ADOBE
ENT & ALLERGY

Patient Name: _____ Date: _____

SIGNATURE AND RELEASE AUTHORIZATION

CONSENT TO EXAMINATION AND TREATMENT: attested by my signature on this form, I hereby consent to allow physicians and medical staff of Adobe ENT & Allergy to examine and treat me (or the person named herein for whom I have legal responsibility) in connection with my visit to Adobe ENT & Allergy.

_____ _____
Date Signature of Patient or Guardian

SURGERY CENTER, RADIOLOGY, AND LABORATORY INTERPRETATION AND TESTING SERVICES: Radiology and laboratory services are provided independently by physicians who are not Adobe ENT & Allergy agents or employees, and who bill separately from Adobe ENT & Allergy for their services.

FINANCIAL RESPONSIBILITY AND RELEASE OF INFORMATION: I understand that I am financially responsible to Adobe ENT & Allergy for charges not covered by my insurance carrier. Payment for services is due at time of service unless prior arrangements have been made. I also agree that, should I fail to assume this financial responsibility and credit action is necessary, I will pay for these costs in addition to the amount of the doctor's charges. I authorize Adobe ENT & Allergy to release to the Social Security Administration or its intermediaries or carriers, or other insurance carrier any medical or other information needed for this or a related insurance claim. A copy of this authorization may be used in place of the original. Continued treatment of my condition(s) may be refused if I fail to pay for services rendered.

_____ _____
Date Signature of Patient or Guardian

CO-PAYMENTS: our contract with your insurance company requires that we collect co-payment at time of service. If the co-payment is not paid at time of the visit, Adobe ENT & Allergy will add an appropriate charge to cover the additional cost of billing.

INSUFFICIENT FUNDS CHECKS: Adobe ENT & Allergy will bill the patient $25 in addition to the amount of the check.

EXTENDED PAYMENT REQUEST (ONE TIME AUTHORIZATION): I request that payment of any authorized insurance or other benefits be made on my behalf to Adobe ENT & Allergy for any services furnished me by that provider. This one time signature will be maintained on file as verification for all subsequent services, which are provided to you by this provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agent or other insurance carriers any information needed to determine these benefits or the benefits payable for related services.

_____ _____
Date Signature of Patient or Guardian

NOTICE OF PRIVACY ACKNOWLEDGEMENT: We keep a record of the health care services we provide you. You may ask to see, copy, or correct that record. Except for when our staff and physicians must exchange patient information to provide continuity of care, or for billing purposes, we will not disclose your record to others unless you authorize us to do so, or the law compels us. You may request to see your record by contacting the Administrator. Our Notice of Privacy Practices will describe in more detail how your health information may be used and disclosed, as well as how you may access your information. I also authorize the release of lab, x-ray, CT and other relevant diagnostic reports to Adobe ENT & Allergy for use in connection with my diagnosis and treatment.

_____ _____ _____
Date Signature of Patient or Guardian Printed name/relationship if signed on behalf of patient