Grand Island ENT - Conditions of Office Visits

Print Patient Name: _____ SSN: _____ Date of Birth: _____

1. CONSENT FOR TREATMENT

I understand that I may have a condition requiring diagnostic procedures, physical examination and/or medical treatment. I hereby voluntarily consent to such diagnostic procedures including, but not limited to, laboratory testing, physical examination and such medical treatment as deemed necessary by my health care providers. Photos may also be taken of you and your condition and placed in your medical record for patient care purposes. I further acknowledge that no guarantees have been made to me as to the results of treatment or examination provided at GRAND ISLAND EAR NOSE THROAT.

2. AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize GRAND ISLAND EAR NOSE THROAT to furnish from my medical records any requested information or excerpts to any insurance company or third-party payer for the purpose of obtaining payment of the account, or any entity providing care to the patient (specialist, hospital, radiology, pathology, imaging clinic, skilled care facility, etc.)

3. PRIVACY PRACTICES -See also financial agreement contract

For a more complete description of the potential uses and disclosure of your health information for treatment, payment and healthcare, refer to GRAND ISLAND EAR NOSE THROAT'S Notice of Privacy Practices.

I understand that I have the right to review the Notice of Privacy Practices prior to signing the consent. The terms of the Notice of Privacy Practices may change, and you may write to our address for a revised copy.

You have the right to request that the provider restrict how your health information is used or disclosed to carry out treatment, payment, or healthcare operations; however GRAND ISLAND EAR NOSE THROAT is not required to agree to requested restrictions.

You have the right to revoke this consent in writing, except to the extent that the provider may have previously acted in reliance on it.

4. FINANCIALLY RESPONSIBLE PARTY: *REQUIRED if patient is a minor = no exceptions! ☐ Self (skip to 5)

Name: _____ Relationship: _____ Date of Birth: _____

Address- if different than patient: _____ Phone: _____

Employer:_____ Employer Phone: _____

5. EMERGENCY CONTACT (preferably not residing with patient)

Name: _____Relationship: _____ Phone: _____

Can we release Protected Health Information to this person: ☐ Yes ☐ No

6. INSURANCE INFORMATION: *REQUIRED if patient is a minor (only exception Medicaid) ☐ Self (skip to 7)

Subscriber's Name: _____ Date of Birth: _____ SSN: _____

Address- if different than patient: _____ Phone: _____

Subscriber's Employer: _____ Employer Phone: _____

7. OTHER INFORMATION: May we contact you or leave a detailed message regarding your health care information?

(check all that apply) ☐ Text ☐ Phone / Voicemail ☐ Email

8. APPOINTMENT POLICY:

If you are running late or need to reschedule, please call the office and we will do our best to accommodate you.

To respect the time of all our patients and providers, ONLY patients with appointments will be seen
If you are going to be more than 10 minutes late, you may be asked to reschedule
If you do not call and do not show for your appointment: First time = No charge
Any time there after = $30.00 charge

UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ THE FOREGOING AND IS THE PATIENT OR IS DULY AUTHORIZED BY OR ON THE BEHALF OF THE PATIENT TO EXECUTE THE ABOVE AND ACCEPT ITS TERMS

Signature: _____ Relationship to patient: _____ Date: _____