Anne Arundel Ear Nose & Throat

600 Ridgely Avenue, Suite 110
Annapolis, MD 21401
(410)573-9191 Telephone
(410)573-5910 Fax

AUTHORIZATION/RESPONSIBILITY AGREEMENT

I authorize my insurance provider(s) to pay the proceeds to any benefits on my behalf directly to Robert B. Meek, III, MD, PA doing business as Anne Arundel Ear Nose and Throat. 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. After this initial 30 day period, a monthly finance charge will be assessed.

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. Should payment be denied to the doctor due to my not obtaining the necessary referrals, then any claims denied due to the lack of said referral will be my responsibility to pay. 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 Private 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

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

Name: _____ Relationship: _____