PRIMARY INSURANCE INFORMATION

PRIMARY INSURANCE NAME

PRIMARY INSURANCE ADDRESS | CITY/STATE/ZIP | PHONE #

POLICY/MEMBER # | GROUP # | COPAY

SECONDARY INSURANCE INFORMATION

SECONDARY INSURANCE NAME

SECONDARY INSURANCE ADDRESS | CITY/STATE/ZIP | PHONE #

POLICY/MEMBER # | GROUP # | COPAY

I hereby authorize payment of benefits directly to Utah Ear Nose and Throat, LLC otherwise payable to me for medical and/or surgical services rendered. I realize that I am responsible for payment of any non-covered service, co-payment, or deductible. I am aware that delinquent accounts will be charged interest.

In addition, I agree to pay any costs of collection including reasonable attorney fees. I also authorize release of information concerning illnesses and treatments of the above name patient to any third party payer with whom the patient is under contract. I also permit the doctor or assistant to take photographs of the above named patient and understand they are for legal documentation or presentation at professional meetings and discussions, and I give permission to use them as such.

SIGNATURE | DATE