Ear, Nose & Throat Consultants of North Mississippi

CONSENT FORM

I understand that Ear, Nose & Throat Consultants may need to use and disclose information about my health or medical problems for the purpose of arranging, conducting or referring my treatment; for obtaining payment for services; and for operating the practice. I consent to the use of my information for the purposes of treatment, payment and healthcare operations. Further, the undersigned authorizes the physician or the clinic to give reasonable and proper medical care by today's standard of care.

I hereby assign and transfer to Ear, Nose & Throat Consultants all of my rights, title and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. **I understand that I am financially responsible for payment for all services rendered. Although the Clinic will bill, or arrange for billing to my insurance carrier, I understand that I am responsible for payment or all charges for services provided, regardless of the availability or any insurance coverage(s). I agree to pay all co-payments and deductibles. In the event that I fail to pay any charges and the account is turned over to a collection agency or an attorney, I agree to pay all collection costs incurred, including, but not limited to, a collection fee, reasonable attorney's fees, and court costs.**

I understand that my consent is not needed if the law requires Ear, Nose & Throat Consultants to report some aspect of my protected health information to a government agency (for example, suspected abuse, communicable disease, and potential for serious bodily harm to myself or other).

I understand that I have the right to review Ear, Nose & Throat Consultants privacy notice, to request restrictions on the use of my information and to revoke my consent at a later date.

I understand that if I withhold consent for the use of my information for the purpose of treatment, payment or operation, Ear, Nose & Throat Consultants may refuse treatment.

_____ _____

Patient's Signature Date
(Or patient's parent or guardian if patient is a minor)

Ear, Nose &Throat Consultants of North Mississippi
Notice of Privacy Practices Acknowledgement

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak to our HIPAA Compliance Office.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices.

_____ _____

Print Name Signature

_____

Date

Authorization To Disclose Protected Health Information

I authorize ENT to obtain copies of my medical records from my doctors, hospitals, and other medical facilities needed for my healthcare. I also give my permission for ENT to fax me as the patient my personal medical information.

_____ _____

Signature Date