Valley Ear, Nose and Throat Specialists, P.A.

PATIENT NAME: _____ DOB: _____

REGARDING DERMATOLOGY PROCEDURES

Please be advised that if there is an office procedure to be performed, it might not be done at your primary visit, unless otherwise decided by the doctor. If the procedure is performed, there is a possibility that your insurance may not cover these procedures as part of the office visit, and/or have these charges apply to your deductible.

I understand that Valley Ear, Nose & Throat will bill my insurance on my behalf. However, I understand that should my insurance not cover a procedure, I will be responsible for the charges incurred.

X _____ _____
Patient/Responsible party Signature Date

NOTE: We send all specimens to Pathology Associates of South Texas. If your insurance company **does not** cover this facility, please inform the nurse **prior** to your procedure.

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HEALTH INSURANCE CLAIMS

I authorize the release of any medical information necessary to process this claim.

I authorize payment of medical benefits to the physician or supplier for services described in the attached claim form.

X _____ _____
Patient/Responsible Party Signature Date

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ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTCE

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed.

X _____ _____
Patient/Responsible Party Signature Date