READ THE FOLLOWING RELEASE OF INFORMATION. PLEASE SIGN AND DATE.

I agree to and authorize medical treatment as deemed necessary by Apex Cardiology, P.C. I hereby authorize Apex Cardiology to furnish information concerning my treatment to insurance companies as deemed necessary, and I hereby irrevocably assign to Apex Cardiology, P.C. all insurance benefits payable to me by my insurance company, not to exceed the charges shown. I understand that I am financially responsible for any amounts that are not covered by my insurance and this authorization. Apex Cardiology, P.C. cannot accept responsibility for collecting insurance claims or for negotiation a settlement in a dispute claim. I understand that I am responsible for my account. The undersigned further agrees that in the event his/her account is turned over to any attorney; the undersigned shall be responsible for all cost of collection, including out of pocket expenses, court costs, and attorney fees. I request that payment of authorized Medicare benefits be made wither to me or on my behalf to Apex Cardiology, P.C. for any services furnished me by that clinic. I authorize any holder of medical information about me to release to the Health Care Financing Administration its agents any information needed to determine these benefits payable for related services.

Signed:_____Date:_____

Name and address of another contact person that doesn't live with you:

_____

_____

Telephone #:_____Cell #:_____

Who is your family doctor? _____

What is the address? _____

Telephone number: _____

Where do you have your prescriptions filled? _____

Telephone number: ____