

HOSPITAL PREFERENCE:

If any testing or surgery is scheduled, I understand it is my responsibility to contact my insurance company to see if any precertification is required and then notify Midwest ENT.

My hospital preference is: _____ This hospital is: Required by my Insurance Personal Preference

IMPORTANT - PLEASE READ THE FOLLOWING INFORMATION/SIGNATURE REQUIRED

- **If any testing is scheduled, I understand it is my responsibility to contact my insurance company to see if precertification is required and notify Midwest Ear, Nose & Throat.**
- **Midwest Hearing Center is provided as a service to our patients for necessary diagnostic testing ordered by the physicians. Your testing may be done at our center or scheduled at a facility of your choice.**

IN ORDER TO SUBMIT A CLAIM FOR PAYMENT TO US FOR SERVICES COVERED UNDER YOUR POLICY, WE MUST HAVE YOUR AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO YOUR INSURANCE CARRIER.

ASSIGNMENT OF BENEFITS TO PHYSICIAN:

I hereby assign all medical and/or surgical benefits including medical benefits to which I am entitled and government sponsored programs, private insurance and any other health plan to: ROBERT T. PARRISH, M.D., JAMES C. HERTENSTEIN, M.D.; MICHAEL J. GOOTEE, M.D.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I hereby agree to pay any and all charges that exceed or that are not covered by insurance unless I am a member of a contractual agreement (such as an HMO/PPO) with which any of the above listed physicians participate. I hereby authorize said assignee to release all information necessary to secure payment.

I have read and understand all of the above information.

PATIENT'S SIGNATURE or
PARENT IF A MINOR _____ DATE: _____