CT ENT® HIPAA, PRIVACY, MESSAGING, FINANCIAL ACKNOWLEDGEMENT

INSURANCE RESPONSIBILITY

I authorize and request my insurance company to pay directly to the practice, CT ENT® (Robert L Weiss, MD, PC), any health benefits resulting from care received in any of our facilities by any of our engaged health PROVIDERS. I understand that my insurance company may NOT cover all services rendered on behalf of me or my dependents and agree to assume responsibility for any services not covered. I consent to the release to my insurance company of any medical record (except psychiatric) necessary to resolve claims for services rendered. I understand that co-pays, deductibles, co-insurance and any services not covered by an insurance company are my responsibility and are DUE IN FULL AT THE TIME OF SERVICE. I understand that it is my responsibility to contact my insurance carrier to determine my coverage, benefits, and financial responsibilities. I also understand that TELEHEALTH visits are considered a billable visit on the date of service and subject to the same terms as an in-office visit as outlines above.

CREDIT AND COLLECTION POLICY

1. For your convenience, we accept Checks, Cash, all Credit Cards.

2. CO-PAYMENTS, COINSURANCE, and DEDUCTIBLE responsibilities for your visit must be paid in full on the date of service. Our staff will assist you to help determine an estimate of these charges. Ultimately, it is your responsibility to check with your insurance carrier for final determination of your coverage and financial responsibilities. Co-payments are legally part of your insurance contract and cannot be waived under any circumstances unless your insurance contract stipulates there is no co-payment for services rendered for a date of service. Co-payments are traditionally charged for most follow-up visits and are always charged for each patient seen. If you have any questions regarding when you owe a co-payment, please contact your insurance company.

3. Our office will charge a fee of $25.00 to your account for NSF checks that are returned by the bank. After a NSF check has beep returned on your account, we will request payment be made by cash or credit card only.

4. If your insurance carrier determines you owe a balance for a date of service, you will receive a statement from our billing service. Payment in full is expected upon receipt of the first statement. PLEASE DO NOT DISREGARD ANY STATEMENTS YOU RECEIVE. Our office will make every effort to assist you in the payment process. Unpaid balances are subject to collection. Payment arrangements can be made at any point during this process prior to the account being sent to a collection agency. However, after the collection process has commenced, it cannot be reversed. Please contact our billing service directly for any questions.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY NOTICE

I HEREBY ACKNOWLEDGE THAT I HAVE BEEN GIVEN THE OPPORTUNITY TO REVIEW THIS MEDICAL PRACTICE'S NOTICE OF PRIVACY PRACTICE WHICH IS POSTED IN THE RECEPTION AREA AND ON OUR WEBSITE, **https://www.ct-ent.com/terms-of-use-privacy-policy** AND THAT I MAY REQUEST A COPY OF ANY AMENDED NOTICE OF PRIVACY PRACTICES AT EACH APPOINTMENT. My signature indicates that I have been given the opportunity to read the HIPAA and Privacy policy notice and consent to the guidelines set forth. By signing this form, I am consenting to allow CT ENT® to use and disclose my protected healthcare information (PHI) to carry out treatment, payment, and health care operations (TPO). I may revoke my consent in writing except to the extent that the practice has

already made disclosures in reliance upon my prior consent. If I choose not to sign this consent, or later revoke it, CT ENT® may decline to provide treatment to me.

MESSAGING

I agree to allow CT ENT® to contact me by ANY of the following methods that I have provided: home phone, work phone, mobile phone, text, email, and regular mail regarding my private health information, evaluation and treatment and appointment scheduling. I authorize CT ENT® to leave messages for me when I am unavailable. Please indicate any RESTRICTIONS ON LEAVING MESSAGES OR CONTACTING YOU by any of the aforementioned methods:

I consent to receive email and/or SMS messages for the purpose of providing educational material and review of your experience. Please let a staff member know if you wish to opt out of this service.

I consent to having my photograph taken for my electronic chart by CT ENT® staff. I also understand that the photograph is for my protection and to alleviate any potential of mistaken identity.

X
_____

Name of patient/agent/guardian _____

I certify that I have read and understand this document. I certify that my medical, medication information, and personal history statements I provide are true and correct. I am aware that it is my responsibility to inform the doctor or other health professional of my current medical or health conditions and to update this history. I understand that a current medical history and accurate medication list are essential to deliver my medical treatment.