



**PRIVACY POLICY**

I HEREBY ACKNOWLEDGE THAT I HAVE BEEN GIVEN THE OPPORTUNITY TO READ THE NOTICE OF PRIVACY PRACTICES FOR EARS OF TEXAS, P.A. I HAVE BEEN GIVEN THE OPPORTUNITY TO ASK ANY QUESTIONS I MAY HAVE REGARDING THIS NOTICE.

PATIENT SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_

**RELEASE OF INFORMATION**

**\*\* Please check each box:**

REGARDING USE OF FACSIMILE (a.k.a. FAX): THERE ARE RISKS THAT CONFIDENTIAL INFORMATION MAY ACCIDENTALLY BE TRANSMITTED TO PEOPLE NOT AUTHORIZED TO RECEIVE SUCH INFORMATION. ALTHOUGH EARS OF TEXAS, PA INSTITUTES EVERY MECHANISM AVAILABLE TO AVOID THE RISK, I AM AWARE OF THE POTENTIAL RISKS AND AUTHORIZE THE USE OF FACSIMILE.

I HEREBY AUTHORIZE WESLEY W.O. KRUEGER, MD, AS A HOLDER OF MEDICAL INFORMATION TO RELEASE TO THE REFERRING PHYSICIAN, FAMILY PHYSICIAN, AND ANY MEDICAL OR MEDICALLY RELATED FACILITY, INFORMATION REGARDING DIAGNOSIS AND TREATMENT VIA TELEPHONE, FACSIMILE, OR MAIL.

I FURTHER AUTHORIZE WESLEY W.O. KRUEGER, MD TO RELEASE MY NAME AND ADDRESS TO OTHER PARTIES FOR THE SOLE PURPOSE OF RECEIVING MEDICALLY RELATED INFORMATION VIA TELEPHONE, FACSIMILE, OR MAIL.

IN ACCORDANCE WITH FEDERAL GOVERNMENT PRIVACY RULES IMPLEMENTED THROUGH THE HEALTHCARE PORTABILITY ACT OF 1996 (HIPAA), IN ORDER FOR YOUR PHYSICIAN OR STAFF TO DISCUSS YOUR CONDITION WITH MEMBERS OF YOUR FAMILY OR OTHER INDIVIDUALS THAT YOU DESIGNATE, WE MUST OBTAIN YOUR AUTHORIZATION PRIOR TO DOING SO. IN THE EVENT OF A MEDICAL EMERGENCY, THE LAW STIPULATES THAT THESE RULES MAY BE WAIVED.

**\*\* Check one box only:**

I DO NOT AUTHORIZE THE PRACTICE TO RELEASE ANY OR ALL INFORMATION CONCERNING MY MEDICAL CARE TO ANY INDIVIDUALS EXCEPT AS SET FORTH ABOVE.

I AUTHORIZE THE PRACTICE TO RELEASE ANY OR ALL INFORMATION CONCERNING MY MEDICAL CARE VERBALLY OR IN WRITING RELEASE ANY OR ALL INFORMATION CONCERNING MY MEDICAL CARE AS SET FORTH ABOVE AND IN ADDITION TO THE FOLLOWING INDIVIDUALS

**(CHECK ALL BOXES THAT APPLY):**

MY SPOUSE    CHILDREN    PARENTS

OTHER (*Please be as specific as possible*): \_\_\_\_\_

PATIENT SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_

**INSURANCE POLICY TO ALL INSURES**

***"IF YOU HAVE AN HMO POLICY OR REQUIRE A REFERRAL, IT IS THE PATIENTS/RESPONSIBLE PARTY'S SOLE RESPONSIBILITY TO COORDINATE ALL NECESSARY REFERRALS BEFORE YOUR VISIT. IT IS ALSO THE RESPONSIBILITY OF THE PATIENT/RESPONSIBLE PARTY TO INQUIRE WITH THEIR INSURANCE COMPANY WHETHER EARS OF TEXAS, P.A. IS A PARTICIPATING PROVIDER WITH THEIR INSURANCE PLAN.***

PROVIDING QUALITY MEDICAL CARE FOR OUR PATIENTS IS OUR PRIMARY CONCERN. WE ARE MORE THAN WILLING TO PROVIDE THAT CARE WITHIN YOUR INSURANCE CONTRACT GUIDELINES IF YOU DO NOT INFORM US OF ANY SPECIAL REQUIREMENTS IN YOUR CONTRACT AND WE SUBSEQUENTLY ORDER SERVICES (SUCH AS TESTS, LAB WORK, OR HOSPITALIZATION) THAT ARE NOT COVERED, WE OR THE SELECTED MEDICAL FACILITY WILL HAVE NO CHOICE BUT TO BILL YOU DIRECTLY FOR THOSE CHARGES. ***PAYMENT FOR THOSE CHARGES IS THEN YOUR RESPONSIBILITY.***

I ALSO AUTHORIZE THE RELEASE OF MEDICAL INFORMATION VIA TELEPHONE, FACSIMILE, OR MAIL TO MY INSURANCE COMPANY OR ITS INTERMEDIARIES INFORMATION NEEDED FOR THIS OR ANY FURTHER RELATED CLAIM (S) AND REQUEST THAT PAYMENT BE MADE TO EARS OF TEXAS, P.A., 2632 BROADWAY #201-202, SAN ANTONIO, TEXAS 78215.

I UNDERSTAND I AM FINANCIALLY RESPONSIBLE TO EARS OF TEXAS, P.A. FOR ALL SERVICES REGARDLESS OF ANY OR ALL REIMBURSEMENTS PAID BY MY INSURANCE CARRIER. I FURTHER UNDERSTAND, IF EARS OF TEXAS, P.A. DOES NOT PARTICIPATE WITH MY INSURANCE PLAN THAT I WILL BE FULLY RESPONSIBLE FOR ALL NON-CONTRACTUAL AMOUNTS AND FEES OVER MY INSURANCE COMPANY'S REIMBURSEMENT FEE SCHEDULE.

WITH YOUR COOPERATION AND HELP, YOU SHOULD BE ABLE TO RECEIVE ALL OF THE BENEFITS OFFERED TO YOU, AND WE WILL BE ABLE TO CONCENTRATE ON CARRING FOR YOUR MEDICAL NEEDS.  
***I HAVE READ AND UNDERSTAND THE OFFICE POLICY STATED ABOVE AND AGREE TO ACCEPT RESPONSIBILITY AS DESCRIBED.***

PATIENT SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_