# Victoria ENT Associates, LLP

**117 Medical Drive, Suite #1 Victoria, Texas 77904-3114**
**Telephone (361) 573-4331**

## AUTHORIZATIONS: Treatment – Insurance – Financial Policy

**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 ENT Associates, LLP.**

**I have read, understand and agree to Victoria ENT Associates, LLP's 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 ENT Associates, LLP 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 ENT Associates, LLP.**

**Patient Name:** _____ **Acct#** _____

**Date:** _____

**Patient/Responsible Party Signature:**_____

## PLEASE READ AND COMPLETE IF APPLICABLE

**Protected Health Information Authorization (PHI)**

**The following individuals can have access to my PHI until such time as this access is rescinded in writing:**

**_____Entire Medical Record _____Financial Record _____Insurance Benefits**

**Specific Information:** _____

**Person:** _____ **Relationship to patient:** _____

**Person:** _____ **Relationship to patient:** _____

**Patient/Responsible Party Signature:** _____

## PERMISSION FOR TREATMENT OF MINOR(S)

**Person(s) who have my permission to present my minor child for treatment with Victoria ENT Associates, LLP in my absence until such time as permission is rescinded in writing:**

**Name:** _____ **Relationship to patient:** _____

**Name:** _____ **Relationship to patient:** _____

**Parent/Responsible Party Signature:**_____