The ENT Center of Central Georgia

Central Georgia Head & Neck Surgery Center
The Allergy Center Georgia Hearing Institute

CONSENT TO MEDICAL TREATMENT **Patient Name** _____

In consideration of medical services to be rendered to me (herein referred to as Patient) at The ENT Center of Central Georgia and/or Georgia Hearing Institute (herein referred to as ENT), Patient does hereby consent as follows:

Consent and Treatment Authorization

Patient (or the undersigned acting on behalf of Patient), who is requiring medical treatment, does hereby consent to the rendering of such care and treatment, which may include diagnostic procedures and such medical treatment and care by the Physician or his/her medical staff and assistants under their direction and orders.

The consent to receive medical treatment includes, but is not limited to, examinations, diagnostic and therapeutic procedures, medications, infusions, transfusions of blood and blood products, surgery, anesthesia and any other medical treatment and services which Patient may require. From time to time there will be observers (medical students, residents, etc.) with the physician unless you request otherwise.

In the event that ENT should decide that blood specimens should be provided by the Patient for testing purposes in the interest of the safety of those with whom Patient may come in contact, Patient does hereby consent to such blood withdrawal and for the testing thereof, as well as to the release of test information where this is deemed medically appropriate or required by law.

Consent for RX History Inquiry

I authorize ENT to obtain my Rx history using the Sure-Scripts-Rx Hub network. I understand that this inquiry will provide my provider with an accounting of my medication history, reported by pharmacy benefit managers and retail pharmacies. I also understand that Sure-Scripts-Rx Hub has certified the use of strict security protocols to align with HIPAA requirements respect to patient privacy. Inquiries and responses are made automatically through secure system-to-system communications.

Disclaimer of Guarantee

Patient hereby acknowledges that the practice of medicine and surgery is not an exact science and that diagnosis and treatment may involve risks of injury and of adverse results. Patient hereby acknowledges that no guarantees have been made to Patient or those acting for Patient as to the results of procedures which Patient may undergo while a patient of ENT.

Acknowledgements of Patient

Patient understands that:

a. It is customary, absent emergency or extraordinary circumstances, that no substantial or invasive medical procedures be performed upon a patient unless and until the patient has had the opportunity to discuss these procedures with the physician or other health professional so that the patient may be informed of the contemplated procedures.
b. Each patient has the right to consent, or refuse to consent to any specific procedure or therapeutic course of treatment. If Patient refuses to consent to the administration of blood or blood products, ENT reserves the right to decline to provide medical care if, in the opinion of the Physician, the refusal of blood products poses a serious threat to the Patient.

COVID-19 I understand that the 2019 novel coronavirus, which causes the disease COVID-19, has been declared a pandemic by the World Health Organization, is extremely contagious, and is believed to be spread by person-to-person contact. I recognize that the staff of ENT has put in place reasonable preventative measures aimed at reducing the spread of COVID-19. However, I recognize and accept the risk of becoming infected by virtue of seeking services in-person at ENT.

Patient Understanding of Consent

This Consent Form has been adequately and fully explained to Patient, and Patient, by his or her signature, indicates satisfaction as to an adequate understanding of this Consent and its significance and that Patient is voluntarily executing the same.

Authorization for Release of Medical Information

I hereby authorize the release of any medical information, including information related to psychiatric care, drug and alcohol abuse and HIV/AIDS confidential information, necessary to process insurance claims or any medical information that is required for any health care related utilization review or quality assurance activities as well as to other physicians for continuity of care issues.

Validity of Consent

This consent is valid during the entire term of my association with The ENT Center of Central Georgia and/or Georgia Hearing Institute and may be relied upon unless, and until, revoked by Patient, in writing.

PLEASE INITIAL _____ *(full signature/date below)*

PERMISSION TO AUTHORIZE TREATMENT AND PROVIDE HEALTH INFORMATION

Patient Name _____ **Date of Birth** _____

I hereby give my permission to the person(s) listed below to authorize treatment and receive information about the care of the above named patient. *In order to obtain information, the party calling must share the patient's date of birth or Social Security Number.*

_____ _____ _____ _____
(*print name)* *(relationship)* *(print name)* *(relationship)*

_____ _____ _____ _____
(*print name)* *(relationship)* *(print name)* *(relationship)*

SIGN HERE

_____ _____ _____
Patient Signature (Guardian or Rep. if patient is a minor) Relationship to patient if minor Date *rev 05/20*

The ENT Center of Central Georgia

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FINANCIAL POLICY **Patient Name** _____

Thank you for choosing The ENT Center of Central Georgia (ENT) and/or Georgia Hearing Institute (GHI) as your health care provider. The following is a statement of our financial policy, which we require you to read and sign prior to treatment. We do require payment at the time of service. We accept CASH, CREDIT CARDS AND CHECKS and if needed, offer an extended payment plan which is available with PRIOR CREDIT APPROVAL.

Co-Payments and Deductibles

Office visits typically require a co-payment from your insurance company. Exceptions may include post operative visits for a determined period of time for some surgical procedures (office visit portion only). A deductible is a portion of the bill that is the responsibility of the patient to pay before an insurance company will cover the service. An office visit with our physicians will include a face to face encounter and evaluation. Generally, a copayment is required for the visit. In addition, some services and ALL procedures performed in the office require the patient to meet their deductible before insurance pays benefits. If you have not met your deductible, you will be responsible for full or partial payment, depending on your insurance contract. Procedures performed in the office are considered the same as surgery to the insurance company, and are billed as surgery. Please be advised that any outside pathology or laboratory services will be billed separately by those providers.

Diagnostic Procedures

Your office visit today may include a scope being placed in your nose or throat. This is considered a diagnostic procedure, which will be coded to your insurance company as an invasive or surgical procedure. Depending on the specifics of your policy, your insurance carrier will pay all, part, or none of the cost of this procedure. **It is the responsibility of you, the insured, to be aware of the limits of your policy prior to this procedure**. Any charges not covered by the insurance carrier will be the responsibility of the patient. YOU HAVE THE RIGHT TO REFUSE THE DIAGNOSTIC PROCEDURE.

Guarantee of Payment and Insurance Coverage

It is the policy of the office that you must pay for services when rendered except in the case of surgery and hospitalization. If this applies to you, we will estimate your responsibility of the charges and collect those (when possible) prior to surgery. We will then file your claim and you will be expected to pay any additional portions not covered by your insurance. If you have any questions, please ask about this before you leave the office.

In the event that my insurance company(ies) or other individuals fail to make prompt payment or deny services due to non-eligibility, I hereby give my personal guarantee of payment for all charges herein incurred. This includes all charges related to office visits, procedures performed, diagnostic testing, co-payments and deductibles. If this account is placed in collections, the undersigned agrees to pay the balance plus costs incurred to collect the debt.

I hereby authorize insurance benefits to be paid directly to the physician, and I am financially responsible for any non-covered services. I also authorize the physician to release my medical information in the processing of this claim.

If my insurance requires a referral or authorization for my visit, I am responsible for making sure the referral is obtained from my primary care physician or insurance carrier. I also understand that if the referral/authorization is not received prior to my appointment, I agree to pay for all services rendered on the day of the visit.

I have read the Financial Policy. I understand and agree to this Financial Policy.

_____

PLEASE INITIAL *(full signature/date below)*

PRIVACY POLICY ACKNOWLEDGEMENT STATEMENT

I hereby acknowledge that I have been made aware that The ENT Center of Central Georgia and Georgia Hearing Institute have a Privacy Policy in place in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). As a patient, I understand and acknowledge the following:

1. ENT and GHI have a privacy policy in effect in their office.
2. ENT and GHI have made this policy available to me for review by placing a complete version in the waiting room.
3. ENT and GHI have made me aware, that as a patient, I can request a copy of this policy for my personal file.

Upon review of the above statements, please sign below acknowledging that you have been advised of the privacy policy implemented by The ENT Center of Central Georgia and Georgia Hearing Institute and have read and understood the acknowledgement form. If you desire a copy of the Privacy Policy, please request one at this time.

Check One: ___ No, I do not want a copy, but acknowledge the Privacy Policy exists. ___ Yes, I do want a copy of the Privacy Policy.

SIGN HERE

_____ _____ _____

Patient Signature (Guardian or Rep. if patient is a minor) Relationship to patient if minor Date

rev 01/2019