SUMMIT ENT ASSOCIATES
5653 Frist Blvd. Suite 231
Hermitage, TN 37076

It is the responsible party's duty to provide to the office ACCURATE INFORMATION at the time services are rendered in order to file claims on the patient's behalf. We file insurance claims for all services unless requested in writing not to do so. In instances where you will be filing your own insurance, we will provide necessary information to do so.

I authorize Summit ENT Associates to release any information concerning the treatment for my dependent(s) or myself. I assign to Summit ENT Associates any BENEFITS normally payable to me to be PAID DIRECTLY TO THE PRACTICE for services rendered. I permit a photocopy of this authorization to be used in place of the original. I recognize AND ACCEPT responsibility for any balances or fees not covered by my insurance carrier. I request and consent to treatment and promise to pay for services and material furnished, plus all collection costs including attorney fees.

I assign payment of authorized Medigap benefits to Summit ENT Associates for medical and/or surgical benefits. I authorize any holder of medical information about me to release to my medical secondary insurer any information needed to determine secondary benefits or the benefits payable for related services. A photocopy shall be as valid as the original.

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PATIENT SIGNATURE (Must be 18 years or older) DATE

_____

SIGNATURE OF PATIENT REPRESENTATIVE (If Patient is a minor or is unable to sign this form) DATE

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RELATIONSHIP TO PATIENT

PLEASE SEE ATTACHED NOTICE OF PRIVACY PRACTICE

I have read (or had read to me), and understand the policies outlined by the practice of Kent R. Murphy MD regarding the release of information. I agree to these policies unless otherwise stated above.

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SIGNATURE OF PATIENT (Must be over 18 years of age) DATE

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SIGNATURE OF PATIENT REPRESENTATIVE DATE
(Required if patient is a minor or unable to sign this form)

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RELATIONSHIP TO PATIENT