

**Family Ear, Nose, and Throat Clinic P.C.
Confidentiality Policy and Insurance Authorization**

PLEASE SIGN BELOW TO ALLOW US TO ASSIST YOU IN FILING INSURANCE AND PROVIDING APPOINTMENT REMINDERS:

A-1: PRIVACY POLICY

Family Ear Nose & Throat Clinic P.C. maintains patient information concerning medical records and insurance in the strictest confidence. Please sign the release below which allows us to share the needed and relevant information with your insurance carrier. Your signature also allows us provide medical information to other physicians responsible for your care. Information will not be shared with any party, without prior written approval, except where required by law.

A-2: AUTHORIZATION TO RELEASE INFORMATION

I authorize any holder of medical or other information about me, or parties for whom I am responsible, to release such information to the insurance carrier, for which I have provided information to Family Ear, Nose and Throat Clinic, P.C. or other party purposes of processing this insurance claim. I permit a photocopy of this authorization to be used in place of the original.

B. ASSIGNMENT OF BENEFITS

I hereby authorize payment to the physicians of Family Ear, Nose & Throat Clinic, P.C. of the insurance benefits otherwise payable to me. I understand that I am financially responsible for the charges not paid by my insurance. A photocopy of this assignment will be considered as valid as the original.

C. AUTHORIZATION OF COMMUNICATIONS

I hereby authorize Family Ear, Nose, & Throat Clinic, P.C. staff to call my home or other designated location and leave a message on voice mail or in person reference to any items that assist the practice in carrying out treatment, payment, and healthcare operations (TPO), such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results or other medical issues. I also authorize Family Ear, Nose, & Throat Clinic P.C. to mail my home or other designated location, or e-mail my home or other designated location in a manner to assist in carrying out TPO as stated above.

D. ACKNOWLEDGEMENT OF PRIVACY RIGHTS

I acknowledge that the Family Ear, Nose, & Throat Clinic, P.C. "Notice of Privacy Practices" has been made available to me for review. I understand that Family Ear, Nose, & Throat Clinic, P.C. reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Family Ear, Nose, & Throat Clinic, P.C., Privacy Officer, 6828 North 72nd. Street, Suite 4500, Omaha, Ne. 68122

E. Acknowledgement of Financial Policy

I acknowledge that I have been given a copy of Family Ear, Nose & Throat Clinic's financial policy. I understand that I am responsible for my bill and by signing this agreement I acknowledge that I understand this policy.

Please Initial: _____ I acknowledge receipt of Family Ear, Nose & Throat Clinic P.C.'s Notice of Privacy Practices.

The undersigned certifies that he or she has read the foregoing, is the patient, patient's guardian, power of attorney, parent or is duly authorized by or on behalf of the parent to execute the above and accept its terms.

Patient's signature/Parent if Minor/Power of Attorney/Guardian

Date

Responsible Party's signature (If Not Same as Patient of Parent)

Insured's Signature

**_Witness to Signatures
Because**

Patient Unable to Sign Consent
