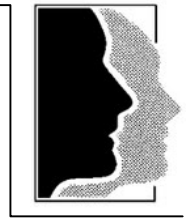


Marc E. Lieberman, MD, FACS
Ear, Nose and Throat
Facial Plastic Surgery



ACKNOWLEDGEMENT OF HIPAA NOTICE OF PRIVACY PRACTICES
AND
CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

I acknowledge that I was provided with a copy of Marc E. Lieberman, MD's HIPAA NOTICE OF PRIVACY PRACTICES describing how my health information may be used or disclosed under federal law in order to carry out treatment, payment or health care operations.

X _____

Patient or Legal Representative Signature

Date

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO RECEIVE PAYMENT OF INSURANCE/MEDICARE BENEFITS AND FINANCIAL POLICIES

I authorize payment of medical benefits for any services rendered to me by Dr. Lieberman. I understand that I am financially responsible for and that Dr. Lieberman is contractually bound to collect any unmet deductible or co-payment not covered by my health insurance if he is a participating provider. I also acknowledge that I am financially responsible for any non-covered services.

I authorize Dr. Lieberman to release medical information about me to my insurance company or to Medicare for the determination and payment of medical benefits to him.

I agree to be responsible for any legal fees and court costs incurred as a result of my failure to pay for services rendered.

If the patient is a minor, the parent/guardian seeking treatment for the minor is responsible for ensuring that Dr. Lieberman is paid.

If I am a self-pay patient without insurance coverage, I will pay all fees at the time service is rendered.

X _____

Patient or Legal Representative Signature

Date

1600 36th Street, Suite A Vero Beach, Florida 32960 Telephone (772) 569-7800 Fax (772) 569-9252

Diplomate, American Board of Otolaryngology
Diplomate, American Board of Facial Plastic & Reconstructive Surgery