**2 signature locations on this form

ent specialists pc℠

FINANCIAL POLICY

Thank you for choosing ENT Specialists, PC, for your ear, nose & throat care. The following is a statement of our financial policy. All patients must accept our financial policy before receiving treatment. Full payment of your bill is considered a part of your treatment.

Insurance

- As a courtesy to you, we will submit medical claims to your insurance company. Any balance after processing of our claim by your carrier is your responsibility.
- We cannot bill your insurance company unless you give us your complete insurance information
- All co-pays are due prior to treatment

Surgery

- We require payment of the dollar amount of your unfulfilled contracted insurance deductible seven days prior to your scheduled surgery date.
- We reserve the right to cancel all elective surgical procedures if the deductible has not been paid.

Payment

- We accept cash, check, Visa, MasterCard, Discover and American Express. Payment plans may be arranged on a pre-approved individual basis.
- A $20 service fee will be charged for all checks returned for insufficient funds. You will also be required to prepay in full using cash or credit card for all future services.
- All unpaid accounts will be forwarded to a collection agency after 90 days.

DISCLOSURE OF PHYSICIAN OWNERSHIP

The physicians at ENT Specialists, PC have an ownership interest in Midwest Surgical Hospital, LLC ("MSH"). You have the right to choose the provider or facility for your health care services. Therefore, you have the option to use a healthcare provider or facility other than MSH for services if you are recommended for surgery.

HIPAA PRIVACY PRACTICES NOTICE

RELEASE OF INFORMATION: I hereby authorize the release of medical records both written and oral, to insurance companies, employers, physicians, HCFA and any other institution or organization that may request information necessary to determine eligibility for health care benefits. I request that payment of authorized Medicare and insurance benefits be made to ENT Specialists, PC, or me. I hereby acknowledge that I was offered a copy of the ENT Specialists, PC HIPAA Notice of Privacy Practices.

PLEASE LIST NAMES OF INDIVIDUALS WHO MAY BE GIVEN BILLING/MEDICAL INFORMATION:

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I UNDERSTAND AND AGREE TO THE TERMS OF ALL THE ABOVE MENTIONED POLICIES.
I consent to the use and disclosure of protected health information for treatment, payment and necessary healthcare operations and have been offered a copy of the Notice of Privacy Practices.

X________________________________ ________________________ ____________________

Signature of patient or responsible party **Print patient's name** **Date**

CONSENT TO TREAT

I hereby acknowledge that I/my child needs medical care and treatment. When applicable, I voluntarily consent to the treatment (examination, procedures, treatment, etc) provided by the medical personnel in this office as well as any diagnostic services that may be deemed necessary. No guarantees have been made tome regarding the results of treatments or examinations.

Patient Signature **X**____ Date____________________

If under age of 19, parent/guardian signature **X**______________________________ Date ____________________