Thomas V. Ripp, M.D. Camille A. Graham, M.D., M.P.H. Neil M. Vora, M.D.
ALLERGY, EARS, NOSE AND THROAT CLINIC OF N. E. TEXAS

4000 Medical Parkway	*4521 Medical Center Dr., Ste 400*	*3000 Horizon Rd.*
Greenville, TX 75401	*McKinney, TX 75069*	*Rockwall, TX 75087*
(903) 454-6481	*972-548-7555*	*(972) 772-4200*
(903) 454-6486 fax	*(972) 542-8561 fax*	*(972) 772-4202 fax*

AUTHORIZATIONS AND FINANCIAL POLICY

PATIENT__________________________________DOB____________SSN______________________

A. AUTHORIZATION

Please review the following information fully and carefully.

_____ I hereby authorize any insurance carrier to pay the total sum of my medical benefits directly to any/all of the physicians of Allergy, Ears, Nose and Throat Clinic of N. E. Texas.

_____ I hereby authorize any hospital, physician or their agents to release to any insurance carrier or any of their agents, all medical records or information deemed necessary to determine the benefits payable for any/all related medical services provided to the physicians of Allergy, Ears, Nose and Throat Clinic of N. E. Texas.

_____ I hereby authorize the physicians of Allergy, Ears, Nose and Throat Clinic of N. E. Texas to release any and all medical records or information they deem necessary to any physician, hospital or other supplier who has or will participate in my medical care either in the past, present or at some time in the future.

_____ I hereby authorize any hospital, physician or other supplier to release to the physicians of Allergy, Ears, Nose and Throat Clinic of N. E. Texas, any medical records or information as they deem necessary to requests participating providers in my medical care whether in the past, present or at some time in the future.

_____ I authorize the rendering of care to me by the physicians of Allergy, Ears, Nose and Throat Clinic of N. E. Texas.

_____ ***I authorize Allergy, Ears, Nose and Throat Clinic of N. E. Texas to leave a recorded message for me at my home and/or work number in order to reach me about my care.***

Now, here it is in English. By initialing above you have given permission for:

1. Your insurance to pay us directly.
2. Your medical records to be released to the insurance company by us, the hospital, the anesthesiologist, or anyone who participates in your care.
3. Your medical records to be released from us to any medical facility or physician that we may refer you to.
4. Your medical records to be released directly to us from any other medical facility or provider as necessary.
5. Us to treat you.
6. Us to leave you a message at home or work.

B. FINANCIAL POLICY

1. Financial responsibility

   a. You are responsible for full payment of all fees incurred with the physicians of Allergy, Ears, Nose and Throat Clinic of N. E. Texas. We file your insurance as a courtesy to you, but this does not diminish your responsibility for payment in full.

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b. We do not get involved in any way with disputes between divorced parents of a child we are treating. If you bring the child for treatment, you are responsible for payment in full for services rendered. We do not bill the other parent. We will provide extra copies of your child's bill should you need it.

c. If the patient is a child 18 years of age or older and still on the parents insurance, you must supply us with a full time student status form from the high school or college they are enrolled in. Until this form has been received, you will be responsible for payment in full for any services rendered.

d. **ATTENTION MEDICARE PATIENTS:** We do require payment for your Medicare deductible and coinsurance at the time of service. We will file your supplemental insurance policy for you one time as a courtesy. In the event your secondary insurance pays us also, you will be refunded. Our refunds are done on or about the 15th of each month.

e. You are responsible for obtaining any required referral from you Primary Care Physician (PCP) to our office. If you do not have a valid referral from your PCP, you will be expected to pay in full for your services.

f. While we expect most patients know their insurance benefits, the following is a brief outline of ***changes that might occur due to the fact that you are seeing a specialist:***

1. Your copayment may be different from the copayment at your PCP's office.

2. Your copayment may cover the office visit only. ***Any procedure done such as a scope of the sinuses or throat and/or hearing tests may be subject to your deductible and coinsurance.*** Payment of deductibles and coinsurance is expected at the time of service.

g. ***Any fees we charge are for our services only.*** Any patient having office laboratory procedures done or having surgery will be billed separately for any laboratory, radiology, anesthesiology or hospital. We have no control or authorization over their fees, rules or financial expectations. You should speak directly with those providers regarding any questions you may have for them.

I have read and understand the Authorization and Financial Policy of Allergy, Ears, Nose and Throat Clinic of N. E. Texas.

____

Signature of Patient or Legal Guardian   Relationship to Patient   Date

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A copy of this document may serve as an original

COORDINATION OF BENEFITS STATEMENT

My signature below denotes my personal certification that the insurance payor(s) listed, if any is the only active source(s) of insurance which pertain to the following:

Name of patient Date(s) of service

For services rendered by the physicians of Allergy, Ears, Nose and Throat Clinic of N. E. Texas.

Primary insurance name and address ***Check here if not applicable*** ڤ

Insured person DOB Relationship to patient

Secondary insurance name and address ***Check here if not applicable*** ڤ

Insured person DOB Relationship to patient

Tertiary insurance name and address ***Check here if not applicable*** ڤ

Insured person DOB Relationship to patient

I do not have any other active insurance in reference to the above-mentioned date(s) of service.

Signature of patient or legal guardian Relationship to patient Date

Signature of witness Date

A copy of this document may service as an original