Monroe Ear Nose and Throat Associates

Patient Name: _____ Today's Date: _____

Medical Services Agreement

General – If you have questions or any uncertainty regarding your insurance coverage or benefits, please do not hesitate to speak to one of our staff about your concerns. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account. Unfortunately, we can not guarantee payment from your insurance carrier.

Acceptance of Medical Services-I understand the medical service agreement of Monroe Ear Nose and Throat. I understand if any services or charges incurred. I authorize Monroe Ear, Nose & Throat to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all of my insurance submissions.

_____	_____	_____
Printed Name of Patient	**Signature of Patient or Parent**	**Date**

I DO Permit this office to discuss my Private Health Information (PHI) with, to disclose my PHI to and to contact in reference to me in an emergency of the following individuals:

_____	_____	_____
Name	Relationship	Telephone
_____	_____	_____
Name	Relationship	Telephone

Privacy Practices

____ (Initials) I have been provided the **Notice of Privacy Practices** from Monroe Ear, Nose & Throat Associates. I have been given the opportunity to discuss the office privacy Practices.

Medicare Authorization For Medicare Patients Only

____ (Initials) I request payment of the authorized **Medicare** benefits be made on behalf of Monroe Ear, Nose and Throat Associates for any services furnished to be by my physician or associates. I authorize any holder of medical information to release to the carrier needed to determine these benefits or the benefits payable. I am responsible for only the deductible, coinsurance and non-covered services.