I hereby authorize my insurance benefits to be paid directly to the above signed physician, realizing I am responsible to pay non-covered services. I also hereby authorize the release of pertinent medical information to insurance carriers and/or other consulting physicians who may require it.

I agree to be responsible for any reasonable collection costs (balance due plus 30%) and/or attorney fees incurred in collecting a delinquent account. Interest will not be charged on the outstanding balance. (This disclosure is in compliance with the Truth-In-Lending Act).

I understand that the physicians of the East Tennessee Ear, Nose, Throat, Allergy, Head & Neck Specialists, P.C. ("ETENTS") perform most procedures at Advanced Family Surgery Center and that some of the ETENTS physicians have an ownership interest in the Surgery Center. I understand I may have the same procedure performed at an alternate facility that is not in any way connected, financially or otherwise, to the referring physician or his or her practice. The alternate facilities are Methodist Medical Center, Baptist Health Corbin, East Tennessee Children's Hospital and Children's West Surgery Center.

Patient Name:_____ DOB:_____
Print

Signed:_____ Date:_____

FOR MINORS ONLY: I, _____ hereby state that I am the☐ biological parent ☐ legal guardian ☐ other (specify)_____ of the patient and am authorized to sign on their behalf. I understand that if I am not the biological parent that I must provide legal documentation.