Kettering
Cardiothoracic & Vascular
SURGEONS INC.

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A partner of Kettering Physician Network

NOTICE OF CONSENT AND FINANCIAL RESPONSIBILITY PATIENT ACKNOWLEDGMENT

I hereby authorize the Physician/Physician group above to provide treatment and/or tests to me. I hereby authorize release of information to my insurance companies. I understand I am responsible for my bill. I authorize payment directly to my Physician/Physician group. I authorize use of this form on all of my insurance submissions. I authorize this practice to act as my agent to help me secure payment from my insurance companies.

I hereby authorize release of medical records or copies of such, and request that they be mailed or faxed to Kettering Cardiothoracic and Vascular Surgeons, Inc. to carry out treatment, payment, and healthcare operations. I also authorize release of my medical records or copies of such from Kettering Cardiothoracic and Vascular Surgeons, Inc. to other healthcare providers to carry out treatment, payment and healthcare operations.

SIGNATURE:_____ **DATE:** _____

NOTICE OF PRIVACY POLICY PATIENT ACKNOWLEDGMENT

The Notice of Privacy Practices describes your rights in regard to your health information, the possible uses of your health information, and how we must protect the confidentiality of your health information.

THIS IS NOT A CONSENT. BY SIGNING BELOW YOU ARE ONLY STATING THAT WE HAVE OFFERED TO PROVIDE YOU WITH A COPY OF OUR NOTICE OF PRIVACY PRACTICES. IF YOU WISH TO RECEIVE A COPY OF THIS FORM, ASK THE STAFF MEMBER WHO IS ASSISTING YOU.

We encourage you to carefully read the full Notice.

I have been given the Kettering Cardiothoracic and Vascular Surgeons, Inc.'s Notice of Privacy Practices:

Printed Patient Name: _____

Signature: _____ **Date:** _____

Relationship to Patient (If patient unable to sign): _____

May we leave a message on an answering machine and/or with a family member: Y N

Witness: _____ **Date:** _____