ACKNOWLEDGEMENT AND AUTHORIZATION:

- I have read and understand the HIPPA Privacy Policy for Lufkin ENT & Allergy.
- I hereby assign my insurance benefits to be paid directly to the healthcare provider.
- I authorize Lufkin ENT & Allergy to release medical information required to process my claim.
- I have read and understand the Financial Policy for Lufkin ENT & Allergy:
  Our office will accept cash, personal checks, Visa, MasterCard, Discover, American Express & Care Credit cards. A statement of fees will be sent regularly. Regardless of medical insurance coverage, our clinic relies on you for settling your account. You are ultimately responsible for all clinic and surgery fees relating to your care. Your health insurance policy is an agreement between you and your health insurance carrier. Please be aware that some companies pay a fixed allowance for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance left unpaid by your insurance company. If you need to make special arrangements for payment, please contact our office manager.
- I understand that Lufkin ENT & Allergy does not accept certain heath insurances such as HMO insurance plans and any expenses incurred are my responsibility.
- I understand that Lufkin ENT & Allergy has a No Show policy and a fee of $25.00 will be charged if appointment is not cancelled within 24 hours prior to my appointment. This is not covered by insurance.
  I understand if I miss three consecutive appointments I will be dismissed as a patient.
- I understand that Lufkin ENT & Allergy will charge a fee of $30.00 if a check is returned to their office from my bank.
- I understand that if surgery is recommended, my insurance benefits will be verified. A cost estimate which shows my financial responsibility will be explained. This may require a deposit for the surgery which is determined by my insurance deductible and co-insurance.
- I authorize Lufkin ENT & Allergy to obtain/have access to my medication history.
- I authorize Lufkin ENT & Allergy to contact me by mobile phone.
- I authorize Lufkin ENT & Allergy to contact me with information regarding hearing products.
- I understand that Lufkin ENT & Allergy includes Brian F Humphreys MD, FACS, PA, and Patricia McAdams, MD.

- I authorize the following individuals to access my medical information, including all billing and/or insurance transactions:

Name: _____ Relationship _____ Phone #: _____

Name: _____ Relationship _____ Phone #: _____

Name: _____ Relationship _____ Phone #: _____

Patient/Guarantor signature: _____ Date: _____