HIPAA, Authorization & Consent Form

Ear, Nose, and Throat Associates
Watauga Hearing

HIPAA Notice of Privacy Practices Acknowledgment
I have had access to or received, read, and understand your Notice of Privacy Practices. I understand that this information will be used to carry out treatment, payment, and normal healthcare operations of the Practice. 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.

Authorization and Consent for Diagnostic Services
Our physicians are Board Certified and use the latest diagnostic technologies to effectively diagnose and treat problems of the ear, nose and throat. I understand I may undergo diagnostic testing for a complete evaluation. Patients with sinus problems may have nasal endoscopy procedures performed at their visits. I understand I may have a diagnostic nasal endoscopy for evaluation of nasal or sinus symptoms and give informed consent for diagnostic procedures, examination, and treatment.

Authorization to Obtain and / or Release Medical and Pharmacy Records
I hereby authorize all physicians, health care entities, and pharmacies participating in my health care to obtain, release, use, and disclosure my entire medical record by mail, phone, fax, and electronic transmission in order to carry out my treatment, payment, and healthcare operations.

Lifetime Signature on File (Applies to Medicare patients)
I request that payment of authorized Medicare benefits be made on my behalf directly to Ear, Nose & Throat Associates, PC or professional associate, Watauga Hearing for any services furnished to me by the practice. I authorize the release of any and all medical or other information necessary for processing claims to the Center for Medicare and Medicaid Services (CMS).

Authorization for Assignment of Insurance Benefits, Information Release, and Financial Responsibility
I authorize the payment of medical benefits be made on my behalf directly to the Practice for any services furnished to me by the physician or practice. I understand that I am financially responsible for any amount not covered by my insurance contract. I authorize the release to my insurance company any and all information concerning health care, advice, or treatment provided to me necessary for processing insurance claims. I understand if my insurance requires a prior authorization for office visits, procedures, inpatient or outpatient surgery, tests, or services, it is my responsibility to make sure the authorization is obtained prior to the visit, procedure, surgery, test, or service being performed. I understand that if I am seen without an authorization I will be considered a self- pay patient and will be required to pay in full for all services performed. **I agree to pay any and all charges that are not covered or are not paid by my insurance plan(s). I agree to pay a monthly handling fee equal to 1.5% per month of any unpaid personal balance after 30 days from the date services are provided. I agree that In the event my account is turned over for collection, I agree to pay any and all collection agency fees, attorney fees, legal fees, and court costs.**

If you would like anyone other than yourself to have access to your information, please complete the section below.
I understand that authorization for release of information can only be revoked upon written notice. (*Circle the type of information which you authorize us to share)*

Name	Relationship	Phone#	*Power of Attorney* *HIPAA Billing* *HIPAA Medical*
Name	Relationship	Phone#	*Power of Attorney* *HIPAA Billing* *HIPAA Medical*
Name	Relationship	Phone#	*Power of Attorney* *HIPAA Billing* *HIPAA Medical*

By signing below, I acknowledge that all sections of this form have been read in full and explained as necessary.

Full Legal Name of Patient or Responsible Party _____

Signature Required: _____ **Date:** _____