ARIZONA ARRHYTHMIA CONSULTANTS

Consents form

Patient Name: _____ Date of Birth: _____

Do you have an Advance Directive? Yes ☐ No ☐
(An Advanced Directive is a legal document expressing your critical care wishes when you are unable to decide for yourself)

Acknowledgement of Notice of Privacy Practices:
I have been offered a copy of the Notice of Privacy Practices. I understand that Arizona Arrhythmia Consultants has the right to change its Notice of Privacy Practices at any time and that I may contact Arizona Arrhythmia Consultants at any time to obtain a current copy.

Signature: _____ Date: _____

Authorization of Release of Health Information:
I authorize the following individual(s) to have access to my personal health information.

Name: _____ Relationship: _____ Phone: _____
Name: _____ Relationship: _____ Phone: _____
Name: _____ Relationship: _____ Phone: _____

Signature: _____ Date: _____

Acceptance of Payment Policy and Patient Financial Agreement:
I have read, understand, and agree to the provisions of the Payment Policy and Patient Financial Agreement.

Signature: _____ Date: _____

Acceptance of Patient Portal Authorization:
By signing below, I acknowledge that I would like a Patient Portal account and agree to the terms and conditions set forth in the Patient Portal Authorization Agreement.

Email Address:

Signature: _____ Date: _____