Contact/HIPAA/ Assignment of Benefit

Circle where you can be reached during business hours: ◯ Home ◯ Work ◯ Cell
May we leave you a message? ◯ Yes or ◯ No
May we send text messages to your mobile phone? ◯ Yes or ◯ No If yes, number:____________________
May we contact you via email? ◯ Yes or ◯ No If yes, email:____________________

Health Insurance Portability & Accountability (HIPAA)

I have been provided the opportunity to review the Notice of Privacy Practices. I, the undersigned authorize Cross Timbers ENT, PLLC (CTENT) to send/receive confidential healthcare information as that term is defined by HIPAA to health care providers, hospitals, laboratories, and other medical caregivers for the coordination of care for the patient. I may revoke this authorization with written notice to CTENT.

☐ CTENT **MAY NOT** discuss my healthcare and may not discuss and / or make financial arrangements with anyone except as permitted by HIPPA and other applicable laws.

☐ CTENT **MAY** discuss my healthcare and **MAY** discuss and / or make financial arrangements with only the following individual immediate family members listed below:

Name____________________ Relationship____________________ Phone____________________

Name____________________ Relationship____________________ Phone____________________

I understand that if I would like to authorize CTENT to disclose my healthcare and / or financial arrangements with anyone other than the individuals listed above, I will need to execute an authorization that meets the requirements of the HIPAA Privacy Standards. (Written authorization).

Please provide a date or event, if any, upon which this Authorization will expire. Please mark only one selection:

☐ No Expiration
☐ Date of Expiration __/__/__
☐ Event: (Describe event upon which this Authorization will expire)____________________

Assignment of Benefits-Financial Agreement

I hereby authorize payment of insurance benefits to be made directly to CTENT and any assisting physicians for services rendered. **I understand that I am financially responsible for all charges whether or not covered by my insurance carrier**. I also authorize CTENT to release all information necessary to secure the payment of benefits. A photocopy of this agreement shall be valid as the original.

Patient's Name:____

Patient / Guardian signature:____ Date:____________