



MONTGOMERY OTOLARYNGOLOGY

Head & Neck Surgery

1722 Pine Street - Suite 804

Montgomery, Alabama 36106-1155

METHOD OF PAYMENT

___CHECK ___CASH

___CREDIT CARD

VISA/MC/AMEX

PLEASE PRINT

PLEASE PRINT

P A T I E N T	MR. MRS. MISS	LAST NAME		FIRST NAME		MIDDLE
	ADDRESS		STREET	APT.#	CITY	STATE ZIP
	SS#	HOME PHONE	DATE OF BIRTH	SEX	MARITAL STATUS	DL#
	EMPLOYED BY	EMPLOYER'S ADDRESS		OCCUPATION	WORK PHONE	
	SPOUSE'S NAME	EMPLOYED BY	EMPLOYER'S ADDRESS	WORK PHONE		
	NEAREST FRIEND OR RELATIVE		RELATIONSHIP TO PATIENT			PHONE

PLEASE READ: All charges are due at the time of service. If hospitalization is indicated, the patient is responsible for furnishing insurance claim forms to the office prior to hospitalization. I understand that I will be responsible for all balances due and if not paid within 90 days, collection action will be taken

R E S P O N S I B L E P A R T Y	MR. MRS. MISS	LAST NAME		FIRST NAME		MIDDLE
	ADDRESS		STREET	APT.#	CITY	STATE ZIP
	HOME PHONE	RELATIONSHIP TO PATIENT			OCCUPATION	
	EMPLOYED BY	EMPLOYER'S ADDRESS		CITY	STATE	ZIP
	<p>I am responsible for all financial obligations of health services for the above patient, and for reimbursement and payment of claim from my insurance company. If for any reason the account should become delinquent. I agree to pay for all rebilling charges, collection costs and reasonable legal fees.</p> <p>I hereby assign, transfer and set over to Montgomery Otolaryngology all of my rights title and interest to my medical reimbursement benefits under my insurance policy.</p> <p>I authorize my insurance to pay to the Doctor</p> <p>I authorize Montgomery Otolaryngology to release my medical information.</p>					
	Sign X					DATE

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

(To be filed in patient's medical record)

I have been presented with a copy of the Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding, my health information.

Signed: _____ Date: _____

I wish to place the following restrictions on disclosure of my health information:

Internal Use Only

If patient representative refuses to sign acknowledgement, please document date and time notice was presented to patient and sign below

Presented on (Date and Time)

By (Name and Title)