Suburban Ear, Nose & Throat Associates, Ltd.

In an effort to provide you with timely information regarding your health care, we are asking that you complete this waiver.

Please provide us with phone numbers where you can be reached with test results and medical information.

(_____)_____Home

(_____)_____Work

(_____)_____Cell

If you are unavailable when we call you, may we leave medical information with another person and/or do you authorize any other person to call regarding your medical information?

_____Yes _____No If yes, with whom?_____

(If your answering machine does not identify you last name or phone number, we will not leave medical information.)

I have been notified of the Privacy Policy for this Practice.

_____	_____	_____
Patient's name	Patient/Guardian Signature	Date

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Please be aware that some services provided in our office may not be covered by your copay and may be subject to your deductible. Our office does not know this until we receive the explanation of benefits from your insurance carrier.

I understand the above statement and agree to be responsible for any amount not covered by my insurance.

_____	_____	_____
Patient's name	Patient/Guardian Signature	Date