GREATER KNOXVILLE
EAR NOSE & THROAT

Annual 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 all bills are
payable upon receipt and I, 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 any bill received once insurance pays will be due upon receipt.

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, Medicaid, 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 Patient Privacy Notice: I have been made aware of Greater Knoxville ENT's Notice of Privacy Practices that is on public display in the lobby and also available on its website (greaterknoxent.com). I understand I may request a paper copy of the Privacy Notice at this location. 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 be 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)

_____

You may leave messages containing my medical information at the following phone number(s) without speaking to a person:

_____ _____

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

Signature: _____ **Date**: _____

Request for restrictions: I request that my protected health information not be disclosed to the following:

_____

Signature: _____ **Date**: _____