Name:
DOB:
Chart:
Age:
Date:

Ō·tō·laryn·gol·ō·gy Associates
ENT & Face, Head & Neck Plastic Surgery
www.otolaryn.com

M/R RELEASE, MESSAGES, FINANCIAL POLICY

I AUTHORIZE THE RELEASE OF THE ABOVE PATIENT'S MEDICAL RECORDS TO THE INSURANCE CARRIER(S) VIA FAX OR MAIL. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS DIRECTLY TO THE PHYSICIAN FOR SERVICES PROVIDED. **I AUTHORIZE THE RELEASE** OF THE ABOVE PATIENT'S MEDICAL RECORDS TO THE PHYSICIANS INVOLVED IN THE CARE VIA FAX OR MAIL. **I FURTHER AUTHORIZE** OTOLARYNOLOGY ASSOCIATES TO LEAVE THE RESULTS OF THE ABOVE PATIENT'S EXAMINATIONS AND TESTS, INCLUDING MESSAGES, APPOINTMENT REMINDERS, LABORATORY TESTS AND X-RAYS ON THE ANSWERING MACHINE/VOICEMAIL AT THE PHONE NUMBER PROVIDED. **I AM RESPONSIBLE FOR ALL FINANCIAL OBLIGATIONS** OF THE HEALTH SERVICES FOR THE ABOVE PATIENT, AND FOR REIMBURSEMENT AND PAYMENT OF CLAIMS FROM THE INSURANCE COMPANY. I UNDERSTAND THE DOCTOR'S CHARGE MAY EXCEED THE INSURANCE CARRIER'S PAYMENT AND IF THE CHARGE IS MORE THAN SUCH PAYMENT, I WILL BE RESPONSIBLE FOR THE DIFFERENCE IF FOR ANY REASON THE ABOVE PATIENT'S ACCOUNT SHOULD BECOME DELINQUENT, I AGREE TO PAY FOR ALL COLLECTION, ATTORNEY FEES, AND COURT COSTS.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

_____ By signing below, I acknowledge that I have received Otolaryngology Associates, LLC* Notice of Privacy Practices ("Notice").

* This includes Whisper Hearing Centers, Biggerstaff & Associates and Balance Point

PRESCRIPTION MEDICATION HISTORY CONSENT

_____ I agree that Otolaryngology Associates, LLC may request and use my prescription medication history from other healthcare providers or third-party pharmacy benefit payors for treatment purposes.

_____ Date _____
Signature (Patient or Authorized Representative)

_____
Printed (Patient or Authorized Representative)

_____
Printed Patient Name