



Virginia Ear, Nose & Throat Associates, P.C.
CONSENT FOR TREATMENT, ASSIGNMENT OF BENEFITS, FINANCIAL POLICIES

Patient #: _____

- **Consent for treatment**

I authorize Virginia Ear, Nose & Throat Associates to provide medical treatment to myself and or my dependent.

- **Assignment of Benefits**

I request that payment of authorized Medicare, Medicaid or applicable private insurance benefits be paid directly to Virginia Ear, Nose & Throat Associates for services provided under their care.

- **Release of medical information**

I authorize Virginia Ear, Nose & Throat Associates to release necessary medical information to my insurance company, its agents, or any third party payor in order for payable benefits for these services to be determined.

- **Financial Responsibility**

I understand that co-pays are due at the time of service.

I understand that Virginia Ear, Nose & Throat Associates will file my insurance claims as a courtesy; however, I am ultimately responsible for full payment of all charges. I further understand if my account is referred to a collection agency or attorney I will be responsible for all expenses and up to 33.33% of collection costs.

- **Referrals/Authorizations**

I understand if my insurance company requires a referral, I am responsible for obtaining a referral prior to my visit. I understand that if I do not have a referral no services will be rendered until the referral is received or until I sign a waiver acknowledging acceptance of financial responsibility, payment in full will be required on the day of your appointment.

- **Missed Appointments**

We require at least 24 hours notice if you must cancel an appointment, failure to do so may result in a \$25 "no show" fee.

- **Returned Checks**

Our office will charge \$25 for any check that is returned for insufficient funds.

I have read the above statements and I understand my responsibilities. A copy of this authorization will be considered as valid as the original.

Signature of Patient or Responsible Party

Date

Printed Name

Relationship to Patient