CONSENT FOR SERVICE AND TREATMENT

ENT Centers of Excellence

Patient name: _____ Date of Birth: _____

(A) RELEASE OF INFORMATION: I acknowledge that records concerning the patient are the property of ENT Centers of Excellence and are maintained for the use and benefit of ENT Centers of Excellence and its staff in providing care and treatment to the patient. I hereby authorize ENT Centers of Excellence to disclose all or any part of my patient record to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory test, X-rays and procedures will be available in your medical record to all health professional who may provide treatment or who may be consulted by staff members.

(B) PAYMENT: Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay services. For example, your health plan may request and receive information on dates of service, the services provided and the medical condition being treated.

(C) ASSIGNMENT OF BENEFITS: I hereby assign and authorize payment of all insurance benefits, basic and major medical for this period of medical treatment to be made directly to ENT Centers of Excellence.

(D) FINANCIAL AGREEMENT: For and in consideration of services rendered, each of the undersigned agrees to pay ENT Centers of Excellence for all charges not covered by insurance payments as statements are rendered. Further, should it become necessary to enforce collection of any unpaid balance for medical services rendered, each of the undersigned agrees to pay all collection and legal expenses incurred by ENT Centers of Excellence including reasonable attorney's fees which shall include, but not limited to, such fees incurred prior to institution of litigation, or litigation, including trial and appellate reviews and in arbitration, bankruptcy, or other administrative or judicial proceedings.

(E) AUTHORIZATION FOR MEDICAL CARE AND TRATMENT: I recognize that a condition exists requires medical care and I voluntarily consent to such medical care and treatment, diagnostic procedure by ENT Centers of Excellence as deemed necessary.

I hereby authorize my physician, as a provider by law to furnish medical treatment, diagnostic, x-ray diagnosis or therapy as he/she considers necessary and proper in the treatment of the patient.

Signature Patient/Parent/Guardian Date Witness Date