ENT & Sinus Center, P.C.
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AUTHORIZATION FOR TREATMENT AND MEDICAL INFORMATION RELEASE

The purpose of medical care is to treat disease, injury and disability by examination, testing and use of procedures in the aid of diagnosis or treatment, and also to obtain information needed in diagnosing and examining patients.

We cannot render services on the assumption that our charges will be paid by an insurance company. All services are charged directly to the patient and he or she remains personally responsible for payment. However, as a courtesy to our patients, we will submit a claim to your insurance company and in doing so, the responsible party authorizes his/her insurance company to pay directly to the doctor and medical service provider.

I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. All bills are due and payable at the time services are rendered. Any other arrangements must be made in advance. We reserve the right to add a late charge on overdue balances and to add Collection fees to the balance should the account have to be placed with a Collection agency or other such service.

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to my or my child during the period of such care to third party payors and/or other health practitioners (including but not limited to the family doctor).

I acknowledge that I have read the above authorization/release.

X _____ / _____

Patient signature | Parent signature (if minor) | Date

Person Responsible for payment and co-pay: