PRE-VISIT PAPERWORK/ PATIENT CONSENTS:

Consent for Treatment:

I authorize Anne Arundel ENT & Facial Plastic Surgery (AKA AAENT), its employees, and agents, including physicians, physician assistants, nurse practitioners, and other employees, to provide any healthcare services that my provider deems necessary for diagnosis and/or treatment. If I am having a specimen sent to a laboratory, I understand that it is my responsibility to inform the provider and/or staff of a specific laboratory, if I chose one. The duration of this consent is indefinite and continues until revoked in writing. I understand that by not signing this consent, I will not be provided medical care except in a case of emergency.

Doctors Meek, Kleiman, Wachal, and Drury feel that a patient presenting to the office with sinus, allergy, throat, or voice complaints may require a thorough examination of that specific area. In some cases, this can only be accomplished with a nasal endoscope which is essentially painless and, in many cases, can be performed quickly. This piece of equipment provides the provider with an excellent view of the areas involved.

My insurance carrier may label this examination as a "procedural fee". In most cases, AAENT will accept the allowed amount from my insurance reimbursement. Please note, some insurance companies may list this diagnostic examination as "surgery" on the insurance remittance notification received.

I have read the above and agree to undergo this procedure/examination, if my provider feels necessary for diagnosis and treatment. I understand that I am obligated to pay my deductible and/or co-payments that are applied to this claim.

_____ **Initial**

Referral Requirements:

I understand that obtaining any referrals from my primary care physician, required by my insurance provider, is my responsibility and must be presented to AAENT at the time of my visit. I understand that if I do not provide a valid referral at the time of my appointment, I will have to reschedule my appointment or my insurance status can be changed to self-pay, in which I will have to pay out of pocket for the appointment. If I decide to be self-pay, it is my responsibility to get itemized receipts for insurance reimbursement.

In case of surgery, I will work with the surgical coordinator(s) of AAENT to assure that all of the required referrals and/or authorizations are obtained prior to surgery. Any benefit verification is my responsibility.

_____ **Initial**

Consent for Photos:

I understand that during the course of treatment, photographs may be taken for clinical and educational purposes. No audio taping, videotaping, or photography is allowed by non-staff members.

_____ **Initial**

Co-Payments:

Co-Payments are due at the time of the office visit therefore I understand that I cannot ask for my co-pay to be billed. If I cannot pay my co-pay at the time of visit, I may have to reschedule my appointment.

_____ **Initial**

Consent for Filing Insurance Claims:

I understand that to file claims and release medical information to my insurance company, Medicare and/or supplemental policy, AAENT is required to keep my signature on file. I hereby authorize Anne Arundel ENT & Facial Plastic Surgery, Dr. Robert Meek, III, Dr. Lee Kleiman, Dr Brandon Wachal, and/or Dr. Emily Drury to receive benefits directly from my insurance company, Medicare and/or supplemental policy when an assigned claim is filed. I authorize AAENT to appeal any denials to my insurance company, Medicare and/or supplemental policy, on my behalf and authorize the release of any medical information to my insurance company, Medicare and/or supplemental policy that is necessary for the processing of claims. I understand that I am financially responsible for the total charges for services rendered which may include services not covered by my insurance company/companies. I agree that all amounts are due upon request and payable to AAENT or Mid-Atlantic ENT. I understand that I will have a grace period of thirty (30) days from the statement date without finance or late charges. I further understand that should my account become delinquent, I shall pay the reasonable collection fee, including attorney fees of twenty-five percent (25%) of any balance due.

I understand that it is my responsibility to notify Anne Arundel ENT & Facial Plastic Surgery if my insurance has changed. If I fail to do so in a timely manner and my insurance fails to process my claim for payment due to the timely filing restrictions, I will be financially responsible for the visit cost in full.

_____ **Initial**

Consent for Electronic Prescription History:

I understand that to offer the best patient care, AAENT will retrieve my prescription history that has been ordered and filled through an EHR (Electronic Health Record) system. I authorize AAENT to import the prescription history obtained through an EHR system into my electronic chart.

_____ **Initial**

Consent for Appointment Reminders/Third Party Communications:

I authorize AAENT to send me appointment reminders via automated SMS text messages, phone calls, emails, and additional information regarding otolaryngology, including health-related messages or services and quality of care surveys provided by Anne Arundel ENT & Facial Plastic Surgery. I authorize AAENT and third-party collection agents to utilize all contact information I have provided in efforts to communicate regarding my account. I agree that affiliates may contact me through text messages, telephone calls, and emails to provide me with my service invoice and to remind me to pay for services provided by AAENT, in compliance with federal and state laws. I understand that I am under no obligation to receive automated notifications and may opt-out of these communications at any time by following the prompts in the reminder and informing the staff at AAENT. I will be asked to complete a detailed form confirming specifics of my request. Further, I may revoke my consent to receive some or all communications.

_____ **Initial**

Cancellation Policy for Appointments:

It is my responsibility to call the office to cancel prior to the scheduled appointment. See breakdown below:

I understand that there is a:

- **$25.00** fee for any missed "non-procedure" appointment.
- **$50.00** fee for any missed "procedure" appointment, including videostroboscopy.

- **$25.00** fee for any videostroboscopy appointment that is cancelled within 24 hours.
- **$50.00** fee for any allergy testing appointment cancelled within 7 days.
- **$250.00** fee for any surgery that is cancelled or rescheduled within 7 days.

Additionally, the office reserves the right to reschedule appointments for which I am over the 10-minute grace period. I understand that my appointment may be rescheduled to the next available opening, which is not guaranteed to be on the same day.

_____ **Initial**

Cosmetic Services:

Payment for surgical cosmetic services is required in full prior to the provision of the service. The surgical coordinator will provide pricing information from the surgeon.

_____ **Initial**

Notice of Privacy Practices:

I have been given a copy and have read the Notice of Privacy Practices which explains how my medical information will be used and disclosed. I authorize the release of my medical information necessary to evaluate and/or treat my condition, to process insurance claims on my behalf, and for other necessary health care operations of AAENT. I understand that I am entitled to receive a copy of the Notice of Privacy Practices.

_____ **Initial**

Patient Name: _____

Date of Birth: _____

Today's Date: _____

Again, the duration of this consent is indefinite and continues until revoked in writing.