

ENT FACULTY PRACTICE, LLP
ASSIGNMENT OF BENEFITS AND GUARANTEE OF PAYMENT

I hereby authorize and direct my insurance carrier to make payment directly to ENT Faculty Practice, LLP and hereby assign to said office and any and all rights, title and interest I have in insurance proceeds or benefits payable to me or on my behalf for services rendered to me by said medical office.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO THE ABOVE NAMED MEDICAL OFFICE FOR ALL CHARGES, INCLUDING THOSE NOT PAID BY INSURERS OR THIRD PARTIES, INCURRED BY ME OR ON MY BEHALF.

I hereby authorize and direct the above named medical office and my attending physician to release such medical information from my medical records as is necessary to complete forms for payment by insurance and other payers.

Date

Time

Signature of patient/responsible person

Witness

IF PERSONS OTHER THAN THE PATIENT SIGNS, INDICATE RELATIONSHIP TO THE PATIENT AND REASON FOR LACK OF PATIENTS SIGNATURE.