Atlanta Heart Group, P.C.
2665 North Decatur Road; Suite 260
Decatur, Georgia 30033

Patient's Name: ____

Record # ____________

Assignment of Insurance Benefits:

I hereby authorize the Atlanta Heart Group, P.C. to furnish information to my insurance carrier(s) concerning my illness, treatment(s) and diagnosis upon written request.

I hereby authorize my insurance carrier(s) to pay directly to the doctor all payments for medical services rendered to myself. I understand that I am financially responsible for any charges not paid by my insurance carrier. This authorization will remain in effect until all charges are paid in FULL. Medicare's assignment of benefits will apply accordingly.

I understand that the co-pay, co-insurance and deductible are to be paid once service has been rendered.

HMO/POS/EPO Patients:

HMO/POS/EPO authorization is required prior to service. I understand that I am responsible for obtaining a referral for my office visit(s). If the authorization is not on file in our office, I understand that I am financially responsible for service(s) rendered on my behalf.

Patient Signature: ________________________ Date: _____________