Acknowledgement/ Consent for Treatment

PATIENT NAME: _____ (Please print)

____(initial) **RECEIPT OF *NOTICE OF PRIVACY PRACTICES***

I have reviewed a copy of Texan ENT Specialists ***Notice of Privacy Practice,*** which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document. (Also available at www.texanent.com)

____(initial) **CONSENT TO TREATMENT**

I consent to the performance of examinations, diagnostic procedures, and rendering of treatment by the medical provider at Texan ENT Specialists and their designated medical office staff as is deemed necessary in the medical provider's judgment. I agree to be financially responsible for the costs of such diagnostic procedures. I authorize and consent to the disposal of materials and substances that would normally be removed in the course of such diagnostic procedures and medical treatment. I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made to me as a result of treatments or examination at Texan ENT Specialists. ***I understand that I have the right to refuse any medical or surgical treatment that I do not want.***

____(initial) **FINANCIAL RESPONSIBILITY**

I understand that ***copays, deductibles/co-insurance will be collected at the time service.*** I further understand that I am financially responsible for all charges, and as a courtesy, my charges will be filed with my insurance carrier. I understand that my insurance may process certain services ***(e.g. nasal endoscopy, nasal debridement) as a diagnostic or surgical procedure and may be applied towards my deductible/coinsurance.*** I understand ***I will be responsible for these charges if the claim is denied, is not paid in a timely manner, or the charges are not covered by my insurance.*** Should my account become a collection problem, I understand I will be financially responsible for any additional fees incurred during the collection process**.** I understand a $25.00 dollar fee will be charged for all returned checks. ***I also understand that all past due accounts must be paid in full prior to making any future appointments.***

____(initial) **RELEASE OF INFORMATION, ASSIGNMENT OF BENEFITS, HSA/HRA, AND AUTHORIZATIONS**

I authorize the release of any medical information (including diagnosis and test results that may include drug and/or alcohol, psychological conditions, or HIV Status/Acquired Immune Deficiency Syndrome) necessary to process an insurance claim on my behalf. I request that my medical insurance carrier make payment directly to Texan ENT Specialists for services rendered to me. I understand ***I will be responsible for these charges if the claim is denied, is not paid in a timely manner, or the charges are not covered by my insurance.***

____(initial) **REFERRALS**

I understand, if a referral from my Primary Care Physician is required, ***I am responsible for obtaining referrals prior to receiving treatment*** from Texan ENT Specialists. If said referral is not on file with Texan ENT Specialists at the time of my visit, and I choose to proceed with treatment, I understand I am responsible for all charges incurred during that visit, payable at the time of service.

My signature below indicates that I have read and agree with all statements that I have initialed above.

_____ _____

(Signature of Patient/Parent/Guardian) **Date**

_____

(Print Patient/Parent/Guardian Name)