PATIENT NAME: _________________________________ DOB: _______________

<u>REGARDING DIAGNOSTIC PROCEDURES/EAR CLEANINGS</u>

It is not our practice to verify insurance coverage for routine diagnostic audio testing, ear cleanings or scopes. Your insurance may not cover these procedures as part of the office visit and/or may apply these charges to your deductible.

If you have any questions regarding test or procedures ordered, please do not hesitate to inquire with our staff.

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

X ____________________________________ ________________
Patient/Responsible Party Signature **Date**

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<u>HEALTH INSURANCE CLAIMS</u>

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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<u>ACKNOWLEDGEMENT OF REVIEW OF</u>
<u>NOTICE OF PRIVACY PRACTCE</u>

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**