

AUTHORIZATIONS

I authorize the release of any medical information necessary to process the insurance claim form for services rendered by Tallahassee Ear, Nose & Throat-Head & Neck Surgery, P.A. I also request payment of government benefits to the party who accepts assignment. I do authorize payment of medical benefits to Tallahassee Ear, Nose & Throat Physicians/Providers.

SIGNATURE: _____ DATE: _____

MEDICARE ASSIGNMENT:

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to the party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act U.S.C. 3801-3812 provides penalties for withholding information). Regulations pertaining to Medicare assignment of benefits also apply.

SIGNATURE: _____ DATE: _____

FINANCIAL RESPONSIBILITY:

Patient/Responsible party shall pay to Tallahassee Ear, Nose and Throat such sums as are now or may become due for services rendered to the patient and for which the patient's health maintenance organization or insurer is not liable for payment for fees to TENT. Guarantor must sign for all minors or dependents. The guarantee of the account hereby assumes full financial responsibility for payment for all medical services by the named patient in accordance with the terms as set forth in the Authorization above.

SIGNATURE: _____ (if patient is a minor or dependent, the Guarantor must sign here)

SIGNATURE: _____ DATE: _____

RECEIPT OF PATIENT PRIVACY NOTICE:

I have received a copy of the Patient Privacy Notice (Form HPPN1) from Tallahassee Ear, Nose & Throat-Head & Neck Surgery, P.A. I understand that for the office to review or discuss my medical/financial issues with anyone besides me, I will complete the Disclosure of Protected Health Information form.

SIGNATURE: _____ DATE: _____

USE AND DISCLOSURE:

I understand that as part of my health care, Tallahassee Ear, Nose and Throat originates and maintains a paper and/or electronic record describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. The use and disclosure of Protected Health Information for treatment, payment or operations is described in the Patient Privacy Notice.

SIGNATURE: _____ DATE: _____

DISCLOSURE OF OWNERSHIP:

Audiology Associates of North Florida, a division of Tallahassee Ear, Nose & Throat, is the only local audiology group able to coordinate your hearing services with physicians on-site. Please be advised that the following physicians own an interest in the audiology services of Tallahassee Ear, Nose & Throat - Head & Neck Surgery, P.A.: Duncan S. Postma, M.D., Spencer E. Gilleon, M.D., Adrian P. Roberts, M.D. and Marie O. Becker, M.D. and Joseph C. Soto, M.D. We feel that the cooperation of the physicians and audiologists in our group is advantageous to our patients, but should you wish to have an alternative provider for these services, we will provide them upon request.

I acknowledge this disclosure of ownership.

SIGNATURE: _____ DATE: _____

For Internal Use Only

PROCESSED BY _____ DATE: _____