Virginia Ear, Nose & Throat Associates, P.C.

CONSENT FOR TREATMENT, ASSIGNMENT OF BENEFITS, FINANCIAL POLICIES

Patient #: ____________________

- **CONSENT FOR TREATMENT**
  I authorize Virginia Ear, Nose & Throat Associates to provide medical treatment to myself and or my dependent.

- **ASSIGNMENT OF BENEFITS**
  I request that payment of authorized Medicare, Medicaid or applicable private insurance benefits be paid directly to Virginia Ear, Nose & Throat Associates for services provided under their care.

- **RELEASE OF MEDICAL INFORMATION**
  I authorize Virginia Ear, Nose & Throat Associates to release necessary medical information to my insurance company, its agents, or any third party payer in order for payable benefits for these services to be determined.

- **COLLECTION OF CO-PAYS AND DEDUCTIBLES**
  Per our agreement with your insurance carrier, you are required to pay any applicable copayments at the time of service. In addition, f you are insured with a high deductible insurance plan and have not met your deductible, we will collect $100 for new patients and $60 for established patients at the time of service.

- **FINANCIAL RESPONSIBILITY**
  I understand that Virginia Ear, Nose & Throat Associates will file my insurance claims as a courtesy; however, I am ultimately responsible for full payment of all charges. Should collection proceedings or other legal action become necessary to collect an overdue account, the patient or the patient's responsible party, understands that Virginia Ear, Nose & Throat Associates has the right to disclose to an outside collection agency all relevant personal and account information necessary to collect payment for services rendered. The patient, or the patient's responsible party, understands and agrees to pay all collection fees in the amount up to thirty-three and one-third percent (33-1/3%) of the total unpaid balance due, plus court costs and filing fees incurred by Virginia Ear, Nose & Throat Associates. I understand and agree that should Virginia Ear, Nose & Throat Associates be awarded judgment relating to this agreement or any debt incurred thereof, I will pay a service charge of one and one-half percent (1-1/2%) per month, eighteen percent (18%) per annum, beginning on the date of judgment.

- **REFERRALS/AUTHORIZATIONS**
  I understand if my insurance company requires a referral, I am responsible for obtaining a referral prior to my visit. If I do not have a referral I will be required to sign a waiver before being seen by the physician and payment in full for services rendered will be collected at the check-out desk.

- **MISSED APPOINTMENTS**
  We require at least 24 hours notice if you must cancel an appointment, failure to do so may result in a $25 "no show" fee.

- **RETURNED CHECKS**
  Our office will charge $25 for any check that is returned for insufficient funds.

I have read the above statements and I understand my responsibilities. I acknowledge that Virginia Ear, Nose & Throat Associates, PC, will scan this document and destroy the original, and agree the scanned document is the same as the original.

______________________________	____________________
Signature of Patient or Responsible Party	(Date)
______________________________	____________________
Printed Name of Patient or Responsible Party	(Relationship to Patient)

OVER

Virginia Ear, Nose & Throat Associates, P.C.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient #: ____________________

I, ____, was offered and:

☐ I have received a copy of the "Notice of Privacy Practices" for Virginia Ear, Nose & Throat Associates, P.C.

☐ I declined a personal copy of the "Notices of Privacy Practices" for Virginia Ear, Nose & Throat Associates, P.C.

As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy. This notice is posted in our offices, on our website and copies are available at any time. I understand that I may ask questions of Virginia ENT if I do not understand any information in the Notice of Privacy Practices.

AUTHORIZATION FORM FOR USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. We have explained that disclosures may be made to family and friends related to the patient's health. It has also been explained that we will only disclose information relevant to current treatment. By signing below I authorize Virginia ENT to disclose health care information to the following individuals (list all that apply):

	In Person	By Phone	OK to Leave Voicemail	Effective:
Spouse Name: ______________________________	☐	☐	☐	__/__/__
Parent(s) Name: ______________________________	☐	☐	☐	__/__/__
Sibling(s) Name: ______________________________	☐	☐	☐	__/__/__
Other: ______________________________ (Name) (Relationship)	☐	☐	☐	__/__/__

Please initial the applicable items below

Virginia ENT staff have my permission to leave ________ Medical Information ________ Messages from our Practice on my _________ home answering machine and/or __________ my cell phone voice-mail

____________________________ Home Phone number

____________________________ Mobile phone number

____ (Signature of Patient)

____________________________ (Date)

____ (Signature of Patient or Patient's Representative)

____________________________ (Date)

____ (Printed Name of Patient's Representative)

____________________________ (Relationship to Patient)