

“Patient Financial Policy”

Date

Patient

Chart #

In order to keep your healthcare cost down, we ask that you read and sign our financial policy. Although you are responsible for the entire balance of your bill, regardless of your insurance status, we have made it our policy to file your claim. We are contracted with a limited number of insurance carriers. For those we have chosen to contract with, you are only responsible for your estimated co-pay, coinsurance or deductible at the time of your visit with us. For those we are **not** contracted with, you are responsible for the entire balance at the time of your visit. As a courtesy we will file your claim to your insurance carrier only after the balance is paid in full, so that you may get any reimbursement due you. It is your responsibility to get any pre-authorizations before coming to your scheduled appointments, and keeping your information current with us. If surgery is indicated, based upon information from your carrier, you will be given an **estimated** deposit that will be due before your surgery date. *Please note: your carrier will not give exact financial reimbursement information nor do they guarantee payment. If you or your insurance carrier neglects your bill at any time, you may run the risk of being terminated from this clinic.*

“New Patient Consent for Treatment”

I understand that as part of my health care, Fayetteville Otolaryngology originates and maintains paper and or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care of treatment. I understand that this information serves as a basic for planning my care and treatment.

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the following right and privilege to review the notice prior to signing this consent.

I understand that Fayetteville Otolaryngology is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.50 of the Code of Federal Regulations. I further understand that Fayetteville Otolaryngology reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations.

I understand that as part of this organization’s treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax. I fully understand and accept the terms of this consent. I wish to have the following restrictions to the use or disclosure of my health information.

Can we disclose your health information with anyone else, ie...spouse, parent, guardian, etc? If so please circle #2 and indicate their name(s), otherwise please circle #1 none.

1) None

2) Other, explain:

Patient signature (parent/legal guardian)

Date

Relationship to patient

Witness