THE EAR INSTITUTE OF TEXAS, P.A.
LANCE E. JACKSON, MD.,F.A.C.S.

PRIVACY POLICY

I HEREBY ACKNOWLEDGE THAT I HAVE BEEN GIVEN THE OPPORTUNITY TO READ THE NOTICE OF PRIVACY PRACTICES FOR THE EAR INSTITUTE OF TEXAS, P.A. I HAVE BEEN THE OPPORTUNITY TO ASK ANY QUESTIONS I MAY HAVE REGARDING THIS NOTICE.

____ ____
PATIENT SIGNATURE **DATE**

RELEASE OF INFORMATION

REGARDING USE OF FACSIMILE: There are risks that confidential information may accidentally be transmitted to people not authorized to receive such information. Although EAR INSTITUTE OF TEXAS try to avoid the risk, it cannot be totally eliminated. I AM AWARE OF POTENTIAL RISKS AND AUTHORIZE THE USE OF FACSIMILE.

I HEREBY AUTHORIZE MY TREATING PHYSICIAN, AS A HOLDER OF MEDICAL INFORMATION TO RELEASE TO THE REFERRING PHYSICIAN, FAMILY PHYSICIAN AND ANY MEDICAL OR MEDICALLY RELATED FACILITY INFORMATION REGARDING DIAGNOSIS AND TREATMENT VIA TELEPHONE, FACSIMILE, OR MAIL.

I FURTHER AUTHORIZE MY TREATING PHYSICIAN TO RELEASE MY NAME AND ADDRESS TO OTHER PARTIES FOR THE SOLE PURPOSE RECEIVING MEDICALLY RELATED INFORMATION VIA TELEPHONE, FACSIMILE, OR MAIL.

IN ACCORDANCE WITH FEDERAL GOVERNMENT PRIVACY RULES IMPLEMENTED THROUGH THE HEALTHCARE PORTABILITY ACT OF 1996 (HIPPA), IN ORDER FOR YOUR PHYSICIAN OR STAFF OF THE PRACTICE TO DISCUSS YOUR CONDITION WITH MEMBERS OF YOUR FAMILY OR OTHER INDIVIDUALS THAT YOU DESIGNATE, WE MUST OBTAIN YOUR AUTHORIZATION PRIOR TO DOING SO. IN THE EVENT OF YOUR MEDICAL CONDITION, THE LAW STIPULATES THAT THESE RULES MAY BE WAIVED.

☐ I DO NOT AUTHORIZE THE PRACTICE TO RELEASE ANY OR ALL INFORMATION CONCERNING MY MEDICAL CARE TO ANY INDIVIDUALS EXCEPT AS SET FORTH ABOVE.

☐ I AUTHORIZE THE PRACTICE TO VERBALLY RELEASE ANY OR ALL INFORMATION CONCERNING MY MEDICAL CARE TO THE FOLLOWING INDIVIDUALS (**CIRCLE ALL THAT APPLY**):

SPOUSE CHILDREN PARENTS OTHER:____

____ ____
PATIENT SIGNATURE **DATE**

BENEFIT ASSIGMENT

INSURANCE INFORMATION/OFFICE POLICY ON ALL INSURERS
PRIMARY INSURANCE COPY OF INSURANCE CARD ON FILE
SECONDARY INSURANCE COPY OF INSURANCE CARD ON FILE NOT APPLICABLE

*IF YOU HAVE AN HMO POLICY OR REQUIRE A REFERRAL, IT IS THE PATIENT'S OR RESPONSIBLE PARTY'S RESPONSIBILITY TO COORDINATE ALL NECESSARY REFERRALS BEFORE YOUR VISIT. IT IS ALSO THE RESPONSIBILITY OF THE PATIENT/RESPONSIBLE PARTY TO INQUIRE WHETHER THEIR PHYSICIAN IS A PARTICIPATING PHYSICIAN WITH THEIR INSURANCE PLAN.

IN ORDER TO ACCOMMODATE THE NEEDS AND REQUESTS OF OUR PATIENTS WE HAVE ENROLLED IN NUMEROUS INSURANCE PROGRAMS. WHILE WE ARE PLEASED TO BE ABLE TO PROVIDE THIS SERVICE TO YOU, IT IS EXTEMELY DIFFICULT FOR US TO KEEP TRACK OF ALL THE INDIVIDUAL REQUIREMENTS OF THE PLANS. EACH ONE HIS DIFFERENT STIPULATIONS REGARDING HOW OFTEN SERVICES MAY BE RENDERED AND, EVEN MORE IMPORTANTLY, WHERE THOSE SERVICES MAY BE PERFORMED. EVEN WITHIN THE SAME INSURANCE COMPANY, THE PLANS DIFFER DEPENDING UPON WHAT TYPE OF CONTRACT YOUR EMPLOYER HAS NEGOTIATED.

PROVIDING QUALITY MEDICAL CARE FOR OUR PATIENTS IS OUR PRIMARY CONCERN. WE ARE MORE THAN WILLING TO PROVIDE THAT CARE WITHIN YOUR INSURANCE CONTRACT GUIDELINES IF YOU LET US KNOW **EACH** TIME OF SERVICE EXACTLY WHAT THOSE GUIDELINES ARE. UNFORTUNATELY, IF YOU DO NOT INFORM US OF ANY SPECIAL REQUIREMENTS IN YOUR CONTRACT AND WE SUBSEQUENTLY ORDER SERVICES (SUCH AS TESTS, LAB WORK, OR HOSPITALIZATION) THAT ARE NOT COVERED, WE OR THE SELECTED MEDICAL FACILITY WILL HAVE NO CHOICE BUT TO BILL YOU DIRECTLY FOR THOSE CHARGES. **PAYMENT FOR THOSE CHARGES IS THEN YOUR RESPONSIBILITY.**

I ALSO AUTHORIZE THE RELEASE OF MEDICAL INFORMATION VIA TELEPHONE, FACSIMILE, OR MAIL, TO MY INSURANCE CARRIER OR ITS INTERMEDIARIES INFORMATION NEEDED FOR THIS OR ANY FUTURE RELATED CLAIM(S), AND REQUEST THAT PAYMENT BE MADE TO THE EAR INSTITUTE OF TEXAS, 18518 HARDY OAK BLVD, SUITE 300 SAN ANTONIO, TEXAS 78258.

I UNDERSTAND I AM FINANCIALLY RESPONSIBLE TO THE EAR INSTITUTE OF TEXAS, FOR ALL SERVICES REGARDLESS OF ANY OR ALL REIMBURSEMENT PAID BY INSURANCE CARRIER. I FURTHER UNDERSTAND, IF THE EAR INSTITUTE OF TEXAS, DOES NOT PARTICIPATE WITH MY INSURANCE PLAN THAT I WILL BE RESPONSIBLE FOR ALL NON-CONTRACTUAL AMOUNTS AND FEES OVER THEIR INSURANCE COMPANY'S REIMBURSEMENT FEE SCHEDULE.

WITH YOUR COOPERATION AND HELP, YOU SHOULD BE ABLE TO RECEIVE ALL OF THE BENEFITS OFFERED TO YOU, AND WE WILL BE ABLE TO CONCENTRATE ON CARING FOR YOUR MEDICAL NEEDS.
I have read and understand the office policy stated above and agree to accept responsibility as described.

____ ____
PATIENT SIGNATURE **DATE**