Anne Arundel ENT &
Facial Plastic Surgery

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Severna Park, MD 21146

621 Ridgely Ave, Suite 401
Annapolis, MD 21401

AUTHORIZATION/RESPONSIBILITY AGREEMENT

I authorize my insurance provider(s) to pay the proceeds to any benefits on my behalf directly to Anne Arundel ENT & Facial Plastic Surgery, Robert B. Meek III MD, Lee Kleiman MD or Brandon Wachal MD. I agree to pay promptly any deductibles or co-pays that are determined by my insurance provider(s) to be my responsibility. I understand that office co-pays are due at the time of the visit. Any additional payments due will be made without delay, upon receipt of a statement from AAENT. I understand that i will have a grace period of 30 days from the statement date without finance or late charges.

I further understand that obtaining any referrals from my primary care physician required by my insurance provider is my responsibility and must be presented to AAENT at the time of my visit. I understand that if I do not provide a valid referral at the time of my appointment, I will have to reschedule my appointment. In case of surgery, I will work with the surgical coordinator of AAENT to assure that all of the required referrals and/or authorizations are obtained prior to surgery. Benefit verification is the patient responsibility.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

1. Conduct, plan, and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third party payers.
3. Conduct normal healthcare operations such as quality assessments and physical certifications.

I have received, read, and understand your “Notice of Privacy Practices”containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its “Notice of Privacy Practices” from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the “Notice of Privacy Practices”. I understand that I may request in writing that you restrict operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

____ ________________________
Patient Signature (or guardian if patient is a minor)   Date

Patient Name

I authorize my medical records and/or medical information to be released to the following:

Date:____

Name: ____

Relationship:____