



Primary Insurance Company: _____

Effective Date: _____ Policy Number: _____ Group Number: _____

Policy Holder: _____ Relationship: Self Spouse Other: _____

Policy Holder's Date of Birth: _____ Sex: Male Female

Policy Holder's Address: _____

Secondary Insurance Company: _____

Effective Date: _____ Policy Number: _____ Group Number: _____

Policy Holder: _____ Relationship: Self Spouse Other: _____

Policy Holder's Date of Birth: _____ Sex: Male Female

Medicare/insurance Authorization to Pay Benefits to Physician

I hereby authorize payment of Medicare and/or insurance benefits to be made directly to Atlantic ENT Associates, P.A., and my assisting physicians, for services rendered. I authorize any holder of medical information about me to release to the Health Care Financing Administration any information needed to determine benefits or benefits payable for related services.

I understand that I am financially responsible for all charges, whether or not they are covered by insurance. In the event of default, I agree to pay all costs of services rendered. **In Medicare and private insurance company assigned cases, the physician agrees to accept the charge determination. I will be responsible for my deductible, co-insurance, and non-covered services.**

A photocopy of this agreement shall be as valid as the original.

Patient/Parent/Guardian's Signature

Date

***Patients are responsible for understanding their insurance benefits.**