Patient's Full Name_____DOB: _____

AUTHORIZATION FOR TREATMENT

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment at this office or any other satellite office under common ownership. The consent will remain in effect until it is revoked in writing. I certify that I have read and understand the above statements and consent to treatment by the health care providers at Northeast Georgia Otolaryngology dba Northeast Georgia ENT (NeGa ENT).

_____

Signature of Patient, Parent or Guardian Relationship to Patient Date

HIPAA ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly;
- Obtain payment from third-party payers; and
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have read and understand the NeGa ENT Notice of Privacy Practices. I understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy.

I authorize NeGa ENT to release and/or obtain my records to/from other physicians for the purpose of continuity of care.
I authorize NeGa ENT to release my information, including diagnosis, records and claims information to the following individual(s):
(Name and relation-Example: Jane Smith, Wife; Jan Smith, Daughter)

1) _____ 2) _____ 3) _____

_____

Signature of Patient, Parent or Guardian Relationship to Patient Date

FINANCIAL POLICY & ASSIGNMENT OF BENEFITS

Financial Policy: Payment is expected at the time of service. We accept cash, check or credit card. If we are contracted with your insurance, we ask that you pay any co-payments, co-insurance and deductibles that have not been satisfied. Co-payments must be paid prior to seeing the doctor. ***If the patient is a minor, financial responsibilities lie with the parent/guardian bringing the child.***

Your insurance policy is a contract between you and/or your employer and your insurance company. ***Depending on your insurance plan, some office procedures (for example, hearing tests and endoscopies) are either not covered or subject to deductibles and co-insurance in addition to your co-payment.*** It is your responsibility to know your insurance plan benefits.

No Show Policy: If an appointment is not cancelled at least 24 hours in advance you will be charged a **$50.00** fee.

Self-Pay Financial Policy: For services rendered in the office, a minimum payment of **$300.00** is required prior to seeing the doctor and the remaining balance is due at check-out unless other payment arrangements are made in advance. For elective surgical services, payment in full is required a minimum of two weeks prior to the surgery date unless other arrangements are made in advance.

Assignment of Benefits: I authorize the release of any information necessary to process claims and direct payment to myself or the doctor who accept assignment.

_____

Signature of Patient, Parent or Guardian Relationship to Patient Date

WAIVER FOR NO REFERRAL (if applicable)

Your current insurance requires a referral from your Primary Care Physician before our physicians can see you and before we can submit a bill to your insurance company for reimbursement. Since you do not have a referral, we require that you pay $75 up front and establish a payment agreement for the balance. If a referral is obtained at a later date or a referral is not necessary and the insurance company's Explanation of Benefits has shown the service to be eligible for payment, you will be reimbursed any overpaid amounts.

I have elected to visit this specialist and to receive services without a written insurance referral from my primary care physician.

_____

Signature of Patient, Parent or Guardian Relationship to Patient Date

For Patients under 18 ONLY:

PARENT/ LEGAL GUARDIAN INFORMATION:

Name_____

Date of Birth_____SS#_____ Work Phone _____

Employer and Address_____