

PATIENT AUTHORIZATION FORM

E.N.T. SURGICAL GROUP

Patient Name _____

Patient Date of Birth _____

I consent to treatment necessary for the care of the above named patient.

I authorize the release of all medical records to the referring and family physicians.

I acknowledge full financial responsibility for services rendered by E.N.T. Surgical group.

I understand that payment of any non-covered service, copays, coinsurance and/or deductibles are due at time of service.

I agree to pay all reasonable attorney fees and collection cost in the event of default of payment.

I authorize and request that assignment of insurance payments be made directly to E.N.T. Surgical Group.

MEDICARE PATIENTS

I request that payment of authorized Medicare benefits be made on my behalf to E.N.T. Surgical Group for any services furnished to me by E.N.T. Surgical Group providers. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits for the benefits payable for related service

MEDIGAP PATIENTS

I request that payment of authorized Medigap benefits be made either to me or on my behalf to E.N.T. Surgical Group for any services furnished to me by E.N.T. providers. I authorize any holder of Medicare information about me to release to my insurance any information needed to determine these benefits payable for related services.

I have read and fully understand the above consent for treatment, financial responsibility, release for medical information and insurance authorization.

(Patient/Guarantor Signature)

(Date)

(Power of Attorney/Guardian)

(Relationship)

(Date)