University Otolaryngology

PATIENT FINANCIAL CONSENT, NOTICE OF PRIVACY PRACTICES & CONSENT TO TREAT

FINANCIAL POLICIES & INFORMATION

University Otolaryngology strives to provide our patients with the finest quality medical care. University Otolaryngology would also like to provide our patients with clarification on some of our financial policies. This information is not all-inclusive; it is the patient's responsibility to understand their insurance benefits and financial responsibilities.

CANCELLATION NOTIFICATION-If you must cancel your appointment, please call us at least 24 hours in advance. This allows us to give your appointment time to another patient in need of our services. University Otolaryngology reserves the right to charge a $25.00 cancellation fee if a 24 hour notice is not given.

CO-PAYMENTS – Most insurance plans require co-payments. It is usually a fixed dollar amount designated by your insurance company. Usually a co-payment amount is designated on the front of your insurance card. Co-payments are due at the time of your visit. A co-payment cannot be waived.

DEDUCTIBLES – Most insurance plans have deductibles. The deductible amounts vary by insurance plan. A deductible is the responsibility of the patient before their health insurance company will reimburse the healthcare provider. A deductible is the responsibility of the patient.

CO-INSURANCE – This is the part of your bill, in addition to a co-payment and/or deductible, the patient must pay to the healthcare provider. Co-insurance is usually a percentage of the allowed amount for a service or procedure.

UNCOVERED SERVICES – Medical insurance usually does not cover the entire cost of medical care, specific procedures, diagnostic testing and/or certain office visits. University Otolaryngology healthcare providers are not aware of your healthcare benefits and therefore are unaware if a particular service, test or procedure is covered by your insurance. It is the patient's responsibility to know their insurance benefits and financial responsibilities.

PROCEDURES – Our healthcare providers will determine what procedures, if any, need to be done at the time of your office visit. Some of these procedures may be classified by your insurance company as surgical procedures. These procedures are separate and apart from the office visit charges. In these cases, the patient is responsible for the office visit charges and the charges for any services, test, or procedures performed.

Examples of Separate Services in ADDITION to the office visit include but are not limited to: Audiology Services (hearing tests), CT Scans, Allergy Services, Physical Therapy, Vestibular Testing, FEEST. Examples of In-Office Medical Procedures include but are not limited to:

Flexible Laryngoscopy – this procedure involves using a fiber optic scope to enter the nasal cavity and throat.

Nasal Endoscopy – this procedure uses a flexible or rigid scope with a light source to view the nasal cavities.

Cauterization of Nosebleeds – this procedure involves applying a chemical to stop the bleeding & packing.

Removal of Cerumen – this is the removal of impacted wax from the ear.

Binocular Microscopy – this procedure uses a microscope to obtain better visualization.

I have read and understand the “Financial Policies & Information” contained herein

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), 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.

·Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

Consent

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

CONSENT TO TREAT

I consent to treatment necessary for my care. I authorize the release of all medical records to the physicians involved in my treatment and to my insurance company, if applicable. I allow fax transmittals of my medical records, if necessary. I acknowledge full financial responsibility for services rendered at this facility. I have read and fully understand the above consent for treatment, financial responsibility, release of medical information and insurance authorization.

Patient/Guardian Signature_____ **Date**_____

Witness_____ **Date**_____