

PRIVACY PRACTICES

I hereby acknowledge that I have seen a copy of Thoracic Cardiovascular Associates and Southwest Vein Institute's Notice of Privacy Practices. I Am aware that I may request and I will be provided a personal copy of the Notice of Privacy Practices for Thoracic Cardiovascular Associates and Southwest Vein Institute.

SIGNATURE_____

DATE_____

PATIENT NAME_____

AUTHORIZATION TO RELEASE/FINANCIAL AGREEMENT

I hereby authorize Thoracic Cardiovascular Associates/ Southwest Vein Institute to release to my insurance company any information acquired in the Course of my examination and treatment that may be necessary to determine the benefits payable for related services. I also authorize payment of benefits directly to Thoracic Cardiovascular Associates/ Southwest Vein Institute, and I understand that I am financially responsible for any charges not covered by this authorization.

SIGNATURE_____

DATE_____

PATIENT NAME_____