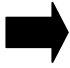
CONSENT TO PROVIDE TREATMENT

I hereby authorize Dr. Ratnamani Lingamallu, Victoria Cornish, ARNP, and Marcy O'Brien, AuD to provide medical services to me or my dependent.



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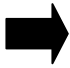
Signature of patient or parent if minor Date

CONSENT TO SUBMIT CLAIM(S) AND ACCEPT PAYMENT

I hereby authorize Central Florida ENT Associates, P.A., Dr. Ratnamani Lingamallu, Victoria Cornish, ARNP, and Marcy O'Brien, AuD to submit claim(s) to the Center for Medicare and Medicaid Services and its agents, or any other third party carrier as necessary to secure payment of any benefits due me. I hereby assign payment of said benefits, to include Medicare benefits, directly to Central Florida ENT Associates, P.A., Dr. Ratnamani Lingamallu, Victoria Cornish, ARNP, and Marcy O'Brien, AuD. As well, I authorize Central Florida ENT Associates, P.A. to accept and deposit any insurance payments made directly payable to me. I understand that I am responsible for all charges regardless of insurance status in compliance with the law. In addition, I authorize Central Florida ENT Associates, P.A. and/or its representatives to file complaints on my behalf with the State of Florida, Department of Insurance, for any reason.



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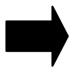
Signature of patient or parent if minor Date

CONSENT FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize Central Florida ENT Associates, P.A., Dr. Ratnamani Lingamallu, Victoria Cornish, ARNP, and Marcy O'Brien, AuD to use and disclose my protected health information (PHI) for the purposes of treatment, payment and healthcare operations.

This consent allows Central Florida ENT Associates, P.A. and its representatives to release your PHI to your Primary Care or referring physician, and/or to a physician or facility we may refer you to in the course of your treatment. This consent allows Central Florida ENT Associates, P.A. to release PHI acquired during the course of your examination and treatment to the Center for Medicare and Medicaid Services and its agents, and/or any other third party carrier as necessary to secure payment for services rendered. In addition, this consent allows Central Florida ENT Associates, P.A. and its representatives to use your PHI in the course of healthcare operations; for example, an internal chart audit.



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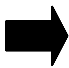
Signature of patient or parent if minor Date

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received Central Florida ENT Associates, P.A.'s "Notice of Privacy Practices."



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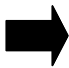
Signature of patient or parent if minor Date

NOTICE OF MARKETING PRACTICES, HIPPA REGULATION 2013

I hereby give permission to Central Florida ENT Associates, P.A. to contact me regarding products for which the practice my receive remuneration. I understand that I may contact the office if I have any questions.



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Signature of patient or parent if minor Date