



PEDIATRIC AND ADULT EAR, NOSE & THROAT

Assignment of Benefits and HIPAA Notice

Assignment of Benefits:

I acknowledge financial responsibility for all facility and physician/provider(s) fees. I understand that the physician billing office will file my insurance claim and I assign direct payment to the physician all payments made under the terms and provisions of my policy. I further understand that any disputes on coverage are between my insurance carrier and myself and I will be responsible for payment for denied services regardless of the outcome of my dispute. I acknowledge financial responsibility for all charges if inaccurate insurance information is given at time of service and the information is not corrected prior to my insurance company's timely filing limit.

Patient/Representative Signature

Date

Acknowledgement of receipt of Notice of Privacy Practice regarding protected health information

I have received the Practice's Notice of Privacy.
Photocopies of this document are to be as valid as the original.

Patient Name

Signature

Date

COMMUNICATION PREFERENCES REGARDING PHI

To assist in your care, it may be necessary to release our *Protected Health Information* to someone other than yourself. To whom may we talk?

- Yes No
- Spouse _____
- Parent _____
- Step-Parent _____
- Other Person(s) _____
- Caregiver _____

May we leave a message on:

- Yes No
- Your answering machine/voice mail at home
- Your voice mail at work

Patient or Representative Signature

Date

Print Name

Account # (Office use only)



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Medicare Assignment of Benefits (Medicare Patients Only)

Medicare Identification Number: _____

I request that payment of authorized Medicare benefits be made either to me or on my behalf to University Otolaryngologists, dba Ohio ENT, for any services furnished to me by one of their physicians/providers. I authorize release to Centers for Medicare and Medicaid Services and its agents any medical information about me to determine the payments for related services.

This authorization is in effect for my lifetime or until I choose to revoke it.

Signature of Medicare Beneficiary

Date