EAR·NOSE·THROAT SPECIALISTS
of Northern Virginia, P.C.

PROFESSIONAL HEARING SERVICES
The Dizziness and Balance Center
The Hearing Aid Center

To Submit Claims To Medicare: I request that payment of authorized Medicare and/or Medigap benefits be made either to me or on my behalf to Ear, Nose & Throat Specialists of Northern Virginia/d.b.a. Professional Hearing Services for any services furnished to me by Professional Hearing Services. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I further authorize any holder of Medicare information about me to my Medigap insurer any information needed to determine these benefits payable for related services.

To Submit Claims To Insurance: I hereby authorize Ear, Nose & Throat Specialists of Northern Virginia/d.b.a. Professional Hearing Services to apply for benefits on my behalf for covered services rendered to the practice, and request that the payment be made directly to Professional Hearing Services. I certify that the information I have reported with regard to my insurance coverage is correct. I further authorize the release of any necessary information, including medical information, for this or any related claim. I permit a copy of this authorization to be used in place of the original. All co-payments are due at the time of service.

Non-Payment: I understand that if my account is turned over to a collection attorney or collection agency for non-payment, I will be responsible for any additional fees allowed by law.

Medical Records: I hereby authorize Ear, Nose & Throat Specialists of Northern Virginia/d.b.a. Professional Hearing Services to release my medical records to, and discuss my care with, my treating physicians, future consulting physicians, other Health Care Providers, and Healthcare Equipment suppliers. I further authorize all of my treating physicians and other Health Care Providers to release my medical records to Professional Hearing Services. Some of my information may be shared with my insurance provider in order to process my claim.

Information may be seen by third parties (e.g. transcriptionists, clerks, etc.) in incident to maintaining my medical record. All reasonable efforts will be taken to maintain my privacy. My information will not be shared with other parties without my specific, revocable consent. I further understand that Professional Hearing Services will maintain my medical records for a minimum of six (6) years from my last treatment date (longer where required by governing laws). After six (6) years from my last treatment date my records may be permanently discarded in a manner compliant with standards under the Health Insurance Portability and Accountability Act of 1996 (HIPPA) to ensure patient medical record confidentiality.

(sign and date the first line, the following lines will be completed with each succeeding year)

Signature _____ Date _____

Signature _____ Date _____

Signature _____ Date _____