

## Consent for Treatment, HIPAA Acknowledgment, and Financial Responsibility

I, or my authorized representative, hereby consent to receive medical treatment from Clarity ENT and Hearsay ENT Docs. I understand and agree to the following:

1. Personal Information: I certify that the information I have provided is correct.
2. Nature of Treatment: I understand this consent provides Clarity ENT and Hearsay ENT Docs with your permission to perform reasonable and necessary medical examinations, testing, and treatment. By signing below, you are indicating that you consent to treatment at this office or any satellite office under common ownership and that you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.
3. Confidentiality: I understand that my medical information will be kept confidential in accordance with the Health Insurance Portability and Accountability Act (HIPAA) regulations, and I authorize the release of my medical information to process insurance claims to insurance companies or their agencies (Medicare), for the purpose of filing and payment of medical claims. Your signature below is acknowledgement that you will receive a copy of our HIPAA/Privacy policy upon request.
4. Emergency Contact: I authorize Clarity ENT and Hearsay ENT Docs to share my medical information or financial information if necessary with the contact I listed as my "important contact" during patient registration. I understand I can make a special request for medical or financial information to NOT be shared if desired.
5. Insurance and Payment: I understand that I am responsible for payment of all medical services rendered to me by Clarity and Hearsay ENT. Please be aware that, in order to determine the correct diagnosis, your physician may need to perform certain in-office procedures such as, but not limited to, nasal endoscopy or nasopharyngolaryngoscopy, which enable that diagnosis to be made. If performed, these diagnostic procedures are billed as a procedure charge on your office visit statement separate from the office visit. Although these procedures are purely diagnostic in nature, your particular insurance carrier may classify them as "surgical procedures." If so, the charge may be subject to the surgical deductible of your particular insurance plan. Your signature authorizes Clarity ENT and Hearsay ENT Docs to bill your insurance company directly for covered services, and you agree that you are responsible for any deductibles, co-payments, or non-covered services.
6. Global Periods: I understand that a global period is a set time frame after a surgical procedure when services related to the surgery are included in the surgical fee; this includes post-operative visits. However, if I am seen during the global period for an issue not related to the surgery, I understand there will be a charge for the visit, and that not all surgeries have a global period.
7. Consent for Minors: If the patient is a minor (under 18 years of age), I, as the parent or legal guardian, give my consent for treatment on behalf of the minor.

I have read and understood the information provided above. By signing this consent form, I acknowledge that all my questions have been answered to my satisfaction.