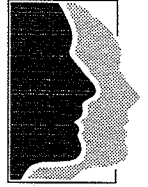


MARC E. LIEBERMAN, M.D., F.A.C.S.
Ear, Nose and Throat
Facial Plastic Surgery



**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 the doctor to release medical information about me to my insurance company or to Medicare for the determination and payment of medical benefits to them.

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 you are a self pay patient with no insurance coverage, all fees must be paid at the time service is rendered.

X _____
Patient or Legal Representative Signature

Date

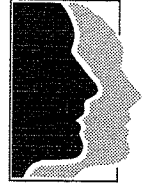
Revised 11/1/21

1600 36th Street, Suite A Vero Beach, FL 32960

(772) 569-7800 Fax (772) 569-9252

Diplomate, American Board of Otolaryngology
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