## ASSIGNMENT OF BENEFIT AGREEMENT AND PAYMENT AGREEMENT

I hereby authorize my insurance company, including Medicare if I am a Medicare Beneficiary, to make payment to Cleveland Head and Neck Clinic, P.C. for medical or surgical services or items rendered to me or my department by Cleveland Head and Neck Clinic, P.C. should my insurance carrier deny Cleveland Head and Neck Clinic, P.C. payment, I understand that I am financially responsible for my charges. I authorize Cleveland Head and Neck Clinic, P.C. to release any kind and all of my records to my insurer, or any other third party payer, legally responsible for the payment of medical expenses. I certify that the information provided or to be provided by me is correct and complete to the best of my knowledge. It is my responsibility to update any and all personal, insurance, and health information. The undersigned waives all right of exemption under the laws of the State of Tennessee. To the extent permitted by law, I agree to pay all court costs and collection expenses incurred in the collection of any amount I owe under this Agreement. If I default and my account is referred for collection to an attorney who is not our salaried employee, I agree to pay the lesser of 1) attorney's fees of 33 1/3% of the amount owed or 2) the attorney's fees in the amount customarily awarded by Sessions Court for the county where the suit is filed. If the bank, for insufficient funds, returns any patient check, we reserve the right to add a penalty charge to that patient's account. The current charge for returned check is $30.00.

## PATIENT PRIVACY PRACTICES

I have had the opportunity to read the Practice Privacy Policy, Financial Policy, Assignment of Benefits Agreement, and the terms and conditions of Waiting Room Solutions (Electronic Medical Record Service that Cleveland Head and Neck Clinic, P.C. is using to assist in records and health management). Each time you visit us, a record of your visit is made. We may use or disclose the health information contained in this record if you initial this for allowing us to do so.

I hereby give permission for any laboratory, x-ray, biopsy, or other Procedures results ordered by Cleveland Head and Neck Cliic to be released over the telephone to any persons and myself listed below. This will be done after careful identification of the person calling and at the clinic's discretion.

I authorize Cleveland Head and Neck Clinic to review my online medication history to assist in medication management.

May we email you to confirm appointments? YES NO

Email address: _____

May we leave a message on your answering machine at home or on your cell phone? YES NO

I have read and agree to the Assignment of Benefits Agreement and Payment Agreement.
I have read the Patient Privacy Practice.
I authorize Cleveland Head and Neck Clinic, P.C. to review my online medication history to assist in my medication management.

**SIGNATURE:** _____

**DATED:** _____

OTHER PERSONS THAT MAY CALL FOR RESULTS:

_____

_____

_____

IDENTIFYING NUMBER (LAST 4 DIGITS OF PATIENT'S SSN): _____