

## Insurance Authorization and Assignment Disclosure

**Commercial\HMO and PPO patients:** If you are covered by any HMO\PPO and wish to receive services at ENT that have not been authorized, WE ARE AVAILABLE and happy to provide care. However YOU WILL be responsible for payment on the day of your exam or service. Depending on the type of service you require, you maybe required to make a deposit or payment agreement for estimated charges PRIOR to being seen.

**Medicare HMO\REPLACEMENT patients:** If you are on a Medicare HMO\PLACEMENT PLAN please be advised **WE ARE NOT PROVIDERS.** We are happy to treat you but you will be responsible for payment in full (at Medicare allowable rates) at the time of check out.

**All patients:** I hereby authorized Ear, Nose & Throat Associates to furnish information to insurance carriers or other guarantors of service concerning my illness and treatment and I hereby assign to the physician(s) all payments for medical services to myself or dependents. I understand I am responsible for any amount not covered or authorized by my insurance carrier for all office or surgical charges.

**Personal information:** Please note this is also verifying you have made us aware of any changes regarding your personal information.

**Have you received a new insurance card?** To make sure your insurance is filed correctly. Please inform us right away if you have received a new card.

**Thank you, ENT Doctors**

**Doctor who requested you consult us:** \_\_\_\_\_

**This will be valid one year from the date of your signature.**

**Please sign:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Patient's phone number:** \_\_\_\_\_

**Primary Ins.** \_\_\_\_\_

**Secondary Ins.** \_\_\_\_\_

**If the patient is a child list the parents name (s):**

\_\_\_\_\_  
**Place of employment:** \_\_\_\_\_

**Work number:** \_\_\_\_\_