1. **YOUR INSURANCE CARD MUST BE PRESENTED AT THE TIME OF YOUR INITIAL VISIT, OR YOUR APPOINTMENT MUST BE RESCHEDULED.**
2. **IF YOUR INSURANCE REQUIRES AN AUTHORIZATION/REFERRAL FROM YOUR PRIMARY CARE PHYSICIAN TO BE SEEN BY OUR DOCTORS, IT IS YOUR RESPONSIBILITY TO MAKE SURE WE HAVE IT AT THE TIME OF EACH VISIT, OR YOUR APPOINTMENT MUST BE RESCHEDULED.**
3. Any balance incurred as a result of not having a required referral or correct insurance information will be your responsibility. **We will not bill an insurance company if we do not have a copy of the card at the time of visit.**
4. Whenever applicable, we will collect your portion of your charges at the time of your visit. Self-pay patients are required to pay for their visit in full at the time they are seen.
5. We bill primary and secondary insurances only.
6. 24-hour advanced notice is required for cancellation of appointment. If no notice is given, you will be billed a $25 no-show fee.
7. 48-hour notification is required for prescription refills and test results.
8. **I have been given the "Notice of Privacy Practices" for the office of Dr. Taliaferro, Dr. Leake, Dr. Miller, and Dr. Towne**
9. **I GIVE MY PERMISSION FOR THIS OFFICE TO OBTAIN MEDICAL RECORDS FROM ANOTHER PHYSICIAN AS DEEMED NECESSARY FOR MY CARE AND TREATMENT.**
10. I hereby authorize North Florida Center for Otolaryngology to send me a copy of my records via fax or mail upon my verbal request with ID verification.

Please complete the following if you would like to authorize either doctor to speak with anyone else about your medical condition:

I give my permission for Dr. Taliaferro/Dr.Leake/Dr. Miller/Dr. Towne and/or staff to speak with:

_____

Print Name Relationship

regarding my medical condition, including but not limited to office visits, treatment, test results, procedures, surgeries, etc.

By signing below, I acknowledge that I have read and agreed to all of the above information:

_____ _____ _____

Patient's Name Patient's Signature Date