CONDITIONS OF REGISTRATION

THE PRACTICE
Feldman ENT Group, P.C. and/or its physicians, employees, agents or assignees will hereafter be referred to as "The Practice".

CONSENT FOR TREATMENT
The undersigned hereby consents to the administration of such medical treatment, diagnostic and/or therapeutic procedures and surgery as required by the physician rendering care for themselves and/or their child(ren). The procedures may include, but are not limited to, surgery, laboratory and x-ray procedures.

AUTHORIZATION & ASSIGNMENT OF INSURANCE BENEFITS
I do hereby authorize The Practice to apply for benefits for services rendered to myself or minor child(ren) under any health insurance policies/programs providing benefits and do hereby also assign and authorize payment of benefits from my (our) insurance company to The Practice (including benefits payable under Title XVII of the Social Security Act and/or any other governmental agency). I irrevocably authorize all such payments to The Practice. I authorize The Practice to contact the employer or insurance company regarding information, existence of insurance and coverage of my (our) benefits.

RELEASE OF MEDICAL INFORMATION
I authorize The Practice to release any and all of my or my minor child(ren)'s medical records and/or other information and records required by my (our) insurance company or its designated review agents who provide insurance benefits on my (our) behalf including if applicable, my employer and/or employer's workman's compensation insurance company, the Social Security Administration, or the Centers for Medicare & Medicaid Services (CMS) needed to determine benefits and to process insurance claims and secure payment of benefits to either the insured of to The Practice; and authorize any hospital, lab, physician, or other healthcare provider and/or their staffs and to release my or my minor child(ren)'s medical records and/or other records and information on myself or my minor child(ren) to The Practice as required for payment of benefits and/or required form medical or any other reasons; and authorize The Practice to release the above mentioned records for any of the above reasons I agree to pay any applicable charges allowed for having records copied. Such charges will include preparation fee plus accrual shipping and handling fees for services performed in Maryland Fees will increase yearly based on the Consumer Price Index. I agree that The Practice may demand payment of these fees and charges before turning the records over to me or other authorized person (such as the patient's parent guardian or lawyer). Applicable law for Maryland, the District of Columbia, shall apply where appropriate in regards to medical records.

REFERRALS AND AUTHORIZATONS
I understand that it is my responsibility, if I (we) have an insurance plan that requires any referrals, pre-certifications or authorization to receive any additional medical services, such as specialty care and diagnostic testing, to obtain such authorization from my (our) primary care physician (PCP) or insurance company prior to such non-emergency services being rendered. Additionally, if any aforementioned procedures are not done, I understand that this may cause reduced or rejected coverage for which I will be held responsible and that any of these aforementioned actions do not guarantee that my insurance company will pay for myself, spouse or my child(ren)'s claims. Any denial of claims is between the policyholder/subscriber and their insurance.

FINANCIAL AGREEMENT
I agree that payment in full is due at the time of service. I the undersigned (jointly and severally if more than one) further agree that I am legally obligated and responsible and do hereby guarantee payment for all charges incurred by myself, my children, step children or any other extended family members, including but not limited to grandchildren, nieces and nephews. I also understand that I (we) may be billed separately for services rendered by other professionals including, but not limited to other physicians, radiologists, and laboratory work, as appropriate and in accordance with the services rendered. The Practice will bill file for insurance benefits and accept payment per The Practice's contractual agreements with the insurance company. Any questions or disputes concerning insurance coverage or payment of benefits are a matter between the insurance subscriber/policyholder and the insurance company. Any assistance in this matter granted by The Practice is given strictly as a courtesy and implies no responsibility on The Practice's part for filing, follow through or confrontation. I agree to pay a $15.00 prescription refill fee for refills after hours. I agree to pay a $25.00 fee for missed office appointments that are not cancelled at least 24 Hours in advance, $100.00 fee for any ENG or Surgery not cancelled 24 Hours in advance and $200.00 for any IME not cancelled 24Hours in advance.
Should any balances arise due to insurance co-payments, co-insurance, deductibles, termination of coverage, not adding a dependant to insurance plan, non-payment at time of service and/or any other reason I agree to pay all charges within 30 days of services rendered. I agree that if for any reason a check is returned on my account I will be responsible for a $30.00 returned check fee in addition to the original fees for services. Service charges of two percent per month will be charged on all accounts over 30 days. If the balance is not paid within the 30 days or if agreed upon payment arrangements on my (our) accounts are not made, I authorize The Practice to retain the services of an attorney and/or collection agency at assist with the collection of any outstanding balance and to notify the credit bureaus of my (our) delinquencies. I understand that this will affect my (our) credit rating. If this account is placed for collections, I agree to pay one-third of the unpaid principal and service charges as an attorney/collection fee. Plus court costs and service charges in the amount of one and one-half percent per month, beginning 30 days after the monies have become due or expenses have been incurred. Any expenses incurred by such collection actions including maximum allowed interest, shall become an additional liability for which I (we) assume full responsibility. I (we) agree to inform The Practice immediately of any change in insurance coverage and/or benefits and change of personal information and to provide any other information needed to secure payment either from myself or my insurance carriers, and further understand that without complete and timely information The Practice may not be able to contact me or able to file for my (our) insurance benefits in a timely manner which would cause me to be responsible for full payment.

COPY OF SIGNATURE
I permit a copy of this authorization and signature to be used in place of this original on all insurance claim submissions and for the release of any medical records and/or other records and information, as stated herein, whether manual, electronic or telephone.

CERTIFICATION
I certify that the information I have reported with regard to my (our) insurance coverage is correct and that the above be honored by my (our) insurance carriers. This certification will also apply to application for benefits under Title XVII of the Social Security Act and/or any other government agency, if applicable. I also certify that I have read the foregoing and as the parent/guardian/guarantor understand and fully accept the terms therein.