**Insurance information**

Please provide your Insurance card and Driver license to the front desk for a Copy.

Insurance Carrier:

Group #:

Policy #:

Effective date:

Primary insurance holder/Grantor name and DOB:

**Insurance Authorization and assignment**

I hereby authorize Heart to Heart cardiology and vascular of Orange county to Furnish information to insurance carrier concerning my illness and my treatment and I hereby assign to the physician/ Heart to heart cardiology and vascular of orange county Inc. all payments for medical services rendered to myself or my dependents. I understand that I am responsible for full amount not covered by insurance. I understand that it is my responsibility to make sure that all services have been pre-authorized. I understand that I am financially responsible to the practice for any and all that may be denied by the insurance company.

I consent to the release of any information required by the insurance carrier with the respect to the course of my medical examination and/or treatment.

Signature:

Date:

**Authorization to release information**

I consent to the release of my applicable medical records, information from any other physician or referring physician as seen necessary by Heart to Heart Cardiology and Vascular Inc. the facility/ Treating physician is permitted to use and disclose my health information to make decisions and plan for my care and treatment, also to refer to a consultant if necessary with other health care providers.

Signature: Date:

Print name: