PRINCETON OTOLARYNGOLOGY ASSOCIATE
7 SCHALKS CROSSING RD., SUITE 324
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(609) 897-0203 (F) (609) 897-0213

I, _____ understand that I am financially responsible for payment of services rendered by Princeton Otolaryngology Associates, P.A. I request that payment for authorized insurance benefits and/or Medicare benefits be made to me or on my behalf to these doctor/s. I authorize any holder of medical information to release to the appropriate agents any information needed to determine these benefits payable for related services. A copy of my signature is as good as the original. Our practice is committed to securing the privacy of your health information. Accordingly, we have available for you to read our **Notice of Privacy Practices** at the front desk. You are not required to read this **Notice.** However, we would like your acknowledgement that you have been notified that the practice has such a **Notice of Privacy Practice.**

_____ _____

Signature Date