CROSS TIMBERS EAR, NOSE AND THROAT

James F. Leffingwell, MD
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Contact/HIPAA/ Assignment of Benefit

Circle where you can be reached during business hours: Home Work Cell
May we leave you a message? Yes or No
May we send text messages to your mobile phone? Yes or No If yes, number:_____
May we contact you via email? Yes or No If yes, email:_____

Health Insurance Portability & Accountability (HIPAA)

I have been provided the opportunity to review the Notice of Privacy Practices. I, the undersigned authorize CTENT (Cross Timbers ENT PLLC) to send/receive confidential healthcare information as that term is defined by HIPAA by facsimile to health care providers, hospitals, laboratories, and other medical caregivers for the coordination of care for the patient. I may revoke this authorization by a five day written notice to CTENT.

____CTENT **MAY NOT** discuss my healthcare and may not discuss and / or make financial arrangements with anyone except as permitted by HIPPA and other applicable laws.

____CTENT **MAY** discuss my healthcare and **MAY** discuss and / or make financial arrangements with only the following individual immediate family members listed below:

Name_____Relationship_____Phone_____

Name_____Relationship_____Phone_____

I understand that if I would like to authorize CTENT to disclose my healthcare and / or financial arrangements with anyone other than the individuals listed above, I will need to execute an authorization that meets the requirements of the HIPAA Privacy Standards. (Written authorization).

Please provide a date or event, if any, upon which this Authorization will expire. Please mark only one selection:

__No Expiration
__Date of Expiration __/__/__
__Event: (Describe event upon which this Authorization will expire)_____

Assignment of Benefits-Financial Agreement

I hereby authorize payment of insurance benefits to be made directly to CTENT and any assisting physicians for services rendered. **I understand that I am financially responsible for all charges whether or not covered by my insurance carrier**. I also authorize CTENT to release all information necessary to secure the payment of benefits. A photocopy of this agreement shall be valid as the original.

Patient's Name:_____

Patient / Guardian signature:_____Date:_____