

**GULFCOAST EAR, NOSE AND THROAT ASSOCIATES  
3007 RIDGELINE BLVD TARPON SPRINGS, FL 34688**

**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 care 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 acknowledge and understand that I am responsible for all charges for services rendered to me or my dependent. Although I have requested that the doctor bill my insurance on my behalf, I understand that it is my responsibility to make sure that the bill is paid within a reasonable amount of time. If for any reason, any portion of my bill is not paid by my insurance company, I agree to make arrangements for prompt payment of the balances.

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 my 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 insurance information given by is correct.

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

Print Name:\_\_\_\_\_

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

**PATIENT HISTORY SHEET**

**PLEASE PRINT. PLEASE ANSWER ALL QUESTIONS AS SPECIFICALLY AS POSSIBLE.**

- 1. REASON FOR VISITING THE DOCTOR: \_\_\_\_\_
- 2. ANY MEDICAL PROBLEMS(OTHER THAN ABOVE): \_\_\_\_\_
- 3. MEDICATIONS PRESENTLY USING: \_\_\_\_\_
- 4. LIST THE MEDICATIONS THAT YOU ARE ALLERGIC TO: \_\_\_\_\_
- 5. DO YOU SMOKE? YES or NO. OF YES, APPROX. HOW MANY PACKS PER DAY?  
\_\_\_\_\_

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HAVE YOU EXPERIENCED ANY OF THE FOLLOWING? **PLEASE CHECK.**

- |                                      |                |
|--------------------------------------|----------------|
| 1. HEARING LOSS                      | YES ___ NO ___ |
| 2. RINGING IN THE EARS               | YES ___ NO ___ |
| 3. EAR INFECTIONS                    | YES ___ NO ___ |
| 4. DIFFICULTY BREATHING THROUGH NOSE | YES ___ NO ___ |
| 5. HOARSENESS                        | YES ___ NO ___ |
| 6. CHANGE IN VOICE                   | YES ___ NO ___ |
| 7. DIFFICULTY SWALLOWING             | YES ___ NO ___ |
| 8. COUGHING UP BLOOD                 | YES ___ NO ___ |
| 9. NASAL DRAINAGE                    | YES ___ NO ___ |
| 10. NOSE BLEEDS                      | YES ___ NO ___ |

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DATE OF INJURY, OR FIRST SYMPTOM OF YOUR ILLNESS: \_\_\_\_\_

HAVE YOU EVER HAD THESE SYMPTOMS BEFORE? YES or NO WHEN? \_\_\_\_\_

DID YOU SEE **DRS. BERRIOS OR MARMOL** IN THE EMERGENCY ROOM OR HOSPITAL? YES or NO? IF SO, WHERE? \_\_\_\_\_ WHEN? \_\_\_\_\_