



**AUTHORIZATION-RESPONSIBILITY AGREEMENT**

I hereby authorize my insurance company to pay the proceeds of any benefits due me directly to Gulfcoast Ear, Nose, and Throat Associates, (Dr. Jose A. Berrios, M.D.) A copy of this agreement will be considered an original for insurance purposes. This will include any Medigap or supplemental insurances.

If I belong to a managed healthcare plan (i.e. HMO/PPO/PPC/POS) and do not have my visits and/or treatments authorized, precertified, or referred, I will be responsible for payment in full. I further acknowledge that authorization for services by my insurance company is NOT A GUARANTEE OF PAYMENT. Payment of benefits are determined according to my eligibility, the limitations, exclusions, and conditions of my health care plan. Gulfcoast Ear, Nose, and Throat Associates cannot guarantee payment from my insurance company and I am responsible for knowing and understanding my insurance coverage. Benefit determination of claim payment will be made at the end of the claims process. Should any claim be denied by my insurance plan, I will be responsible for payment in full.

I completely understand that I am responsible for any applicable co-pays, co-payments and deductibles. I further give permission for the release of any medical information pertaining to evaluation/treatment, if necessary for payment of any claim.

I understand and will comply with the above agreement. I affirm that to the best of my knowledge all the insurance information given by me is correct.

Signature of Patient or Guardian (if a minor) \_\_\_\_\_

Date: \_\_\_\_\_

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Ear, Nose and Throat Disorders, Head and Neck Surgery, Plastic and Reconstructive Surgery,  
Pediatric Otolaryngology, Comprehensive Hearing Services