Please complete and initial each statement as indicated; then sign once, at the bottom of the page. Thank you.

Initials:	Authorization/Acknowledgement
_____	**Acknowledgement of receipt of "What We Want Our Patients to Know"** I have received a copy of Lake Mary Ear, Nose, Throat & Allergy's patient payment policy which outlines my financial responsibility for medical services/treatment provided by Lake Mary Ear, Nose, Throat & Allergy and agree to comply with its requirements.
_____	**Assignment of Benefits/Acceptance of My Personal Financial Responsibility** I hereby authorize my insurance benefits to be paid directly to Lake Mary Ear, Nose, Throat & Allergy for medical services/treatment, it provides. I further understand that this assignment of insurance benefits does not relieve me of the contractual obligation I may have with my medical insurance carrier(s) to pay my portion of the fees associated with the medical services/treatment I receive (co-payment, co-insurance, annual deductible) from Lake Mary Ear, Nose, Throat & Allergy at the time of service. I also understand and agree that I am ultimately responsible for payment in full of any balance on my account not covered by health insurance and on any account on which I am the guarantor. Finally, I certify that the information I have given is true and correct to the best of my knowledge and understand I am responsible for notifying Lake Mary Ear, Nose, Throat & Allergy of any changes in the information I have provided.
_____	**Valid Signature on File (initial *only* if you are covered by Medicare)** "I request that payment of authorized Medicare benefits be made either to me or on my behalf to Lake Mary Ear, Nose & Allergy for any services furnished to me by that physician. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable for related services."
_____	**Acknowledgement of receipt of "Notice of Privacy Practices"** I have received a copy of Lake Mary Ear, Nose, Throat & Allergy's "Notice of Privacy Practices." I further acknowledge that Lake Mary Ear, Nose, Throat & Allergy may amend this document from time to time and that I may contact Lake Mary Ear, Nose, Throat & Allergy at any time to obtain the then-current copy of its "Notice of Privacy Practices."
_____	**Disclosure Authorization** If you do **NOT** complete this section, Lake Mary Ear, Nose, Throat & Allergy will take reasonable precautions to release your medical information **ONLY** to you. If you want us to share information about your treatment, billing, etc, with family members, etc., please provide their names and indicate their relationship to you below. You have the right to revoke or modify this authorization, *in writing*, at any time. Those with whom we may share information: Print name(s) below — What we can share (check all that apply): ☐ Spouse: _____ ☐ Anything in my medical record ☐ Child(ren): _____ ☐ Billing and/or insurance information ☐ Parent(s): _____ ☐ Lab results/X-ray reports ☐ Other: _____ ☐ Other: _____
_____	**Authorization for Medical Treatment** I consent to receiving medical services/treatment from healthcare providers (including PAs, Nurse Practitioners, Audiologists, etc.) practicing on behalf of Lake Mary Ear, Nose, Throat & Allergy. I recognize that healthcare is not an exact science and certify that no guarantees of outcomes have been made or implied. I agree that healthcare providers in training may participate in providing or observing the care I receive.

_____ _____ _____ / / _____

PRINT Your Name Above **SIGN** Your Name Above *Date signed*

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