HIPAA Consent for Use and Disclosure of Health Information

Patient's Printed Name: _____ Date of Birth: _____

I understand that Ear Nose & Throat Specialists (ENTS) may use and disclose my personal health information to provide health care to me, to handle billing and payment, and take care of the other health care operations. In general, there will be no other uses or disclosures of this information unless I authorized it in writing. I understand that sometimes the law may require the release of this information without my permission.

ENTS has a Notice of Privacy Practices which contains detailed information about the policies and practices protecting my privacy. By signing this agreement, I am stating that I have read and received a copy of the Notice of Privacy Practices. I understand that ENTS may update the Notice of Privacy Practices as necessary, and I may request to receive a copy of the most current version at any time.

Below is a list of whom I agree to release account and/or medical information to along with their relation and contact #.

Name: _____ Relationship: _____ Contact #: _____
Name: _____ Relationship: _____ Contact #: _____
Name: _____ Relationship: _____ Contact #: _____
Name: _____ Relationship: _____ Contact #: _____

Below is a list of my medical and/or financial power of attorneys and/or caregiver and contact #.

Medical POA: _____ Contact #: _____
Financial POA: _____ Contact #: _____
Caregiver: _____ Contact #: _____

Under the terms of this consent, I can ask ENTS to limit how my personal health information is used or disclosed to carry out treatment, payment, or health care options. I understand that ENTS does not have to agree to my request. If ENTS does agree to my request, I understand they will follow those agreed limits.

I may update my consent by completing a new HIPAA Consent for Use and Disclosure of Health Information or I may cancel this consent in writing at any time by writing, signing, and dating a letter to ENTS. The letter must state that I want to revoke my consent to authorize the use and disclosure of my personal health information for treatment, payment, and health care operations. If I revoke this consent, ENTS does not have to provide any further healthcare services.

My signature below serves as agreement to the above for my healthcare needs.

_____ _____

Patient or Legal Authorized Individual Signature Date

Financial Policies Notice to Patients 05.24

Insurance

- It is your responsibility to know your insurance benefits.
- It is your responsibility to know if your chosen provider is contracted with your insurance.
- It is your responsibility to obtain all necessary insurance required referrals BEFORE your appointment.
- As a courtesy to our patients, we will file your insurance claim for you. However, the balance on your account is your responsibility if insurance does not pay.
- It is your responsibility to provide ENTS the correct insurance information for every visit. If we do not have your current insurance policy information on the day of your visit, you are responsible for providing us the correct information within 30 days of your date of service. If that information is not received, we will be unable to bill the insurance company and you will be responsible for the full balance.
- It is your responsibility to communicate coverage issues to your insurance. Insurance companies will not communicate or make changes/corrections with third parties regarding your benefits.
- If you acquire insurance after a visit that was retroactive to the time of that visit, it is your responsibility to communicate all necessary information to ENTS in time for ENTS to submit a claim and be paid. You may be reimbursed after payment is received from the insurance carrier. There will be no submission of claims greater than 30 days after date of service.
- Your estimated portion due for each visit is due on the date of service. Your insurance carrier may leave an additional balance as your responsibility to pay after the claim is processed.

In Network vs Out of Network Insurance

- Your insurance coverage and benefits are a contract between you and your insurance company; therefore, all disputes must be handled between you and your insurance company.
- If you have insurance coverage under a plan with which we do not have a contract, you will be treated as a self-pay patient.

Auto Accident or Liability Injury

- If your visit today is due to an auto accident or injury due to another party's negligence, you are required to pay for services upfront.
- ENTS will not file the insurance claim for you but will provide you with a receipt to do so yourself.

Workers' Compensation

- ENTS will bill workers' compensation claims on your behalf as a courtesy if provided the required information to include name, address, phone number, and fax number of the workers' compensation insurance company where the claim is to be sent, name and phone number of the workers' compensation case manager, workers' compensation claim number, and date the injury occurred.
- If the claim is denied, you will be responsible for the balance within 30 days from your first billing statement date.

Payment Due at Time of Service

- Co-pays and co-insurance amounts, deductibles and all non-covered items and charges are the insured's/patient's financial responsibility and are due during the check-in process.
- Your copay cannot be waived by our practice, as it is an insurance carrier requirement.
- Failure to produce payment at check-in may result in your appointment being rescheduled.
- Our goal is to calculate your financial responsibility accurately; however, with so many different policies and fee schedules, we are not always exact. Therefore, you may receive a statement from our office after your insurance carrier has processed your claim.
- Self-pay patients are required to pay the self-pay rates for services in full at time of service.
- Failure to pay any balance may result in discharge from the practice with the balance sent to a collection agency.

Refunds

- Refunds are issued to the party that made the overpayment.
- Patient refunds will not be processed until all active or past due charges are paid in full.
- Refunds may take up to ten business days to process once requested.

Returned Checks

- There will be a $35 charge to you for any check returned by your bank for any reason, which is not billable to your insurance and will be your responsibility.
- Future payments may be required to be made by cash, credit/debit card or money order.

Collections and Outstanding Balances

- If you receive a bill from us, your insurance carrier has allocated the balance to be your responsibility. Please contact your insurance company if you think there is a problem with what they have or have not paid.
- Any amount not covered by your insurance is due within 30 days of the date of your patient statement.
- If you cannot pay your entire balance, please call our office to discuss payment arrangements.
- Any outstanding balance without payment after 90 days of the first statement sent may be sent to an outside collection agency.
- Accounts referred to an outside collection agency will receive a collection fee of 25% that will be added to the total balance due as well as any court cost, and/or reasonable attorney fees that may be incurred in the collection of the outstanding balance. That balance must then be paid to the collection agency.
- Patients with unpaid accounts sent to a collection agency will not be allowed future appointments until the balance is paid or may be dismissed from our practice.

You are welcome to obtain a copy of this notice simply by asking a member of the front office staff.

No Show Fee Policy

Ear, Nose and Throat Specialists (ENTS) values patient time and hopes our patients value our time as well.

Unfortunately, we find it necessary to implement a No-Show Fee policy effective June 3, 2024, which is summarized in this acknowledgement.

Patients are given a 15-minute grace period for scheduled appointments **except** audiology appointments. Patients running late are expected to call the office to notify our team what time they expect to arrive. If the delay will not negatively impact the other scheduled patients or the provider's schedule, they will be advised to continue to the office; however, the appointment may need to be rescheduled. There is no guarantee the provider will be able to see any patient that does not arrive before their appointment time.

Patients arriving past the grace period or who do not make their scheduled appointment at all will be billed a No-Show Fee, which is not covered by insurance and is solely patient responsibility. Furthermore, all No-Show Fees must be paid prior to any other service or appointment being kept or made.

Any patient that doesn't reschedule or cancel their appointment no later than one full business day before the appointment will be billed a **No-Show Fee of $50** for the missed service.

The signature below signifies acknowledgement of the No-Show Fee Policy and agreement to No-Show Fees that are appropriately charged if the signee fails to comply.

_____ _____

Patient's Printed Name Patient/Guardian Signature

This acknowledgement does not expire unless the policy changes at which time the patient/guardian will be provided a new acknowledgement to review and sign.

Ear, Nose & Throat Specialists, LLC

Notice of Privacy Practices

www.entspecialists.net
770.922.5458
1370 Wellbrook Circle NE
Conyers, GA 30012

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

➤ ***See page 2*** *for more information on these rights and how to exercise them*

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

➤ ***See page 3*** *for more information on these choices and how to exercise them*

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

➤ ***See pages 3 and 4*** *for more information on these uses and disclosures*

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.
Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. • If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

September 12, 2023

This Notice of Privacy Practices applies to the following organizations.

Ear, Nose & Throat Specialists, LLC

Mae Huffman-Mote, CPCO, CPPM
mhmote@entspecialists.net
770.922.5458

Consents Acknowledgement

Patient's Printed Name:_____Date of Birth:_____

I acknowledge that I have read and completed the **HIPAA Consent for Use and Disclosure of Health Information**. I have also been given the opportunity to ask any questions and/or receive any needed clarifications of this policy.

I have read and understand the **Financial Policies Notice to Patients** to include the **No Show Fee Policy** and agree to abide by their guidelines. Furthermore, I have received a copy of Ear, Nose & Throat Specialists' (ENTS) Financial Policies. I acknowledge that if I had any, my questions have been answered with explanations given for any needed clarification.

I acknowledge that I have read a copy of ENTS' **Notice of Privacy Practices**. I am also aware that I have been given the opportunity to ask any questions and/or receive any needed clarification of these policies and can obtain a copy of the notice whenever I request.

Treatment Authorization: I authorize ENTS to give me reasonable and proper medical care which the medical doctor deems is in my best medical interest.

By signing below, I acknowledge that I have been provided a copy of ENTS' policies outlined above to read, review, and get clarification. I acknowledge that I have been given an opportunity to ask questions and clearly understand the above policies. I also understand that I can receive a printed copy today or at any time by asking ENTS staff.

_____

Patient/Guardian Signature Date

_____

ENTS Witness Signature Date

Parent/Guardian Minor Authorization Form

I am the legal parent/guardian of _____,

Date of Birth: ____/____/____, who is a patient under the care of Ear, Nose and Throat Specialists, LLC (ENTS).

If I am unable to attend my child's office visit at ENTS, I hereby authorize the following person(s) to serve as my representative. I also authorize the physicians and staff of ENTS to provide services, treatment, and the release of medical records to the following person(s) regarding my child's immediate care.

This authorization form is valid for one year from the date of signature.

Name _____ Relationship_____ Phone #_____

Name _____ Relationship_____ Phone #_____

Name _____ Relationship_____ Phone #_____

Name _____ Relationship_____ Phone #_____

_____ _____

Parent/Guardian Printed Name Patient/Guardian Signature

_____ _____

ENTS Witness Signature Date Signed

05.24

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4181 Hospital Drive Suite 102
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