Victoria ENT Associates, LLP

117 Medical Drive, Suite #1 Victoria, Texas 77904-3114
Telephone (361) 573-4331

AUTHORIZATIONS: Treatment – Insurance – Financial Policy

I, the undersigned, by presenting for services at this facility, request and authorize evaluation, diagnosis, treatment and diagnostic examination and/or tests by my physician and or his designee of Victoria ENT Associates, LLP.

I have read, understand and agree to Victoria ENT Associates, LLP's Financial Policy. I have been offered/given a copy of their financial policy. I understand that charges not covered by my insurance company, as well as applicable co-payments and deductibles are my responsibility and I will make payment. I further understand that even though I have been quoted my insurance benefits, Victoria ENT Associates, LLP is also informing me that the quote is not a guarantee of payment and that I would be responsible for any unpaid fees.

I authorize my insurance benefits be paid directly to my physician and/or Victoria ENT Associates, LLP.

Patient Name: _____ Acct# _____

Date: _____

Patient/Responsible Party Signature: _____

PLEASE READ AND COMPLETE IF APPLICABLE

Protected Health Information Authorization (PHI)

The following individuals can have access to my PHI until such time as this access is rescinded in writing:

_____Entire Medical Record _____Financial Record _____Insurance Benefits

Specific Information:
_____

Person: _____ Relationship to patient: _____

Person: _____ Relationship to patient: _____

Patient/Responsible Party Signature: _____

PERMISSION FOR TREATMENT OF MINOR(S)

Person(s) who have my permission to present my minor child for treatment with Victoria ENT Associates, LLP in my absence until such time as permission is rescinded in writing:

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

Parent/Responsible Party Signature: _____