The ENT Center of Central Georgia

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

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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, 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.

I understand photographs, videotapes, digital and/or other images may be made/recorded for treatment and payment purposes only. Audio and transcripts are never stored or saved to ensure privacy and security.

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.

Information Exchange I acknowledge that ENT may use health information exchange systems to electronically transmit, receive and/or access my medical information which may include, but is not limited to, treatments, prescriptions, labs, medical and prescription history, and other health care information.

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.

Permission to email & SMS text

I, the undersigned, give ENT, its employees or agents, express prior consent to contact me via email or SMS text if necessary, for the purpose of appointment reminders, documents general communication, reviews, payment requests, practice updates, or events.

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.

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.

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 b	pelow)	
PERMISSION TO AUTHOR	IZE TREATMENT AND PROVIDE	HEALTH INFORMATION	
Patient Name		Date of Birth	
, , , ,	1 \ /	horize treatment and receive information abouent'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 04/07/25

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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 SIGN HERE	Privacy Policy exists Yes, I do want a copy of	y of the Privacy Policy.	
Patient Signature (Guardian or Rep. if patient is a minor)	Relationship to patient if minor	Date	