

The following pages outline our billing policies, authorization for treatment, assignment of benefits, release of medical information, and our privacy policies to comply with the Health Insurance Portability and Accountability Act (HIPPA).

BILLING

- I (patient, parent, or legal guardian) understand that if the current insurance information is not received at the time of service, I will be responsible for full payments at the time of services are rendered.
- If I am a self-pay patient, I am financially responsible for all services received and that payment is expected at time service is rendered.
- In the situation of third part financial responsibility to cover the cost of your visit, the primary and ultimate responsibility for payment rests with you (patient, parent, or legal guardian).
- Fees are based on the medical condition. The federal CPT code guidelines establish a complicated range of categories for office visits based on a number of factors.
- We are contracted with a number of managed care plans (PPO, HMO, and IPA). We must follow the terms of these plans including their financial relationships and mandatory co-payments and deductibles, which are required at time service is rendered.
- In regards to federal programs (Medicare and Texas Medicaid), we have agreed to accept as full payment the government’s discounted payment schedule. You are responsible for any mandatory co-payments and deductibles at the time of service (although you may have supplemental co-insurance which may cover the co-payment).

 Signature of Patient/Parent/Legal Guardian

 Date 00-00-0000

AUTHORIZATION FOR TREATMENT

I hereby voluntarily consent to medical care for the above names patient encompassing diagnostic procedures and medical treatment by the physician, his/her assistants, or designees as may be necessary in his/her judgment. I acknowledge that no guarantees have been made as to the results of treatments or examination.

 Signature of Patient/Parent/Legal Guardian

 Date 00-00-0000

ASSIGNMENT OF BENEFITS

I hereby assign to Raza Pasha, MD, PA, Raza Pasha, MD, Philip A. Matorin MD, PA, Philip A. Matorin MD, or Texas Otolaryngology Partners (TOPs) all rights, title, and interests in the benefits payable to me by an insurance policy(ies) or benefits plan under which I am covered for services rendered by the physician. I understand that I am responsible for all charges not covered by the assignment along with any deductibles and/or co-insurance and hereby promise to pay any remaining balance.

 Signature of Patient/Parent/Legal Guardian

 Date 00-00-0000

NOTICE OF PRIVACY PRACTICES

I have reviewed this office’s Notice of Privacy Practices, posted in the lobby. It explains how your medical information will be disclosed. I understand that I am entitled to receive a copy of this document.

 Signature of Patient/Parent/Legal Guardian

 Date 00-00-0000

NOTICE OF PRIVACY PRACTICES

I also authorize the following relatives, friends, or other people that may be informed about my general medical condition or diagnosis:

 Name

 Name