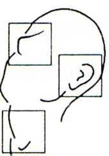

Ear, Nose & Throat Specialists of Abilene

OTOLARYNGOLOGY • HEAD & NECK SURGERY (ENT) • ALLERGY • AUDIOLOGY

JEFFREY BRAATEN, D.O. TAYLOR R. TIDMORE, M.D. GARY D. GOODNIGHT, D.O.

Assignment of Benefits Form

Financial Responsibility: All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms with be completed to file for insurance carrier payments.

I have requested medical services from **ENT Specialists of Abilene, LLP**, on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

Assignment of Benefits: I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health / medical plan, to issue payment check(s) directly to **ENT Specialists of Abilene, LLP**, for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Patient Consent for Disclosure of Information: I have read the Notice of Privacy Practices and have had any questions answered by this office. I understand that by signing this form, I consent to the following:

(a) Sharing information for purposes of treatment; this includes sharing this information with all members of my treatment team, both within and outside of this office (examples: laboratory services, radiology, primary care physicians, hospitals, etc...);

(b) Sharing information for purposes of payment: includes all necessary information to process insurance claims generated in the course of examination or treatment. This includes both governmental payers and non-governmental payers and includes any representatives appointed by the insurance carriers for purposes of benefit determination, utilization review and billing; I also consent to allow a photocopy of my signature to be used to process insurance claims for the period of lifetime.

(c) Sharing of information for purposes of operations; this includes all ongoing operations of this office including, but not limited to, credentialing, peer review, accreditation and compliance with federal and state laws.

My consent is freely given. I understand that I may revoke this assignment and consent at any time if that revocation is in writing, but any disclosures given in reliance of this prior consent will be permissible.

I have read and understand the financial policy on the reverse side of this page and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

PATIENT NAME PRINTED

SIGNATURE OF PATIENT / RESPONSIBLE PARTY IF MINOR DATE

WITNESS DATE

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