

**INSURANCE AUTHORIZATION AND ASSIGNMENT
DISCLOSURE FOR
MANATEE HEARING AND SPEECH CENTER (MHSC)**

COMMERCIAL/HMO AND PPO PATIENTS: If you are covered by an **HMO/PPO** and wish to receive services at MHSC that have not been authorized, we are available and happy to provide the service. You will however be responsible for **payment on the day of service**. You will also be responsible for any **deductible, copay or coinsurance** that is assigned to you from your insurance company.

MEDICARE: We accept assignment from Medicare on our testing, You will be responsible for your Medicare **deductible and the 20% coinsurance** if your secondary insurance denies payment. Please inform us if you are living in a **SKILLED NURSING FACILITY** as we need to make other arrangements for payment.

MEDICARE HMO/REPLACEMENTS: If you are on a Medicare HMO/Replacement plan, be advised that **we are not providers**. We are happy to see you but **you will be responsible for payment in full (Medicare allowable) at the time of service**.

SELF PAY: If you are not covered by insurance or are filing your own insurance claim, **you are responsible for payment in full** to MHSC for services provided at the time of service.

ALL PATIENTS: I hereby authorize Manatee Hearing & Speech Center to furnish information to insurance carriers or other guarantors of service concerning my illness and treatment and I hereby assign to the MHSC all payments for medical services rendered. **Services performed by Manatee Hearing and Speech do not reflect any changes incurred by Ear, Nose & Throat Associates as we are two separate entities.**

I understand that I am responsible for any amount not covered or authorized by my insurance carrier.

I understand and agree to the policies above.

SIGNATURE: _____

DATE: _____