Victoria Hearing Center, LLC

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AUTHORIZATIONS: Financial Policy – PHI – Permission for Treatment

Item 1: Financial and Treatment Authorization

I, the undersigned, by presenting for services at this facility, request and authorize evaluation, diagnosis, treatment and diagnostic examination and/or tests by my physician and or his designee of Victoria Hearing Center, LLC.

I have read, understand and agree to Victoria Hearing Center Financial Policy. I have been offered/given a copy of their financial policy. I understand that charges not covered by my insurance company, as well as applicable co-payments and deductibles are my responsibility and I will make payment. I further understand that even though I have been quoted my insurance benefits, Victoria Hearing Center is also informing me that the quote is not a guarantee of payment and that I would be responsible for any unpaid fees.

I authorize my insurance benefits be paid directly to my physician and/or Victoria Hearing Center.

Patient Name: _____

Appointment Date: _____ Acct#: _____

Patient/Responsible Party Signature:_____

Item 2: Protected Health Information Authorization (PHI)

The following individuals can have access to my **PHI** until such time as this access is rescinded in writing:

Please check your choice(s) allowing individuals' access to your PHI.

____Entire Medical Record ____Financial Record ____Insurance Benefits

Person: _____ Relationship to patient: _____

Person: _____ Relationship to patient: _____

Patient/Responsible Party Signature: _____

Item 3: TREATMENT OF MINOR(S) Authorizations

Person(s) who have my permission to present my minor child for treatment with Victoria Hearing Center in my absence until such time as permission is rescinded in writing:

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

Parent/Responsible Party Signature: _____