ENT Surgery Center of Atlanta LLC

5673 Peachtree Dunwoody Road, Suite 945 • Atlanta, GA 30342

PATIENT INFORMATION

I request that payment of authorized benefits be made to **ENT SURGERY CENTER OF ATLANTA, LLC.** I authorize any holder of my medical information to release to the Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine the benefits or the benefits payable for related services.

DATE ______________ **SIGNATURE** ______________________________

I hereby authorize the release of any confidential information, including information related to psychiatric care, drug and alcohol abuse and HIV/AIDS, necessary to process insurance claims or any other medical information that is required for any health care related utilization review or quality assurance activities or to any healthcare professional requiring this information in order to treat me.

I hereby assign and authorize payment to **ENT SURGERY CENTER OF ATLANTA, LLC** for all medical and/or surgical benefits including major medical policies, to which I am entitled under any insurance policy or policies, any self-insurance program, or any other type of benefit plan. I understand and acknowledge that this assignment of benefits does not relieve me of my financial responsibility for all medical fees and charges incurred by me or anyone on my behalf. I hereby accept such responsibility, including, but not limited to, payment of those fees and charges not directly reimbursed to **ENT SURGERY CENTER OF ATLANTA, LLC** by any insurance policy, self-insurance program or other benefit plan.

This authorization shall remain in effect until revoked by me in writing. A photocopy of this authorization shall be considered as effective as the original. I understand that I have the right to receive a copy of this authorization.

SIGNATURE OF PERSON PROVIDING AUTHORIZATION ______________________________

RELATIONSHIP TO PATIENT IF NOT PATIENT ______________________________

DATE ______________

ALTERNATIVE CONTACT AUTHORIZATION

I ☐ **DO** ☐ **DO NOT** authorize **ENT SURGERY CENTER OF ATLANTA, LLC.** to contact me or leave messages for me at my place of work. Date: ______________ Initials: ____________

I hereby authorize **ENT SURGERY CENTER OF ATLANTA, LLC.** to leave messages on my home answering machine regarding appointments and to inform me that laboratory results are available. I realize I must call the office to obtain laboratory results. Date: ______________ Initials: ____________

I ☐ **DO** ☐ **DO NOT** authorize **ENT SURGERY CENTER OF ATLANTA, LLC.** to discuss my appointments, medical evaluation, treatment and results to relatives or other persons indicated.

Authorized person(s)/relationship: ____

Date: ______________ Initials: ____________

LIVING WILL/ADVANCE DIRECTIVES

I acknowledge that I am aware of the need for a Living Will/Advance Directives and that I understand information is available if needed. I also acknowledge that I ☐ **DO** ☐ **DO NOT** have such Directives. If I do not have such Directives at this time, but establish them at a later date, I will provide the Center with a copy. Date: __________ Initials: ______

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the **"NOTICE OF PRIVACY PRACTICES"**, **"PATIENT RIGHTS AND RESPONSIBILITIES"** and **"FINANCIAL POLICY"** for my records.

Date: ______________ Initials: ____________