Ear, Nose, & Throat of Northwest Georgia
NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT
AUTHORIZATION TO TREAT
INSURANCE OR MEDICARE ASSIGNMENT OF BENEFITS

I have been given the opportunity to review the "Notice of Privacy Practices" of Ear, Nose, & Throat of Northwest Georgia. This document contains a description of the uses and disclosures of my healthcare information, and my rights regarding such information.

I understand that this organization has the right to change its "Notice of Privacy Practices" and that if changes are made, a revised copy of the notice will be posted in the office of Ear, Nose, & Throat of Northwest Georgia.

I also understand that if I have any questions, or wish to receive additional copies or a current copy of this "Notice of Privacy Practices", I may contact: Privacy Officer: Ear, Nose, & Throat of Northwest Georgia
107 John Maddox Drive Rome GA 30165
Phone: (706) 235-0116 Fax: (706) 235-7008

THE FOLLOWING PEOPLE MAY HAVE ACCESS TO MY MEDICAL AND FINANCIAL INFORMATION AT ENT OF NWGA: LIST NAME AND RELATIONSHIP:

1) _____ 2)_____ 3)_____

Patient Name (Printed): _____ Signature: _____

Relationship to Patient: _____ Date: _____

I hereby assign all medical and/or surgical benefits under the terms of my insurance or legal award to: Ear, Nose, & Throat of Northwest Georgia. I hereby authorize Ear, Nose, & Throat of Northwest Georgia to release and disclose information necessary to any party in order to determine liability for payment and/or to secure reimbursement. I authorize Ear, Nose, & Throat of Northwest Georgia to release information regarding my medical condition to my insurance company and any health care professional or individual involved in my medical care.

I authorize Ear, Nose & Throat of Northwest Georgia to leave messages on my answering machine/phone regarding my care, appointments, and/or bills.

This assignment and authorization will remain in effect until revoked by me in writing. A photocopy of this assignment and authorization is considered to be as valid as the original. I understand that I am personally responsible for the payment of all charges that occur as a result of my medical treatment and I agree to pay all charges including those not covered by insurance.

I understand that I have the right to revoke all or any portion of these consents, in writing, at any time except where Ear, Nose, & Throat of Northwest Georgia has already made a disclosure in reliance on this consent. This authorization does not expire unless withdrawn in writing. I understand that if NO objection is noted above, I am giving consent for ALL listed above.

I authorize Ear, Nose, & Throat of Northwest Georgia or their representative to take clinical pictures of me, to be kept as part of my medical record. I agree and give my consent to all procedures and treatment that the physician or physician extenders perform or request.

_____ Date: _____/_____/_____
Patient or Authorized Signature

MEDICARE LIFETIME AUTHORIZATION

I authorize any holder of medical or other information about me to release to the CMS, its intermediaries or carriers, any information needed for this or any Medicare related claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

_____ Date: _____/_____/_____
Signature of Patient or Guardian