

# Ear, Nose and Throat Associates of South Florida, P.A.

## ***Financial Consent***

I hereby authorize said assignee to release all information necessary to secure payment.

I certify that the information given by me for payment by my insurance plan(s) is correct. I authorize any holder of medical or other information about me to release to the above plan or its intermediaries or carriers any information needed for this or any related insurance claim. I request that the payment of authorized benefits be made on my behalf. I assign the benefits payable for medical services to the physician or organization furnishing the services or authorize such physician to submit a claim to the above insurance company for payment to me.

I understand that I am financially responsible for all charges whether or not paid by my insurance, including any deductibles and co-pays, and that payments are due at the time services are rendered.

I understand and agree that in the event that I fail to make payments for services rendered to me, my name and account may be turned over to an attorney or a collection agency, and I agree to pay collection agency's fees for collection, court costs, and/or reasonable attorney's fees that may be incurred in the collection of any outstanding balance.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

## ***Privacy Consent***

I have been provided with a copy of the practice's Notice of Privacy Practices

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

## ***Consent for Treatment***

I, \_\_\_\_\_ (the \_\_\_\_\_ of \_\_\_\_\_), hereby voluntarily consent to outpatient care at ENT Associates of South Florida, P.A., encompassing routine diagnostic procedures, examination and medical treatment including, but not limited to, routine laboratory work (such as blood, urine and other studies), taking of x-rays, and administration of medications prescribed by the physician.

I further consent to the performance of those diagnostic procedures, examinations and rendering of medical treatment by the physicians and their assistants, including audiologists, medical assistants or their designees as is necessary in the physician's judgement.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

## ***Medicare Consent***

I certify that the information given by me in applying for payment under Title SVIII and /or Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediary carriers any information needed for this or a related Medicare or Medicaid claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician(s) services. I understand that I am responsible for my health insurance deductibles and coinsurance.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_