Lafayette Otolaryngology Associates, Inc.
** LAFAYETTE ENT **
2320 Concord Road, Lafayette, IN 47909 (765) 477-7436
EAR, NOSE AND THROAT
HEAD AND NECK SURGERY
FACIAL PLASTIC AND RECONSTRUCTIVE SURGERY

MEDICARE OR MEDICAID BENEFITS

_____ I request that payment of authorized Medicare or Medicaid benefits for any services, including my physician services, furnished to me by LAFAYETTE OTOLARYNGOLOGY ASSOCIATES, INC., DBA "LAFAYETTE ENT", be assigned to Lafayette ENT. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or benefits for related services.

MEDIGAP INSURANCE

_____ I request that payment of authorized Medigap benefits for any services, including my physician services, furnished to me by LAFAYETTE OTOLARYNGOLOGY ASSOCIATES, INC., DBA "LAFAYETTE ENT", be assigned to Lafayette ENT. I authorize any holder of medical or other information about me to release to the Medigap Insurance Company and its agents any information needed to determine these benefits or benefits for related services

PRIVATE INSURANCE AUTHORIZATION AND ASSIGNMENT

_____ I authorize LAFAYETTE OTOLARYNGOLOGY ASSOCIATES, INC.,DBA "Lafayette ENT", to disclose information to insurance carriers concerning my illness and treatment and I hereby assign all payments from third parties to LAFAYETTE ENT for medical and surgical services rendered to my dependants or myself. I understand that I am financially responsible for the charges not covered by this assignment.

I AGREE THAT I WILL PAY ALL ATTORNEY FEES AND COURT COSTS INCURRED BY LAFAYETTE ENT IN THE COLLECTION OF ALL SUMS DUE.

A FINANCE CHARGE OF 8% A.P.R. OR 0.67% PER MONTH WILL BE CHARGED ON ALL ACCOUNTS 60 DAYS OR OLDER.

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Signature of Patient Date

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Witness Date