

**EAR, NOSE AND THROAT SURGEONS
OF WESTERN NEW ENGLAND, LLC**

**ASSIGNMENT OF BENEFITS/CONSENT FOR TREATMENT, PAYMENT &
HEALTH CARE OPERATIONS**

By signing below, I understand that I hereby authorize the Practice to disclose my medical information so that the Practice may treat, seek payment from third parties for such treatment, and generally carry on the Practice's health care operations. I understand that I am responsible for payment in full of all charges. I request that payment of authorized Medicare and other insurance benefits be paid directly to Ear, Nose and Throat Surgeons of Western New England, LLC. I also authorize Ear, Nose and Throat Surgeons of Western New England, LLC to release all information necessary for the processing of insurance claims to HCFA, its agents or any other insurance company to determine the benefits payable for related services.

Signature: _____ Date: _____

INSURANCE STATEMENT OF UNDERSTANDING

This office will gladly submit your private insurance claims for office/surgical services rendered. You must supply us with your current ID card. All efforts will be made to collect your insurance benefits. Your insurance coverage is a contract between you and your insurance company. Any deductible or co-payment designated by your contract is your responsibility. You are also responsible for any non-covered services as well as obtaining and maintaining a current referral and any services denied by your insurance company. Co-payments are due at the time of your office visit.

COPAY POLICY

Many health insurance plans require a copay for services rendered which is expected at the time of service. If we must bill you for your copay, a \$25 service charge may be added. Thank you for your cooperation in this matter

“NO-SHOW”/CANCEL POLICY

If you cannot keep your scheduled appointment, please call 24-hours in advance to avoid “no-show ” office charges. We reserve the right to charge for missed appointments if you do not honor this policy.

If you repeatedly “NO-SHOW” and/or CANCEL your appointments, we reserve the right to discharge you from care.

Signature: _____ Date: _____

Additional Information on reverse side

**CONSENT TO DISCLOSE PROTECTED HEALTH INFORMATION TO
FAMILY, FRIENDS. AND/OR OTHER REPRESENTATIVES**

By signing below, I have authorized Ear, Nose and Throat Surgeons of Western New England to disclose my Protected Health Information to the following family members and friends:

NAME	Relationship	Telephone #

Signature: _____ Date: _____

Notice of Privacy & Acknowledgement Form Given to Patient _____
(date)