CONSENT TO TREATMENT, BILLING, AND HIPAA PRIVACY

Name: ____ Birthdate: ____________________________

Thank you for choosing Valley Facial Plastics and ENT, PA (henceforth referred to as VFPENT). Please carefully read the information below. By initialing beside each policy, you are acknowledging that you have read and understand our clinic's policies and procedures as they relate to each topic. A copy of our privacy practices is available to you on request and displayed in our lobby.

PERSON(S) AUTHORIZED TO ACCESS AND DISCUSS MEDICAL INFORMATION
Choose and initial option 1 or 2

Option 1: Initial: _____ I voluntarily authorize VFPENT to disclose my complete health record and healthcare status including, but not limited to, diagnosis, lab test results, treatment, billing records, and appointments for all conditions on an as-needed basis to the person(s) listed below. Forms of disclosure may include in-person, fax, email, web portals, telephone, and printed copy. I recognize that I can change this information at any time and that this information does not have an expiration date and is valid until I change it.

Name: ____ Phone: ________________________
Relationship to patient: ____
Name: ____ Phone: ________________________
Relationship to patient: ____

Option 2: Initial: _____ I currently choose **NOT** to authorize any person to have access to my health information.

NOTICE OF DISCLOSURE OF FEE/PAYMENT POLICY

Initial: _____ I authorize VFPENT to file claims with my insurance carrier for services rendered. I acknowledge that copayments are due at the time services are rendered. I understand that I am responsible for any part of the charges that are not paid by my insurance carrier, and I will be billed directly for those services. I understand that I am fully responsible for payment in full for all services rendered in the event that VFPENT is not contracted or in-network with my insurance carrier. SELF PAY patients are required to pay at the time of service. Patients who pay for all services provided the same day are eligible for a 10% discount (not applicable to hearing aids, supplies, or medication). All self-pay patients who cannot pay in full on the date service are required to pay a minimum deposit of $100 and a payment plan must be arranged with the billing department at that time. I acknowledge it is my responsibility to notify the billing department of changes to my insurance carrier or financial situation should it impact my billing or payment situation.

MULTI-SPECIALTY PRACTICE

Initial: _____ I am aware that Valley Facial Plastics & ENT is a multi-specialty practice, and that I may be billed for more than just an office visit. Additional charges may include audiometry, binocular microscopy, cerumenectomy, nasal cautery, laryngoscopy, administering of medications, biopsy, cryotherapy, excisions, fine needle aspiration, post-surgical debridement, ultrasounds and more. These are not inclusive of all the additional charges that may be billed separately from an office visit. I understand that the final cost of care will be based upon treatment rendered at the time of service.

CONSENT TO OBTAIN AND SHARE MEDICAL INFORMATION

Initial: _____ I authorize VFPENT to use and share my protected information electronically with and from healthcare providers, pharmacies, and insurance companies I am actively covered by within full compliance of HIPAA laws that may be used in my healthcare and/or for insurance claims billing on my behalf. Valley Facial Plastics & ENT complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

CONSENT TO TREAT

By signing this form, I consent to and authorize my provider(s) at VFPENT to treat me or my legal delegate listed on this form. I understand that my provider(s) is/are available to explain treatments before they are provided, and I have the right to refuse treatments. I understand that consent remains valid as long as I receive services from any provider associated with VFPENT and has no expiration date.

Patient/Guardian Signature: ____ Date: __________________