

**MEDICARE AND /OR BENEFITS;**

I request that payment of authorized Medicare Benefits be made to McCalla Ear, Nose and Throat, P.C. on my behalf for any services furnished. When appropriate, McCalla Ear, Nose and Throat, P.C. reserves the right to select situations to accept assignment. I authorize my holder of medical information about me to release to Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

This assignment also gives McCalla Ear, Nose and Throat, P.C. the authority to use or disclose my health information for treatment, payment or healthcare operations.

SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_

**OTHER INSURANCE BENEFITS**

I request that payment of authorized \_\_\_\_\_  
(Name of Your Insurance Company)

insurance benefits be made to McCalla Ear, Nose and Throat, P.C. on my behalf for any services furnished. When appropriate, McCalla Ear, Nose and Throat, P.C. reserves the right to select situations to accept assignment. I authorize my holder of medical information about me to release to the above named insurance companies or their agents any information needed to determine these benefits payable for related services. I understand that my insurance may not pay for services it determines not medically necessary or not covered under my policy. Should my insurance deny payment, I agree to be personally responsible for payment to McCalla Ear, Nose and Throat, P.C.

This assignment also gives McCalla Ear, Nose and Throat, P.C. the authority to use or disclose my health information for treatment, payment or healthcare operations.

SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_