



# Kern Cardiology Medical Group -Since 1978

(Sam) Sarabjit Singh, MD. FACC. FSCAI

## Patient Consent Form (Confidential)

**Patient Name:** \_\_\_\_\_ **Birth Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

Please be noted that you have the right to review Kern Cardiology Medical Group’s Notice of Privacy Practice before signing this patient consent form. **A copy is attached.** With your consent, Kern Cardiology Medical Group Inc. may use and disclose PHI about you to carry out treatment, payment, and healthcare options.

### Acknowledgment of Receipt of the Notice of Privacy Practice

I, the undersigned, have received a copy of Notice of Privacy Practice from Kern Cardiology Medical Group Inc. I hereby understand my signature agrees that I acknowledge my rights and how my PHI will be used.

**Patient/Responsible Party Initial** \_\_\_\_\_ **Date:** \_\_\_\_\_

### Insurance Authorization

I, the undersigned, have insurance coverage with \_\_\_\_\_ and assign directly to Kern Cardiology Medical Group Inc. all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by the insurance. I hereby understand my signature requests that payment be made and authorized release information necessary to pay the claim. I authorize to this signature on all insurance submissions.

**Patient/Responsible Party Initial** \_\_\_\_\_ **Date:** \_\_\_\_\_

### Authorization for Contacts

I, the undersigned, authorize Kern Cardiology Medical Group Inc. to speak to the persons listed below regarding my medical care. I hereby understand with my signature I am authorizing the release of written or oral communications by Kern Cardiology Medical Group and its staff from all legal responsibility that may arise from the act hereby authorized.

\_\_\_\_\_  
Authorized Person                      Relationship to Patient                      Phone Number

\_\_\_\_\_  
Authorized Person                      Relationship to Patient                      Phone Number

**Patient/Responsible Party Initial** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Authorization for Communication**

I, the undersigned, authorize Kern Cardiology Medical Group Inc. to contact me by  
Email address: \_\_\_\_\_ Phone/Voice Mail # \_\_\_\_\_

Mailing Address: \_\_\_\_\_

I understand that messages may at times include some protected health information, including test results and instructions. I hereby understand with my signature I am authorizing the release of written or oral communications by Kern Cardiology Medical Group and its staff from all legal responsibility that may arise from the act hereby authorized.

**Patient/Responsible Party Initial** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Financial Responsibility**

I, the undersigned, understand that I am financially responsible for all charges whether or not paid by the insurance. I hereby with my signature agree to bear full financial responsibility for ALL services provided as listed below at full cost if

- Services are NOT covered under your insurance benefit plan
- Services have not been otherwise approved for payment by your insurance company
- There is no payment from your insurance

**(Patient's balance not paid upon receiving the first statement is subject to \$25 for late charges; returned checks are subject to \$25 finance charges; An appointment not kept, cancelled or rescheduled less than 24 hours are subject to \$25 finance charge; testing appointment not kept, cancelled or rescheduled less than 24 hours are subject to \$50 finance charge and must be paid before visit and/or test can be rescheduled)**

**Patient/Responsible Party Initial** \_\_\_\_\_ **Date:** \_\_\_\_\_

This form is provided to you so that our office may comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

By Signing below, I acknowledge that I have reviewed and agreed with the terms.

**Patient/Responsible Party Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

Should have any questions, please contact our Office Manager at: 661-327-0807 or email her at [clangille@kerncardiology.com](mailto:clangille@kerncardiology.com).