PATIENT CONSENT AND ACKNOWLEDGEMENT FORM

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH IINFORMATION

I consent to have NJ Regional Ear, Nose & Throat Center, LLC disclose my protected health information for payment, treatment and healthcare operations, and for such other purposes that are permitted under HIPAA regulations without written authorization. Notice of Privacy Practices available upon request.

OFFICE PROCEDURES/FINANCIAL POLICIES

I hereby give consent to NJ Regional Ear, Nose & Throat Center, LLC to provide treatment and service(s) the assigned provider may deem necessary. I authorize any holder of medical information about me to release to any appropriate insurance company and its agent's information needed to determine these benefits payable for related services.

- I understand and agree that (regardless of my insurance status); I am ultimately responsible for any balances on my account for professional services rendered. .
- I understand that if my insurance company requires a co-payment, it is my responsibility and is due at the time of service, otherwise a charge of $10 will be incurred.
- I understand that I am responsible for charges not covered by my insurance policy, such as deductibles and or coinsurance.
- I understand that I am responsible for a fee of $25.00 for any returned check.
- I understand that I am responsible for a fee of $25.00 for not cancelling an appointment 24 hours prior to the appointment time, or for a "no show" appointment.
- I understand that should I need private disability forms filled out by my provider that I am responsible for a fee of $15.00.
- I understand that if my account becomes assigned to a collection agency, I agree to pay a 25% collection fee, interest in the amount of 6%, court costs, and attorney fees, as allowed by law

RELEASE OF CONFIDENTIAL INFORMATION & AUTHORIZATION

I hereby consent and grant permission for Practitioners employed by NJ Regional Ear, Nose & Throat Center, LLC to discuss my medical treatment with my referring physician, primary care physician, and or any other healthcare practitioner, relating to my care and treatment. I hereby authorize any practitioner examining and/or treating me, to release to any third party(such as an insurance company or governmental agency)any medical information and records concerning the diagnosis and treatment when requested for use in determining payment of claims. I understand that this is a lifetime release of information. I hereby consent and authorize NJ Regional Ear, Nose & Throat Center, LLC to file claims for treatment, electronically or manually, to my insurance carrier(s) for services rendered to me.

ASSIGNMENT OF BENEFITS

I hereby consent and authorize payment to be paid directly to NJ Regional Ear, Nose & Throat Center, LLC for any services rendered for treatment. Any services for which assignment is accepted but are not covered under my insurance policy are acknowledged as being my full and complete financial responsibility.

I have read, understand and agree to all the above.

Patient's Signature	Patient's Printed Name	Date Signed
Representative's Signature	Representative's Printed Name	Date Signed

**Disclaimer: Failure to sign this form will discontinue submission of claims(s) to appropriate insurance company and patient will be responsible for payment at time of service.