Princess Anne ENT & Allergy, PC.

828 Healthy Way, Suite 280, Virginia Beach, VA 23462

AUTHORIZATION FOR TREATMENT

I hereby authorize treatment by Princess Anne ENT & Allergy (PAENT) and or affiliated medical staff member(s) on behalf of myself and my minor children, including stepchildren.

The possibility exists (during such treatment) for health care workers to become directly exposed to my blood or bodily fluids. In the event of such exposure, State law requires a sample of my blood to be tested for the presence of infectious diseases.

RELEASE OF INFORMATION

I hereby authorize the release of any and all medical and/or charge information as is necessary for reimbursement from any third party or governmental agency involved in the payment of my treatment including but not limited to Insurance Payers, HMOs, Workers Compensation carriers, Medicare, Tricare, and Medicaid. I also authorize the taking and use of photographs. I understand these photos will become part of my medical records.

I hereby authorize the release of the minor's immunization record to the school nurse or the daycare center at which my child is enrolled. _____ (initials)

OBLIGATION OF PAYMENT

I direct and assign payment from any insurance coverage, workers compensation, governmental agency or disability benefits, and assignment of proceeds from all settlements, judgments or verdicts in favor of the undersigned from the third party liability claims for injuries treated hereunder, in an amount equal to the full amount of all charges (including attorney's fees, collection agency fees, costs and interest) due hereunder is to be made to PAENT. I understand that if I have insurance, my insurance policy is a contract between me and my insurance company. I am responsible to PAENT for any charges not covered by my insurance, including but not limited to co-payments, deductibles, and fees for non-covered services. The patient and the undersigned guarantor are primarily liable for payment of the Patient's account and unless otherwise indicated by my initialing here, PAENT will send all appointment reminders and billing information to the person responsible for payment of my bill. _____ (initials) It is their sole responsibility to comply timely with all requirements, and supply all information and documents necessary to obtain payment of benefits by any third party of governmental entity as listed above. Some insurance plans (i.e. Medicare, Blue Cross, and Champus) require that lab work be billed directly by the laboratory performing the testing. In these instances, a separate statement and bill will be sent from the lab performing the test.

PAST DUE BALANCES AND PROCEDURES FOR COLLECTION

Any balance remaining on the account after any insurance pays will be due upon receipt of my statement. Charges for non-covered services are due at the time of service.

The undersigned agree(s) to pay all charges made by medical providers at their current rate. The obligation of each undersigned is an original, direct and independent promise to pay based on the exclusive credit of each, and not a collateral or contingent promise to answer for the debt of another. If payment is not made, I understand that PAENT may take action to collect its fees. I agree to pay all costs incurred by PAENT for collecting its fees, including an attorney's fee of thirty-five percent (35%) of the unpaid bill. The return check fee is $25.00.

ACKNOWLEDGMENTS

I the Patient/Guarantor acknowledge that I was provided with a PAENT Rights and Responsibilities form and given an opportunity to ask questions about the information provided in this form.

NOTICE OF PRIVACY PRACTICES

Effective April 14, 2003, I acknowledge that I have received, have previously received, or have been offered by decline to receive the PAENT Notice of Privacy Practices. _____ (initials)

In providing my email address, I authorize PAENT to use the address for the purpose of communicating health-related information or services. I acknowledge that I may opt-out of such communication at any time and my email information will not be shared with any organization outside PAENT and its affiliated companies.

Patient Name (please print): _____

Patient/Guarantor (signature): _____ Date: _____

Witness: _____ Date: _____

Thank you for selecting Princess Anne ENT & Allergy as your Health Care partner.