Information in health care records including history and physical examinations, evaluation, testing and x-rays, HIV test results or documentation relating to HIV, records of care and treatment, progress and prognosis, medical, surgical, pathological, psychiatric and psychological. I understand that this includes information provided by physicians, nurses and any other health care providers and information disclosed may include reference to or testing or treatment for alcohol, drug abuse, emotional illness or developmental disorders.

This authorization is in effect until I choose to revoke it by written notification to Cardiothoracic Surgery Group, SC and applies to past and future medical records.

A photocopy, fax copy, or other mechanical reproduction of this form and signature is as valid as the original.

I have read the above and I understand its content.

SIGNED: _____ **DATE:** _____

Relationship to patient: _____