ENT CONSULTANTS OF EAST TENNESSEE

Financial Responsibility Form

I understand that I have not met appropriate referral or authorization requirements or otherwise complied with the terms of my health: benefit plan. There may be a decrease in my coverage or no coverage at all for some or all of the services which I am about to receive. I acknowledge that I will be financially responsible for all services not covered by my health benefit plan.

Patient Name: _____

Patient Signature: _____

Date: _____

Witness: _____

(Employee of Providers Office)

Date: _____

Procedure Date: _____ **Location:** _____

CPT Codes: _____

Physician: _____