

Insurance Authorization & Financial Agreement



Patient's Name: _____

ANYONE (AUNT, GRANDMA, STEP PARENT) BRINGING A MINOR CHILD FOR THEIR APPOINTMENT MUST HAVE A WRITTEN AUTHORIZATION FROM LEGAL PARENT OR GUARDIAN. WE CANNOT SEE A CHILD WITHOUT ONE!

I authorize payment from my insurance company for medical and surgical benefits to Michigan Institute for Ear, Nose, Throat Health for any services furnished to me by this provider. I understand some services may not be covered by my insurance. (Examples: Audiogram, tympanogram, somnoplasty, allergy testing & therapy and microscope exam.) **I AGREE TO PAY ANY COPAY AMOUNTS AND ALL CHARGES THAT EXCEED OR ARE NOT COVERED BY MY INSURANCE AT THE FRONT WINDOW UPON CHECKING IN.**

Signature: _____ Date: _____
Patient, Parent or Guardian

WE PARTICIPATE WITH **MOST** INSURANCE COMPANIES. CHECK WITH YOUR INSURANCE COMPANY IF IN DOUBT. WE WILL BILL YOUR INSURANCE AS A COURTESY FOR YOU.

IF YOU HAVE AN **HMO** INSURANCE (HEALTH PLUS, BLUE CARE NETWORK, MCLAREN MEDICAID OR HEALTH PLUS MEDICAID) OR ANY OTHER INSURANCE THAT MAY REQUIRE AN AUTHORIZATION OR REFERRAL **IT IS THE PATIENT'S RESPONSIBILITY** TO MAKE SURE WE HAVE IT **PRIOR** TO YOUR APPOINTMENT. WE **WILL NOT** BE ABLE TO SEE YOU WITHOUT THIS INFORMATION. YOU WILL NEED TO RESCHEDULE YOUR APPOINTMENT WITH THE RECEPTIONIST.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES: The undersigned patient or legally authorized representative of the patient acknowledges that he or she has personally read and/or received a copy of our privacy policies on the date listed below.

Signature: _____ Date: _____
Patient, Parent or Guardian

I authorize ENT clinic, P.C. to release any and all medical information to the following **NAMED PEOPLE ONLY:**
(If you do not want anyone listed, please write "NONE")

I understand I may revoke this authorization at any time.

Signature: _____ Date: _____
Patient, Parent or Guardian