METROPOLITAN NEUROEAR GROUP
BALANCE CENTER OF MARYLAND

HEARING & BALANCE DISORDERS
FACIAL NERVE DISORDERS
ACOUSTIC NEUROMAS, COCHLEAR IMPLANTS
HEAD & NECK SKULL BASE SURGERY

SANJAY PRASAD, M.D., F.A.C.S.
Diplomate American Board of Otolaryngology
Subspecialty Otology, Neurotology/Cranial Base Surgery
www.earsite.com

NOTICE OF PRIVACY PRACTICES

Effective: April 14, 2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

Each time you visit a doctor, hospital, pharmacist or any other person that provides you health care services, a record of your visit is made. Typically this record contains information about you, such as reasons why you are seeking medical care, a plan for future care and billing information**. Metropolitan NeuroEar Group/Balance Center of Maryland**, (sometimes referred to as "we", "our", or "us") understands that this information, often referred to as your "medical information" or "health information", is personal.

Metropolitan NeuroEar Group/Balance Center of Maryland is required by law to maintain the privacy of your health information, and to provide you with a notice of our legal duties and privacy practices with respect to such information. This Notice of Privacy Practices ("Notice") describes your legal rights, advises you of our privacy practices, and lets you know how the **Metropolitan NeuroEar Group/Balance Center of Maryland** is permitted to use and disclose your Personal Health Information ("PHI") We will provide you with a copy of the current Notice the first time you receive services from **Metropolitan NeuroEar Group/Balance Center of Maryland**. We will also visibly post a copy of the current Notice in our facility.

Metropolitan NeuroEar Group/Balance Center of Maryland is required to abide by the terms of the Notice currently in effect. In most situations we may use this information as described in this Notice without your permission (known as an "authorization"), but there are some situations where we may use it only after we obtain your written authorization, if law requires that we do so.

Metropolitan NeuroEar Group/Balance Center of Maryland reserves the right to change our privacy practices and revise our Notice. Such changes will be effective immediately and will apply to all health information that we maintain. The Notice will contain the effective date on the first page. If we have already provided you with a copy of the Notice, and later our privacy practices change and we revise our Notice, you may obtain a copy of the revised Notice by asking for a copy of the current Notice to take home with you the next time you visit or receive health care services from **Metropolitan NeuroEar Group/Balance Center of Maryland**, or by contacting 301-493-9409, and/or submitting your request in writing to our Privacy Officer, Marshall Besch, at the address noted below.

WHO WILL FOLLOW THIS NOTICE

- The Practice, its employees and personnel.
- Students who are studying to become health care professionals (such as nursing students and medical students) who are authorized by the Practice to observe medical procedures as part of their training.
- This Notice applies to vendors only when they are performing duties contemplated by under their contracts with the Practice and are generating PHI in medical records maintained by the Practice. Many of these vendors maintain business records and may have different privacy policies and practices relating to their use or disclosure of PHI created or maintained outside of the Practice. Use of this Notice by such vendors does not mean that they are operating as agents or employees of the Practice and will not affect the medical decisions made in your care and treatment.

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION

The following categories describe different ways that we may use and disclose your PHI, and include some examples to explain such uses and disclosures. Not every use or disclosure in a category will be listed.

Some uses and disclosures of PHI may be subject to additional restrictions under federal and state laws and regulations, such as those that apply to substance abuse treatment, HIV/AIDS testing and treatment, and mental health treatment. Under certain circumstances these federal and state laws will provide your PHI with additional privacy protections beyond what is described in this Notice. We may also be further bound by the physician-patient privilege to protect your PHI.

For Treatment

We may use and disclose your health information to provide, coordinate and manage the services, supports, and health care you receive from us and other providers. We may disclose your health information to other doctors, nurses, technicians, home health providers and other persons who may be involved in providing your care. We may share your health information with other health care providers when we consult with them about the services that you receive from the Practice. For example, our staff may discuss your PHI with your primary care physician prior to your undergoing a procedure and may provide your physician with results obtained from the procedure.

For Payment

We may use and disclose your PHI so we can be paid for the services we provide to you. This can include billing a third party, such as Medicare, Medicaid or your insurance company. For example, we may need to provide your insurance plan with information about the services we provide to you (such as a diagnosis code) so we will be reimbursed for those services. Your insurance plan may require some additional clinical information as a condition of payment. We also may need to provide the Medicare program with information to ensure you are eligible for services you are receiving. If you do not wish us to release any information to your insurance plan or other third party payor, you will be responsible for the full

cost of the treatment, since insurance plan or other third party payor will not pay us without that information. We may also provide your PHI to another health care provider or entity for their payment activities (such as another physician that provides you treatment).

For Health Care Operations

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We may use and disclose your PHI as necessary for us to operate and to maintain the quality of services that we provide to our patients. For example, we may use your PHI to review the services we provide and the performance of our employees that work with you. We may disclose your PHI to train our staff and students that may be observing procedures as part of their medical school training. We also may use PHI to study ways to more efficiently manage our organization, for licensing activities or for our continuous quality improvement.

There are also some circumstances that we are permitted to disclose your PHI to another health care provider (such as your primary care physician) for his or her own health care operations.

Business Associates
We may disclose your PHI to certain individuals and companies that we contract with (our "business associates") so that they can perform the job we have asked them to do. For example, we may contract with a billing company to assist us with billing insurance companies and third party payors so that we can be paid for the services that we provide to you. To protect your PHI, however, we require our business associates to appropriately safeguard your PHI and to meet the same confidentiality standards that we are required to meet.

Appointment Reminders, Treatment and Service Alternatives and Health Related Benefits and Services
We may use and disclose your PHI to contact you to remind you of a scheduled procedure or to contact you about treatment and service alternatives or health-related benefits and services that may be of interest to you.

Marketing Communications
We may use and disclose your PHI to tell you about a product or service to encourage you to purchase the product or service. For example, we may send you a newsletter or other mailing about certain educational programs. We will not, however, sell or distribute your PHI to third parties who do not have a relationship with us unless we have obtained an authorization from you. For instance, we would not release information or patient lists to pharmaceutical companies for those companies' drug promotions unless we have your authorization to do so.

Disclosures to Family and Others
We may disclose your PHI to one of your family members, relatives or close personal friends or to any other person identified by you, but we will only disclose information which we feel is relevant to that person's involvement in your care or the payment for your care. If you are feeling well enough to make decisions about your care, we will follow your directions as to who is sufficiently involved in your care to receive information. If you are not present or cannot make these decisions, we will make a decision based on our experience as to whether it is in your best interest for a family member or friend to receive information about you and how much information they should receive. If there is a family member, or other relative, or close personal friend that you do not want us to disclose your PHI to, please notify the staff that assists you.

We may disclose your PHI to an entity assisting in disaster relief efforts (for example, the American Red Cross) so your family can be notified about your condition, status and location in an emergency.

Required by Law
We will disclose your PHI when we are required to do so by federal, state or local law. For instance, we are obligated to report suspected child abuse to the proper authorities.

Public Health Activities
We may disclose your PHI for public health activities and purposes. For example, we may report PHI to a public health authority that is authorized by law to collect or receive the information for purposes of preventing or controlling disease, neglect, reporting reactions to medication or problems with health care products or notifying a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

Victims of Abuse, Neglect or Domestic Violence
We may disclose PHI to a government authority authorized by law to receive reports of abuse, neglect or domestic violence. We will make every effort to obtain your permission before releasing this information, but in some cases we may be required or authorized to act without your permission.

Health Oversight Activities
We may disclose PHI to a health oversight agency for activities authorized by law, including audits, investigation, inspections, licensure or disciplinary actions. These and similar types of activities are necessary for appropriate oversight of the health care system, government benefit programs, and entities subject to various government regulations. For example, we must make our books, records and other information available to the government agencies in charge of overseeing Medicare and Medicaid so that we can show these agencies that we are complying with Medicare and Medicaid requirements placed on the Practice.

Judicial and Administrative Proceedings
We may disclose your PHI if we are ordered to do so by a court or administrative tribunal. We may also disclose your PHI in response to a subpoena, discovery requires, or other lawful process, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Disclosures for Law Enforcement Purposes
We may disclose your health information in very limited circumstances if asked to do so by a properly identified law enforcement official. However, most other disclosures to law enforcement will only be in response to a court order.

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Uses and Disclosures about Decedents
We may release information about a deceased person to a coroner or medical examiner to identify the person, determine the cause of death or perform other duties recognized by law. We may also release a deceased person's PHI to funeral directors as necessary to carry out their duties.

Organ, Eye or Tissue Donation. If you are an organ donor, we may disclose your PHI to organ procurement organizations or other entities engaged in the procurement, banking or transplantation of organs, eyes or tissues.

Research
Under certain circumstances, we may use or disclose your PHI for research. Before we disclose PHI for research, the research will have been approved through an approval process that evaluates the needs of the research project with your needs for privacy or your PHI. We may, however, disclose your PHI to a person who is preparing to conduct research to permit them to prepare for the project, but no PHI will leave the Practice during that person's review of the information. Enrollment in most of these research projects can only occur after you have been informed about the study, had an opportunity to ask question, and indicated your willingness to participate in the study by signing a consent form. Other studies may be performed using your PHI without requiring your consent. These studies will not affect your treatment or welfare, and your PHI will continue to be protected. For example, a research study may involve comparing the health and recovery of all patients who received one type of procedure to those who received another for the same condition.

To Avert Serious Threat to Health or Safety
We may use or disclose your PHI if we believe that you present a serious danger of future violence to yourself or another, and the use of disclosure is necessary to alert appropriate parties to such danger. In such cases, we will only share your information with someone able to help prevent the danger. For example, we may make a disclosure to appropriate parties if medical personnel at the Practice determine that you are in such mental or emotional condition as to be dangerous to yourself or another identifiable person.

For Specified Government Functions
In certain circumstances, federal regulation authorize us to use or disclose your PHI to facilitate specified government functions relating to military and veterans, national security and intelligence activities, protective services for the President and other, medical suitability determinations, inmates and law enforcement custody. For example, if you are a member of the Armed Forces, we may use and disclose your PHI to appropriate military command authorities for activities they deem necessary to carry out their military mission.

Workers Compensation
We may disclose your PHI as authorized by and to the extent necessary to comply with laws relating to workers compensation or similar programs that provide benefits for work-related injuries or illness.

Uses and Disclosure Requiring Your Written Permission
Other uses and disclosures of your PHI not covered by this Notice or the laws that apply to us will be made only with your specific written permission (sometimes know as an "authorization"). If you provide us permission to use or disclose your PHI, you may revoke that permission, in writing, at any time. If you revoke your permission to use or disclose your PHI, you may revoke that permission, in writing at any time. If you revoke you permission, we will no longer use or disclose your PHI for the reasons covered by your written permission. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

YOUR RIGHTS WITH RESPECT TO YOUR PERSONAL HEALTH INFORMATION
Although your health record is the physical property of the Practice, the information contained in the record belongs to you. The following describes your rights with respect to your PHI that we maintain.

Right to Request Restrictions
You have the right to request that we restrict the uses or disclosures of your PHI that we may make to carry out treatment, payment, or health care operations. You also have the right to request that we restrict the uses or disclosures we make to a family member, other relative, a close personal friend or any other person

identified by you. To request a restriction, you may do so at any time. If you request a restriction, you should do so by submitting your request in writing to our Privacy Officer at the address noted below and tell us: (a) what information you want to limit, (b) whether you want to limit use or disclosure or both, and (c) to whom you want the limits to apply (for example, disclosures to your spouse).

We are not required to agree to any requested restriction. However, if we do agree, we will follow that restriction unless the information is needed to provide emergency treatment. Even if we agree to a restriction, you can let us know later that you do not want us to continue to comply with your request.

Right to Receive Confidential Communications
You have the right to request that we communicate your PHI to you in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. We will not require you to tell us why you are asking for the confidential communication. If you want to request confidential communication, you must do so in writing our Privacy Officer at the address noted below. Your request must state how or where you can be contacted.

We will use our best efforts to accommodate all reasonable requests. However, we may, if necessary, require information from you concerning how payment will be handled. We also may require an alternate address or other method to contact you.

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Right to Inspect and Copy
With a few very limited exceptions, you have the right to inspect and obtain a copy of your medical record that we maintain. To inspect or copy this information, you must submit your request in writing to our Privacy Officer at the address noted below. Your request should state specifically what information in the medical record you want to inspect or copy. If you request a copy of the information, we may charge a fee for the costs of copying and, if you ask that it be mailed to you, the cost of mailing. We may deny your request to inspect and copy our medical record in certain very limited circumstances. For example, psychotherapy notes are not part of your medical record, and we are not required to provide such notes to you. In some instances, if you are denied access to your medical record, you may request that the denial be reviewed. Another licensed health care professional chosen by us will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend
You have the right to request an amendment (correction) to your health record if you feel that the information we have about you is incorrect or incomplete. You have the right to request an amendment for as long as we keep the information. To request an amendment, you must submit your request in writing to our Privacy Officer at the address noted below. In addition, you must provide a reason that supports your request. Although you are permitted to request that we amend your health information, we may deny your request if it is not in writing or does not include a reason to support your request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is not longer available to make the amendment;
- Is not part of the health information we keep;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

Right to an Accounting of Disclosures
You have the right to an "accounting of disclosure". An accounting of disclosures is a list of the disclosures of your PHI that we have made, with some exceptions. To request this list, you must submit your request in writing to your Privacy Officer at the address noted below. You request must state a time period which may not be longer than six years and may not include dates before April 14, 2003. The first list you request within a twelve-month period will be free. For additional lists, we may charge you for the costs of providing the list.

Right to Copy this Notice
You have the right to obtain a paper copy of our Notice of Privacy Practices. You may request a copy of our current Notice of Privacy Practices at any time by (1) asking for a copy of the Notice to take home with you the next time you visit or receive health care services at our facility, (2) contacting our Privacy Officer at (479) 782-2700, or (3) submitting your request in writing to our Privacy Office at the address noted below.

Complaints
If you believe your privacy rights have been violated, you can file a complaint with us and with the Secretary of the U.S. Department of Health and Human Services.

To file a written complaint with us, please contact our Privacy Officer at (301) 493-9409, or send your complaint to the Privacy Officer in care of:

Marshall Besch
Metropolitan NeuroEar Group/Balance Center of Maryland
1101 Wootton Parkway Suite 900
Rockville, Maryland 20852-1059

To file a complaint with the Secretary of the U.S. Department of Health and Human Services – Office for Civil Rights:

Region III - Philadelphia (Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, West Virginia)
Paul Cushing, Regional Manager
Office for Civil Rights
U.S. Department of Health and Human Services
150 S. Independence Mall West
Suite 372, Public Ledger Building
Philadelphia, PA 19106-9111
Main Line (215)861-4441
Hotline (800) 368-1019
FAX (215)861-4431
TDD (215)861-4440 **Questions and Information**

If you have any questions or want more information concerning this Notice of Privacy Practices, please contact our Privacy Officer at:
Marshall Besch
Metropolitan NeuroEar Group/Balance Center of Maryland
1101 Wootton Parkway Suite 900
Rockville, Maryland 20852-1059

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Metropolitan NeuroEar Group/Balance Center of Maryland
Financial Responsibility and Assignment of Benefits Form

Assignment of Insurance Benefits Up to Amount of Medical Services. In consideration of medical and other healthcare services rendered or to be rendered (the **Medical Services**) to me (or to the patient, If am the guarantor thereof), from time to time, now and/or in the near future, I _____, the undersigned patient, or guarantor of a patient named _____ (the patient), of Metropolitan NeuroEar Group and Balance Center Of Maryland, individually, (and on behalf of the patient if I am the guarantor of the patient) hereby assign and transfer, and authorize to be assigned and transferred, to Balance Center Of Maryland and/or Metropolitan NeuroEar Group any benefits payable to or for my benefit (or to or for the benefit of the patient if I am the guarantor of the patient) under hospitalization or health or sickness insurance, and under any other insurance coverage, to include but not limited to major medical, for payment of such healthcare services rendered(or to be rendered) to me (or to the patient, if I am the guarantor) by medical for payment of such healthcare services rendered (or to be rendered) to me (or to the patient, if I am the guarantor) by Balance Center Of Maryland and/or Metropolitan NeuroEar Group (i.e., **Medical Services**). This assignment of benefits is irrevocable and extends to the total amount owed by me to Balance Center Of Maryland and/or Metropolitan NeuroEar Group from time to time. I hereby certify that the insurance and other information that I have provided Balance Center Of Maryland and/or Metropolitan NeuroEar Group is true and accurate as of the date(s) the Medical Services are to be performed and that I am responsible for keeping such information updated, I am fully aware that having health insurance does not absolve me (and the patient, if I am the guarantor) of my responsibility to ensure that the medical bills is paid in full. I also understand that my Insurance Company(s) might not pay 100% of the amount billed by Balance Center Of Maryland and/or Metropolitan NeuroEar Group for the Medical Services and, to the extent permitted by applicable law, I am responsible for any and all amounts charged by Balance Center Of Maryland and/or Metropolitan NeuroEar Group for Medical Services that are not paid by my Insurance Company(s), including but not limited to any portion paid and not applied "in network" benefits for any "out of network" services. Examples of services that might not be covered by my Insurance Company(s) include but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the health care service plan furnishes to the patient; treatment or tests not authorized by the health care service plan; "non-covered" services; services not considered medically necessary by my Insurance Company(s); insurance deductibles; co-insurance; and copayments. Insurance companies reimburse on a fee schedule, which may bear no relationship to the current standard and cost of care in this area. The undersigned agrees to cooperate with **Balance Center Of Maryland and/or Metropolitan NeuroEar Group** to obtain necessary authorizations from my Insurance Company(s) or other insurers.

OTHER INSURANCE: I understand that Balance Center Of Maryland and/or Metropolitan NeuroEar Group maintains a list of healthcare service plans with which it contracts. A list of such plans is available from the business office of Balance Center Of Maryland and/or Metropolitan NeuroEar Group and that Balance Center Of Maryland and/or Metropolitan NeuroEar Group has no contract, expressed or implied, with any plan that does not appear on the list. I agree that I am the individually obligated to pay the full charges of all services rendered to me (or the patient, if I am the guarantor) by Balance Center Of Maryland and/or Metropolitan NeuroEar Group if I belong to a plan that does not appear on the above mentioned list.

NON-COVERED SERVICES: I understand that if my Insurance Company(s) is/are not on the list of Balance Center Of Maryland and/or Metropolitan NeuroEar Group of healthcare service plans, my contract of insurance is a contract only between me(or the patient, if I am the guarantor) and my Insurance Company(s). Balance Center Of Maryland and/or Metropolitan NeuroEar Group is then not a party to that contract.

Authorization to submit insurance claims: I hereby authorize Balance Center Of Maryland and/or Metropolitan NeuroEar Group to submit claims, on my behalf to my Insurance Company(s), which is/are the insurance company(s) ["my Insurance Company(s)"] listed on the copy of the current insurance card(s) I have provided Metropolitan NeuroEar Group and Balance Center Of Maryland, which I represent I have provided to Balance Center Of Maryland and/or Metropolitan NeuroEar Group "in good faith" and which I represent provide current medical coverage for the contemplated Medical Services. I fully agree and understand that the submission of a claim does not absolve me (or the patient, if aim the guarantor) of my responsibility to ensure the claim is paid in full.

Limited Attorney-in Fact to Obtain Payment: I hereby irrevocably designate, authorize and appoint Balance Center Of Maryland and/or Metropolitan NeuroEar Group as my true and lawful personal representative and attorney-in-fact for the limited purpose of obtaining payment from my Insurance Company(s) with the regard to the Medical Services; including the power to receive any and all payments from the Medical Services from my Insurance Company(s) or other third parties, submit any and all requests for benefits information to my Insurance Company(s), receive and review any and all applicable plan documents from my Insurance Company(s) and to pursue all remedies as to claims as to the Medical Services with or against my Insurance Company(s), including but not limited to formal complaints, appeals, administrative reviews or litigation to any State or Federal agency, insurance board or insurance company that has jurisdiction over benefits that are or may be available to pay for all or part of the Medical Services.

*This is **power of attorney** shall automatically terminate. Without formation action being taken, as soon as Balance Center Of Maryland and/or Metropolitan NeuroEar Group has received payment in full and all remedies available there to under applicable regulatory guidelines for all medical care services provided to me. I hereby confirm and ratify all actions taken by my attorney-in-fact pursuant to the authority granted herein.*

ERISA Authorization: I hereby authorize and direct my **Insurance Company(s)** to assign and transfer any application ERISA plan benefits and rights to Balance Center Of Maryland and/or Metropolitan NeuroEar Group including the right to receive any applicable plan documents and/or remedies, and to pursue appeals, administrative reviews or litigation on my behalf. This authorization includes any other rights due me (or the

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patient, I am the guarantor) permissible under state and federal laws. I authorize Balance Center Of Maryland and/or Metropolitan NeuroEar Group to request and pursue on my behalf as needed, all levels of appeal or any administrative review rightfully due me (or the patient, If I am the guarantor) by U.S. Dept of Labor, Department of Community Health, or Department of Insurance pursuant to State and/or Federal ERISA Claim Regulatory Guidelines.

Direct Payment Authorization: I hereby instruct and directly Insurance Company(s) to pay Balance Center Of Maryland and/or Metropolitan NeuroEar Group directly. I understand the ERISA that I have the right and authority to direct where payment for services rendered is sent. If my current insurance policies with my Insurance Company(s) prohibit direst payment to the provider of services, I (under my rights per state and federal ERISA regulations) hereby instruct and direct my Insurance Company(s) to provide SPD documentation evidencing the existence of such non-assign ability clause to myself and Metropolitan NeuroEar Group and Balance Center Of Maryland. Upon receipt by Balance Center Of Maryland and/or Metropolitan NeuroEar Group of non assignability documentation, I instruct that the Insurance Company(s) to make out the check to me (or the patient, if I am the guarantor) and I will mail it directly to Balance Center Of Maryland and/or Metropolitan NeuroEar Group3200 Tower Oaks Boulevard Suite 100 Rockville, Maryland 20852 for the professional or medical expense benefits and otherwise payable to me (or the patient, if I am the guarantor) under my current insurance policy as payment towards the total charges for the Medical Services rendered. I agree and understand that any funds I receive from my Insurance Company(s) due me (or due the patient, if I am the guarantor) for services rendered by Balance Center Of Maryland and/or Metropolitan NeuroEar Group will be immediately signed over by me and sent directly to Metropolitan NeuroEar Group and Balance Center Of Maryland.

Check Deposit Authority: Whenever, with or without authority, my Insurance Company(s) might send a check directly to me for Medical Services provided by Metropolitan NeuroEar Group and Balance Center Of Maryland. If I deposit such a check into an account other than Metropolitan NeuroEar Group and Balance Center Of Maryland, I agree to send Balance Center Of Maryland and/or Metropolitan NeuroEar Group a payment for the equivalent amount. If I receive from an insurance company, Medicare or Medicaid, an Explanation of Benefits (EOB), I agree to send a copy of the EOB, by U.S. Mail or fax directly to: Balance Center Of Maryland and/or Metropolitan NeuroEar Group(301) 770-1624. This is a direct assignment of my rights and benefits under my Insurance Policy(s). Upon receipt by **Balance Center Of Maryland and/or Metropolitan NeuroEar Group** of any and all checks made payable to me or patient, I authorize Balance Center Of Maryland and/or Metropolitan NeuroEar Group to receive and such check, endorse it for deposit only, and to deposit it and to apply all the proceeds toward payment on my account for Medical Services.

Submission of Insurance Claims Courtesy/Financial Arrangements: Unless **Balance Center Of Maryland and/or Metropolitan NeuroEar Group** has agreed as a courtesy to submit my claim to my Insurance Company(s) for Medical Services, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Balance Center Of Maryland and/or Metropolitan NeuroEar Group for payment. If my account with Balance Center Of Maryland and/or Metropolitan NeuroEar Group is referred to an attorney or outside agency for collection, the undersigned shall pay reasonable attorney fees and collection expenses. All delinquent accounts bear interest at the legal rate. I understand and agree that if my account is delinquent, I may be charged a service fee.

Confession of Judgment: In addition to Metropolitan NeuroEar Group and Balance Center Of Maryland's other remedies at law, I, the undersigned authorize any attorney to appear in a court of record and confess judgment, without process, against me, in favor of Balance Center Of Maryland and/or Metropolitan NeuroEar Group, for any sum unpaid and due thereto, together with collection costs including attorneys' fee at 25% of the principle balance due, which percentage is stipulated and deemed reasonable.

Today's Standards: I authorize Balance Center Of Maryland and/or Metropolitan NeuroEar Group and its associates to provide medical care to me/patient reasonable by today's standards.

Release of medical records to obtain coverage: I authorize the release of any medical or other information reasonably necessary to determine benefits available or benefits payable by my Insurance Company(s) or for the purposes of satisfying charges billed by Balance Center Of Maryland and/or Metropolitan NeuroEar Group for Medical Services to the Health Care Financing Administration, my Insurance Company(s) or other medical entity. A copy of this assignment will be sent to the Health Care Financing Administration, my Insurance Company(s) or other entity, if requested. I hereby release and forever discharge Balance Center Of Maryland and/or Metropolitan NeuroEar Group and its respective employees, directors, officers, shareholders, agents, assigns and legal representatives (collectively, "Balance Center Of Maryland and/or Metropolitan NeuroEar Group Parties") from any and all obligations, claims, liabilities, damages, debt, liens, and deficiencies arising out of or in connection with Metropolitan NeuroEar Group and Balance Center Of Maryland's use or disclosure of my health information in accordance with this Financial Responsibility and Assignment of Benefits ("Assignment")

A photocopy of this Assignment shall be considered as effective and valid as the original