MISSOURI
EAR, NOSE, AND THROAT
CENTER

Authorization for Treatment and Financial Responsibility

Consent: I authorize my physician and other providers who may attend me, their associates and assistants to provide the medical care, tests, procedures and services considered advisable by my physician.

Storage and Release of Information: I consent to the electronic storage and transmission of patient health information. I hereby authorize Missouri Ear, Nose and Throat Center to release by electronic means or otherwise any medical and/or billing information concerning my care, including copies of my medical records to the following:

- Any governmental or other entity as required by law for the purposes of reporting or purposes of determining eligibility in government sponsored benefit programs.
- The listed insurer(s) and/or agents of these companies.
- Any referring provider, continuing care, residential or long-term care facility or home health agency, hospital or surgery center where a procedure has been scheduled for the purpose of providing services for my care.

CommonWell and CareQuality Electronic Information Exchange: CommonWell and CareQuality interoperability hub provides access to medical information from healthcare facilities using Cerner and Epic electronic medical records. If you do not wish for Missouri ENT to have access to external medical records through this exchange, please notify our office.

Medicare Insurance Benefits: I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize the release of medical or other information to the Medicare Program or its intermediaries or carriers concerning this or a related Medicare claim filed by my treating provider(s). I request that payment of authorized benefits be made on my behalf to my healthcare providers. I understand that I am responsible for the Part B deductible for each year, the remaining co-insurance and any other non-covered charges. I request payment of authorized Medigap benefits be made to this provider and also authorize the release to the named Medigap insurer any information needed to determine benefits payable to the provider.

Guarantee of Payment: In accordance with the above terms and in consideration of the services provided to the below named patient by Missouri Ear, Nose and Throat Center, the undersigned agrees, whether he/she signs as the patient or guarantor, to pay Missouri Ear, Nose and Throat Center for all services ordered by the providers, or requested by the patient and the patient's family. If requirements for referral, second opinion or precertification of care, as outlined by the insurer, benefit plan or other payor, have not been followed the patient and/or guarantor may, in some instances, be personally responsible for all charges incurred. If an account is forwarded to a collection agency for nonpayment the fees incurred will be charged to the guarantor of the account.

Assignment of Insurance Benefits: In consideration of any and all services furnished by Missouri Ear, Nose and Throat Center, I authorize direct payment to Missouri Ear, Nose and Throat Center of all insurance benefits applicable to services rendered by providers which are now or shall become due and payable to me.

Notice of Privacy Practices Acknowledgement of Receipt: I have received or I have been provided the opportunity to receive a copy of the ***"Notice of Privacy Practices"*** that explains when, where, and why my confidential health information may be used or shared. I acknowledge that Missouri Ear, Nose and Throat Center providers and staff may use and share my confidential health information with others in order to treat me, in order to arrange for payment of my bill and for issues that concern Missouri Ear, Nose and Throat Center's operation and responsibilities.

I hereby authorize the following individual(s) to receive information regarding my medical condition(s) and related billing information:

_____ _____ _____

Do you have a Durable Power of Attorney (DPOA)? NO YES (Please enter name below)

Name of DPOA:_____

The undersigned certifies that the conditions of treatment have been read and understood. The undersigned is the patient or is duly authorized to act on behalf of the patient to execute these conditions of treatment and accept the terms thereof.

_____

Signature of patient/person authorized to consent Printed Name Date

_____

Signature of Witness Date

Patient Name:_____ **Date of Birth:**_____