Name: ______________________

Date of Birth: ________________

Midwest Cardiovascular
Research Foundation

PLEASE SIGN AS INDICATED BELOW TO ACKNOWLEDGE YOUR RECEIPT AND ACCEPTANCE OF THE FOLLOWING STATEMENTS:

#1 Insurance & Demographic Verification

I have reviewed/updated my insurance and demographic information. I hereby verify that this information is accurate.

Patient Signature: ______________________________ Date: ______________________

#2 Payment Authorization

I hereby authorize payment of any medical benefits for services rendered by Midwest Cardiovascular Research Foundation directly to Midwest Cardiovascular Research Foundation that would have otherwise been payable to me. I understand that amounts deemed by my insurance carrier to be beyond the "unusual", reasonable, and/or customary" charges for said services will be paid by me.

No Insurance and Insurance denial financial responsibility include but not limited to:

- Dietitian – Initial visit $35 per unit (15 min.) $30 per unit thereafter.
- Vascular Screening - $100
- Provider visit - $100 + $30 EKG

Patient Signature: ____________________________ Date: ________________________

#3 Notice of Information Practices

I have read and understand the notice of Information Practices provided to me by Midwest Cardiovascular Research Foundation. I hereby authorize Midwest Cardiovascular Research Foundation to disclose all or any part of my personal health information for treatment, payment and health operations as outlined in the notice of Information Practices.

Patient Signature: ___________________________ Date: _________________________

 # 4 Research Authorization

I have read and understand the authorization to use and disclose health information for research purposes only provided to me by Midwest Cardiovascular Research Foundation. I hereby authorize Midwest Cardiovascular Research foundation to disclose all or any part of my personal health information for research purposes as outlined in authorization to use and disclose health information for research purposes only.

Patient Signature: _________________________ Date: ___________________________

 # 5 Photography Consent

I, _______________________ hereby grant permission to Midwest Cardiovascular Research Foundation, Davenport, Iowa, to take and use photographs and/or digital images for use in their publications, promotions and website. Understand that names will NOT be revealed unless agreed to upon. I authorize the use of these images without compensation.

Patient Signature: __________________________ Date:___________________________