GK ENT GREATER KNOXVILLE EAR NOSE & THROAT

One Time Authorization Form

Patient's Name _____ **Date** _____
(Please Print)

Assumption of Responsibility: I agree in consideration of services to be rendered, I obligate myself, assume financial responsibility and agree to pay upon demand to above named PROVIDER all charges for such services and incidentals incurred, including all non-covered services. Should the account be referred to an attorney for collections, I shall pay reasonable attorney fees and collections expenses. Even though insurance may be filed, I understand that all bills are payable upon receipt and I and not the insurance company, am responsible for the payment of all services.

Initial: _____

Responsibility for Co-Pay Amounts: I agree to be fully responsible for paying co-pay of set amount at the time of physicians visit. Further, I understand that if my co-pay is a percentage, I will be responsible for payment immediately after insurance benefits have paid. This meaning that any bill received once insurance paid, will be due upon receipts.

Initial: _____

Assumption of Referrals: I understand that if I have insurance coverage, which requires a referral from a Primary Care Physician, it must be received in order to receive the maximum benefits from the insurance company. I further understand that it is my responsibility to obtain a hardcopy referral from my Primary Care Physician. I have been given the opportunity by the above said provider to obtain a referral or reschedule my appointment. I understand that if I refuse that I am taking full responsibility for payment.

Initial: _____

Assignment of Insurance Benefits: I hereby assign direct payment of any hospital insurance benefits, medical insurance benefits including Medicare, Medigap, major medical benefits, insurance disability benefits, or injury benefits payable because of liability of a third party or organization, and so forth, payable to or for the above said patient until account is paid in full.

Signature: _____ **Date**: _____

Acknowledgement of Receipt of Privacy Notice: I acknowledge receiving today a copy o f the PROVIDER'S notice of privacy policies. I consent to the PROVIDER'S use of protected health information as described in the notice for treatment, payment or health care operations. I understand that I must provide a separate authorization before any other disclosures may b e made.

Signature: _____ **Date**:_____

Authorization for Release: By signing below I am authorizing the practice to disclose my protected health information about my current health condition to the following:

☐ Spouse ☐ Parents ☐ Children ☐ Clergy ☐ Other (list names)
_____

I understand my right and how to revoke this permission as described in the Notice of Privacy Practices given to my by the practice.

Signature: _____ **Date**: _____

Request for restrictions: I request that my protected health information mot be disclosed to the following:

_____

Signature: _____ **Date**: _____