



**GREATER MILWAUKEE OTOLARYNGOLOGY, LLC  
FINANCIAL RESPONSIBILITY AGREEMENT**

**PATIENT/GUARDIAN STATEMENT**

**I understand that some procedures performed in our specialty clinic may be costly but necessary for medical decision making.**

I understand that I am financially responsible for my deductible, co-insurance, procedures which are deemed not medically necessary by my insurance provider and any amount exceeding what my insurance company pays, except where exempt by contractual agreement. I understand that payment is expected at the time service is rendered. Greater Milwaukee Otolaryngology, LLC accepts cash, check, Mastercard or Visa. There will be a \$20.00 fee imposed on all checks returned NSF. I further understand that I am responsible for providing current insurance information and complying with any regulations that my insurance carrier may have regarding referrals, pre-authorization, and second opinions.

I hereby authorize payment of health insurance benefits directly to Greater Milwaukee Otolaryngology, LLC for services rendered. I authorize the release of any medical information necessary to process my claims.

I understand and agree that if care at Greater Milwaukee Otolaryngology, LLC requires Primary Care Physician referral, prior approval or authorization, it is my responsibility to see that the referral is current prior to receiving care at Greater Milwaukee Otolaryngology, LLC. If no referral/authorization is presented in advance, I agree to be personally responsible to pay for services rendered by Greater Milwaukee Otolaryngology, LLC.

I hereby request payment of authorized Medicare benefits be made to me or on my behalf to Greater Milwaukee Otolaryngology, LLC for any services furnished to me by that provider. I authorize the release of any medical records to the Centers for Medicare and Medicaid Services and its agents to determine benefits and/or benefits payable. This agreement will remain in effect until revoked by me in writing. A copy of this document is considered as valid as an original.

**Patient Name:** \_\_\_\_\_

**Relationship to Patient:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_