THE EAR, NOSE AND THROAT CLINIC & HEARING CENTER | RENEW FACIAL PLASTIC SURGERY

CONSENT AND PAYMENT AUTHORIZATION FORM

I. Consent and Authorization for Release of Information

1. Release of Information. I consent to the release and use by The Ear, Nose and Throat Clinic & Hearing Center (ENTHC) of medical and other information about me to the extent permitted by law:
   a) To a health care provider being advised or consulted in connection with my treatment or care;
   b) To a health plan, insurer, third party payer or administrator, Medicare or other organization providing me with health benefits, for the purposes of claims payment and benefit determinations, fraud investigations, or quality of care studies or reviews;
   c) To a person or organization in connection with ENTHC's health care operations. These operations may include quality improvement activities, performance evaluations, business management, and other related activities; and
   d.) To the following individuals (name of spouse or family member, coach, trainer, employer, or others):

   List person(s)/Relationship(s): _____
2. Revocation. I understand that this consent is valid for one year or until I revoke it, which I may do at any time by giving written notice to ENTHC.
3. External Prescription History: I consent for ENTHC to obtain patient prescription history via Surescripts. The Surescripts database stores prescription history from most pharmacies and provides us with information such as medication name, prescription date, dosage, prescribing physician, and refill history. This also allows us to load prescription information directly into the electronic medical record. It will make it easier for you to share your medical history with us and give us the ability to provide you with better, more efficient quality care.

II. Notice of Privacy Practices

1. Confidentiality. It is the policy of ENTHC to protect the privacy and confidentiality of patients' medical information.
2. Notice of Privacy Practice. ENTHC's Notice of Privacy Practices explains how ENTHC may use and disclose my medical information. It also explains my rights regarding this kind of information. ENTHC may revise its Notice of Privacy Practices at any time and will provide me with a copy of the revised Notice of Privacy Practices at my request. ENTHC's Notice of Privacy Practices is available at www.enthc.com.
3. Acknowledgment of Receipt. I acknowledge that I have received ENTHC's Notice of Privacy Practices.

III. Payment Authorization

1. Payment Authorization. I authorize ENTHC to directly bill my health plan, third-party payer or Medicare for services rendered to me by or on behalf of ENTHC, but acknowledge that ENTHC is not obligated to submit claims to third-party payers on my behalf unless required by law or by its contract with a particular third party payer. I also authorize my health plan, third-party payer or Medicare to make payment directly to ENTHC for such services. I understand and agree that ENTHC is not responsible for collecting third-party payments or negotiating disputed settlements on my behalf.
   You may request an estimate of your charges prior to, during or after receiving services from ENTHC.
2. Workers' Compensation. We require the Insurance Company Name, Claim Number, Date of Injury, and Employer's Name and Address. We will submit your claim. If the claim is denied by the carrier or if the claim is in litigation, you will personally be responsible for payment of the charges.

IV. Financial Policy

1. Payment Responsibility. I agree to pay for all services furnished to me by ENTHC, including, but not limited to charges that are not paid in full by my insurance, government program benefits or other third-party payers, except as prohibited by ENTHC's contract with my health plan or applicable law. I also agree to pay or reimburse ENTHC for all costs it may incur in collecting such amounts, including, but not limited to, attorneys' fees and collection agency fees. I agree that copayments are due at the time of service.
   Children: The parent who signs this document is responsible for all fees incurred. We will provide additional copies of the bill if requested.
2. Late Cancellations and Missed Appointments. I have read and understood the Late Cancellation & Missed Appointment Policy as provided to me. I understand that after TWO late cancellations or missed appointments, I will be required to pay the Late Cancellation or Missed Appointment fee of $50 prior to making another appointment. Missing 3 or more appointments within a year means I may be discharged from the clinic.
3. In-Office Procedures. I understand that most diagnostic procedures performed in the office are billed separately and in addition to office visit charges. These diagnostic procedures are classified by many insurance carriers as "surgery" and may be processed differently than office visits, including being subject to higher deductible. I understand that these diagnostic procedures are important to my care and will only be performed when deemed medically necessary.
4. Returned Checks: I acknowledge the $10 returned check fee on all checks returned to ENTHC for non-sufficient funds.

Patient's Name:_____ Date of Birth:_____

Signature of Patient or Legal Guardian: _____ Date:_____

Printed Name of Signer (if other than patient): _____