ACKNOWLEDGMENTS / CONSENTS / FINANCIAL RESPONSIBILITY / DISCLOSURES

_____ RECEIPT OF HIPAA PRIVACY NOTICE & PATIENT NOTICES

(Initials)

I have reviewed a copy of River ENT's Notice of Privacy Practices (also available at www.river-ent.com under patient forms), which describes the ways in which the practice may use and disclose my information for its treatment, payment, health care operations and other described and permitted uses and disclosures. I understand that this information may be disclosed electronically by the medical provider or the medical provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in River ENT's Notice of Privacy Practices. I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint.

_____ CONSENT TO TREATMENT

(Initials)

I consent to the performance of examinations, diagnostic procedures and rendering of treatment by the medical provider and their designated medical office staff as is deemed necessary in the medical provider's judgment. I understand that I have the right to refuse any medical or surgical treatment that I do not want. I have the right to discuss the treatment plan with my medical provider about the purpose, potential risks and benefits of any test ordered. If there are any concerns regarding any test or treatment recommended by my medical provider, I am encouraged to ask questions. This consent will remain fully effective until it is revoked in writing.

_____ FINANCIAL RESPONSIBILITY, RELEASE OF INFORMATION & ASSIGNMENT OF BENEFITS

(Initials)

I understand that copays and deductibles/coinsurance will be collected at the time of service. I further understand that I am financially responsible for all charges, and as a courtesy, my charges will be filed with my insurance carrier, including Medicare. WE STRONGLY RECOMMEND THAT YOU READ YOUR INSURANCE BOOKLET OR CALL YOUR INSURANCE COMPANY REQUESTING A BENEFIT DESCRIPTION FOR A SPECIALIST OFFICE. I understand that my insurance may process certain services (e.g., nasal endoscopy, nasal debridement) as a diagnostic or surgical procedure, and they may be applied toward my deductible/coinsurance. I authorize the release of any medical information necessary to process an insurance claim on my behalf. I request that my medical insurance carrier make payment directly to River ENT for services rendered to me. I understand I will be responsible for these charges if the claim is denied or is not paid in a timely manner.

Primary Care Referrals: I understand, when required by my insurance plan, I am responsible for obtaining referrals from my Primary Care Physician prior to receiving treatment from a River ENT provider. If said referral is not on file with River ENT at the time of my visit, and I choose to proceed with treatment, I understand I am responsible for all charges incurred during that visit, payable at the time of service.

Quotes: I understand that any quote provided is an estimate based on my insurance benefits at the time of verification.

Parental Financial Responsibility: The parent or guardian who brings the child to the office for care is responsible for payment at the time of service, no matter if the account is self-pay, participating insurance or nonparticipating insurance. The practice does not honor divorce specifics (e.g., percentage of financial responsibility) and will not bill a divorced spouse for the patient's services.

Patient Appointment Cancellations: We request that at least a 24-hour advance notice be given to our office if you are unable to keep your scheduled appointment. This allows us to release your appointment time to another patient. We charge an administration fee of $45.00 for no-shows. Patients who repeatedly "no-show" for appointments may be discharged from the practice.

Additional Fees:

Paperwork preparation: $25.00	**Missed office appointments:** $45.00	**Returned check fees:** $35.00
Medical records: $6.50	**Missed surgery appointments:** $100.00	**Collection accounts:** $25.00

Continued on reverse side.

Past-Due Balances: Should my account become a collection problem, River ENT has the right to discharge me as a patient and submit my account to a collection agency. I understand I will be financially responsible for any additional fees incurred during the collection process. I also understand that all past-due accounts must be paid in full prior to making any future appointments.

_____ **DISCLOSURE TO FAMILY MEMBERS & FRIENDS**
(Initials)

I authorize River ENT to discuss my health care account, including, but not limited to, results, findings and care decisions with the following person(s). I release River ENT and its employees from any liability in connection with the use or disclosure of the information and records released to any party pursuant to this authorization. Any changes to this document must be made in writing.

Name	Phone	Relationship

_____ **CONSENT TO EMAIL, CELLULAR TELEPHONE OR TEXTS USAGE FOR APPOINTMENT REMINDERS & OTHER HEALTH CARE RELATED COMMUNICATIONS**
(Initials)

If, at any time, I provide an email address or cellphone number at which I may be contacted, I consent to receive unsecured instructions and other health care communications at the email or text address I have provided or you have obtained and at any text number forwarded or transferred from that number. These instructions may include, but not be limited to, post-procedure instructions, follow-up instructions, educational information and prescription information. Other health care communications may include, but are not limited to, communications to family or designated representatives regarding my treatment or condition or reminder messages to me regarding appointments for medical care. Note: You may opt out of these communications at any time through the patient portal. River ENT does not charge for this service, but standard text messaging rates or cellular telephone minutes may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

_____ **DISCLOSURE OF PHYSICIAN OWNERSHIP**
(Initials)

Please carefully review the information contained in this notice and feel free to ask any questions.

- One or more of our physicians have an ownership/financial interest in Northwest Surgery Center and River ENT's CT scanner.
- You have the right to choose the provider of your health care services, including utilizing an alternative medical facility or having your CT scans performed at a location other than River ENT. You may ask the front desk for a list of alternate locations in our area if you choose.
- The physicians at River ENT will not treat you differently if you choose to obtain health care services at a facility other than those listed above.
- Speech-pathology services provided at River ENT will be billed by Kristy Armer, MS, CCC-SLP, not by River ENT.

If you have any questions concerning this notice or anything in it, please feel free to ask your physician or a River ENT representative.

My signature below indicates that I have read and agree with all statements/sections that I have initialed above.

Signature of Patient (or Guardian): _____ Date: _____

PRINTED Name of Patient: _____ Date of Birth: _____

PRINTED Name of Guardian: _____