



Virginia Ear, Nose & Throat Associates, P.C.
CONSENT FOR TREATMENT, ASSIGNMENT OF BENEFITS, FINANCIAL POLICIES

Patient #: _____

- **Consent for treatment**

I authorize Virginia Ear, Nose & Throat Associates to provide medical treatment to myself and or my dependent.

- **Assignment of Benefits**

I request that payment of authorized Medicare, Medicaid or applicable private insurance benefits be paid directly to Virginia Ear, Nose & Throat Associates for services provided under their care.

- **Release of medical information**

I authorize Virginia Ear, Nose & Throat Associates to release necessary medical information to my insurance company, its agents, or any third party payer in order for payable benefits for these services to be determined.

- **Collection of co-pays and deductibles**

Per our agreement with your insurance carrier, you are required to pay any applicable copayments at the time of service. In addition, if you are insured with a high deductible insurance plan and have not met your deductible, we will collect a payment at the time of service.

- **Financial Responsibility**

I understand that Virginia Ear, Nose & Throat Associates will file my insurance claims as a courtesy; however, I am ultimately responsible for full payment of all charges. I further understand if my account is referred to a collection agency or attorney I will be responsible for all collection costs including 33 1/3% of the total outstanding indebtedness, (which includes but is not limited to principal, accrued interest and late charges) then due, and all costs of collection. I agree to pay the aforesaid attorney's fees and costs of collection whether or not the attorney files suit.

- **Referrals/Authorizations**

I understand if my insurance company requires a referral, I am responsible for obtaining a referral prior to my visit. If I do not have a referral I will be required to sign a waiver before being seen by the physician and payment in full for services rendered will be collected at the check out desk.

- **Missed Appointments**

We require at least 24 hours notice if you must cancel an appointment, failure to do so may result in a \$25 "no show" fee.

- **Returned Checks**

Our office will charge \$25 for any check that is returned for insufficient funds.

I have read the above statements and I understand my responsibilities. I acknowledge that Virginia Ear, Nose & Throat Associates, PC, will scan this document and destroy the original, and agree the scanned document is the same as the original.

Patient Name (printed)

Date

Signature of Patient or Responsible Party

Relationship to Patient

Virginia Ear, Nose & Throat Associates, P.C.

Patient #: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received a copy of the "Notice of Privacy Practices" for Virginia Ear, Nose & Throat Associates, P.C. As provided in our notice, the terms of our notice may change. If we changes our notice, you may obtain a revised copy. This notice is available in our office.

I understand that I may access my medical records at any time and that I may copy and/or inspect my PHI to be used or disclosed in accordance with Virginia Ear, Nose & Throat Associates' policy. I understand that Virginia Ear, Nose & Throat Associates may charge me for copies of such records, or completion of medical record forms, however a fee schedule will be provided to me.

I understand that Virginia Ear, Nose & Throat Associates has the right to deny me access to my records in certain circumstances, in accordance with the law; however, in such instance they will provide me with a denial in writing.

AUTHORIZATION FORM FOR USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. It has been explained to the patient that disclosures may be made to family and friends related to the patient's health. It has also been explained that we will only disclose information relevant to current treatment. Our patient has agreed that we will only disclose health care information to (list all that apply):

	<u>In Person</u>	<u>By Phone</u>	<u>Effective:</u>
Spouse Name: _____	<input type="checkbox"/>	<input type="checkbox"/>	__/__/__
Parent(s) Name: _____	<input type="checkbox"/>	<input type="checkbox"/>	__/__/__
Sibling(s) Name: _____	<input type="checkbox"/>	<input type="checkbox"/>	__/__/__
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	__/__/__
(Name)		(Relationship)	

I, _____, authorize the use or disclosure of my PHI as specified in the Notice of Privacy Practices for Virginia Ear, Nose & Throat Associates, P.C. I understand the purpose of the authorized use of disclosure of PHI is for use within Virginia, Ear, Nose & Throat Associates, P.C. or for authorized disclosure from another entity that is subject to the privacy rule to Virginia Ear, Nose & Throat Associates, P.C. for treatment, payment or health care operation purposes. I also understand that if the organization authorized to receive my PHI is not a health plan or health care provider, that organization may disclose my PHI. In the event that this happens, I understand that my information may no longer be protected under the federal privacy rule and regulations. I understand that this authorization is voluntary and may be revoked at any time. I understand that I may ask questions of Virginia Ear, Nose & Throat Associates, if I do not understand any information contained in the Notice of Privacy Practices.

(Printed Name of Patient) _____
(Date)

(Signature of Patient or Patient's Representative) _____
(Date)

(Printed Name of Patient's Representative) _____
(Relationship)