EAR NOSE & THROAT CONSULTANTS, INC.
PATIENT INFORMATION AND CONSENT

Patient Name: _____ Date of Birth: _____

Please initial all boxes and sign on the signature line*

Thank you for choosing Ear Nose and Throat Consultants. We take your healthcare very seriously. In order to take care of you in the best way and according to your wishes we need your permission for several different things. Please initial each section to indicate consent. Please inquire with staff if you wish to receive a full copy of the consent.

➡ **_____ I give permission to be treated by the providers and staff at Ear Nose & Throat Consultants, Inc**. Initialing indicates that you give us permission to provide you care. No means we are unable to treat you and you will not be brought into an exam room.

➡ **_____ I give permission to Ear Nose & Throat Consultants, Inc. to check my prescription eligibility and prescription history.**

➡ **_____ I give permission to Ear Nose & Throat Consultants, Inc. to bill my insurance and acknowledge that I have been notified of the billing policy at Ear Nose and Throat Consultants**. This allows us to furnish your information to your insurance company for purposes of payment for services rendered. It also allows us to collect from you and funds not covered by your insurance such as co-pays and deductibles. Please be aware, we are unable to know in advance how your individual policy will handle the charges given the terms of your policy. Some common office based care may be applied a higher co-pay or be applied to your deductible. These portions of your charge will be your responsibility. Not initialing here would make you responsible for the full amount of the charges related to the services you receive according to our billing policy.

➡ **_____If I am a member of a managed care health plan, I understand I have an obligation to obtain a referral from my primary care physician**. If a referral is not obtained, I may be responsible for payment of services. Not initialing here would make you responsible for the full amount of the charges related to the services you receive according to our billing policy.

By signing this form I acknowledge that I am requesting evaluation and treatment from ENT Consultants. If I am a member of a managed care health plan, I understand I have an obligation to obtain a referral from my primary care physician. If a referral is not obtained, I may be responsible for payment of services. Referrals, co-payments and deductibles for services rendered are your responsibility. Office procedures may be required to provide you appropriate care. Procedures might include nasal endoscopy, excision of lesions, biopsies, removal of impacted ear wax, and flexible fiberoptic laryngoscopy, or other office procedures deemed necessary by the provider. Some insurance companies bill these procedures under their "surgery" guidelines. You may be responsible for separate co-pay or deductible for "surgical" procedures after insurance payments and adjustments. I have the right to notify the provider prior to a procedure if I choose not to have the procedure: otherwise, my signature on this form represents consent for these commonly done procedures. I will assume liability if a diagnosis is delayed or missed due to my refusal.

This agreement is valid for the duration of your care for any of the providers at Ear Nose & Throat Consultants, Inc. Please feel free to ask questions if you have any concerns regarding this agreement. You are responsible for the timely payment of your account.

Effective Period. This Consent Form will remain in effect until the day you withdraw your authorization, submit a written request revising your consent(s), or until such time as Ear Nose & Throat Consultants, Inc. ceases, whichever is sooner.

PLEASE READ THE ENTIRE FORM BEFORE SIGNING BELOW:

➡ **Signature of Patient or Patient's Legal Representative: _____ Date: _____**

Print Patient's Name: _____

Print Name of Legal Representative (if applicable): _____