PALM BEACH CARDIOLOGY CENTER

CONSULTATIVE & INTERVENTIONAL CARDIOLOGY
Board Certified In Cardiology, Nuclear Cardiology & Interventional Cardiology

EDWARD MOSTEL, M.D., F.A.C.C.
HTWE H. SEIN, M.D., F.A.C.C.
STEVEN KESSEL, M.D. F.A.C.C.
CYRUS KAVASMANECK, M.D
TOBIA PALMA, M.D., F.A.C.C
MORTEZA TAVAKOL, M.D.
ROBIN J. HAHNER, M.P.H., P.A.-C.

3365 Burns Road, Suite 101
Palm Beach Gardens, FL 33410
Phone (561)775-1061
Facsimile (561)775-1064

Lifetime Authorization: Medicare and Medicaid

I certify that the information given to me in applying for payment under Title XVIII and/or Title XIX, of the Social Security Act is correct, and request said payment of authorized benefits are made on my behalf. I understand that I am financially responsible for my health insurance deductibles, coinsurance and non-covered services. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediary carriers, any information needed for this or a related Medicaid claim. I hereby irrevocably assign payment to Palm Beach Cardiology Center and otherwise payable to me.

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Date Patient's Signature

Auth. To Pay Benefits: ***Must sign* if you have insurance**

I understand that Palm Beach Cardiology will assist me in submitting my claim to my insurance carrier (if they are a provider of that insurance). I hereby authorize payment directly to Palm Beach Cardiology, otherwise payable to me, for the services provided. I understand that I am financially responsible for my health insurance deductibles, coinsurance and non-covered services.

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Date Patients' Signature

Additional Charges ****Must sign****

Missed Appointment Fee: I understand that I have an obligation to assist in the management of my healthcare and do my best to attend all appointments. I agree that missing appointments and canceling less than 24 hours prior to appointments may result in a $25.00 charge that is not covered by my insurance policy and will be my responsibility.

Delinquent Accounts: I agree to payment of $50.00 collections fee in the event that my account is placed into collections at 120 days.

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Date Patient's Signature

Consent to Obtain Prescription History ****Must sign****

I understand that in order to obtain prescriptions from Palm Beach Cardiology, they require my prescription history. This will assist in providing me with the safest patient care available.

Primary Pharmacy used _____

Address _____

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Date Patient's Signature