## **EAR NOSE THROAT ALLERGY CENTER** MARK WEICH DO FAOCO

PATIENT INFORMATION	2,775					
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EMPLOYER			EMPLOYER ADDRESS		CITY,STATE	ZIPCODE
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Allergy Center is set forth in the NOTICE OF PRIVACY ACTS. A copy has been furnished to me and is posted in the clinic.

I understand and agree that I am ultimately responsible for the balance on my account for any professional service rendered. Medicare rules and Ear Nose Throat and Allergy Center insurance agreements may affect patient responsibility for the account. I have completed the above questions and certify this information is true and correct to the best of my knowledge. I will notify upon of any changes in my insurance status or any of the above information. I request that payment of authorized medical benefits, if any, be made to Ear Nose Throat and Allergy Center on my behalf for any unpaid services rendered by Ear Nose Throat and Allergy Center physicians.

l authorize the release of medical record information to the health plan indicated for information requested by the health plan to determine the payment of medical benefits. The information authorized for release may include information about communicable or noncommunicable disease, mental health, substanse or alcohol abuse.

1	acknowledge	receipt o	f the	NOTICE C	OF PR	IVACY	<b>PRACTICES</b>

Signature

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