

ADVANCED CARDIOLOGY, INC.

INSURANCE COVERAGE ASSIGNMENT

NAME OF PATIENT

SECTION I MEDICARE COVERAGE

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me, to release to the Center for Medicare and Medicaid Services Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for covered Medicare Services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment for services rendered to me.

I request that payment of authorized Medicare benefits be made directly to Advanced Cardiology, Inc. for any services furnished me by the physician. I authorize release to the Center for Medicare and Medicaid Services and its agents any medical information needed to determine that these benefits are payable.

SIGNATURE OF PATIENT _____ DATE _____

HEALTH INSURANCE CLAIM NUMBER _____

SECTION II PRIVATE INSURANCE

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize Advanced Cardiology, Inc. to release such information in connection with this form as the physician in its sole discretion may seem proper.

SIGNED _____ DATE _____

Patient (If minor - parent, legal guardian, or representative)

ASSIGNMENT OF INSURANCE BENEFITS: In consideration of the physician services received or to be received for these services, I assigned to further warrant that such benefits are or will be justly owing to me, that no part of same has been assigned or encumbered by me, and that said physician shall be irrevocable.

GUARANTEE OF ACCOUNT: I hereby guarantee payment of any and all physician charges not covered by this assignment and waive any and all notice and demands in the event of non-payment thereunder.

SIGNED _____ DATE _____

Insured/Certificate Holder