

## INSURANCE AUTHORIZATIONS

**\*Port Huron E.N.T., P.C. participates with several insurance plans. For these plans, we are able to accept the carrier's approved amounts for services. The patient/responsible party will be billed for any non-covered services, co-insurances or deductibles.\***

In order for our office to bill and receive direct payment from your medical insurance company, it is required that we keep on file the following authorizations.

### **Release of Information & Assignment of Benefits(Non Medicare)**

I hereby authorize Port Huron E.N.T., P.C. to release any medical or other information as needed to my medical insurance carrier and authorize payment of any benefits provided by the policy directly to Port Huron E.N.T., P.C. for the patient listed below. I acknowledge that I am responsible for all co-insurance or deductible amounts and charges not covered by my insurance carrier.

Print patient name: \_\_\_\_\_

Patient Signature (Parent/Legal Guardian for minor):

\_\_\_\_\_ Date: \_\_\_\_\_

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**\*Port Huron E.N.T., P.C. is a participating provider with the Medicare program. Our office will accept Medicare's approved amount for services. The patient/responsible party will be billed for Medicare's indicated co-insurance's and/or deductibles and any non-covered services as allowed by Medicare.\***

### **Release of Information & Assignment of Benefits (Medicare)**

I hereby request payment of authorized Medicare Benefits be made on my behalf to Port Huron E.N.T.,P.C. I authorize Port Huron E.N.T., P.C. to release to the Medicare Carrier or it's agents any medical or other information needed to determine these benefits or the benefits payable to related services. I acknowledge that I am responsible for co-insurance and deductible amounts or services not covered under the Medicare program

Print Patient Name: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_