ENT Specialists of Arizona, P.C.
1492 S Mill Avenue Suite 301, Tempe AZ 85281
10238 E Hampton Avenue Suite 411, Mesa AZ 85209

Patient Financial Responsibility and HIPAA notification

Patient name: _____ Date of birth:_____

I. Financial Policy

Please bring your current insurance and ID to every visit. You are obligated to ensure that our fees are paid in full. We will verify your coverage and bill your insurance carrier on your behalf. You agree that you will pay any deductible, co-payment, and/or co-insurance as determined by your insurance plan. Those payments will be due at the time of service. Many insurance companies have additional requirements or stipulations that may affect your coverage. You are responsible for any amounts not covered or payable by your insurance. If your insurance denies any part of your claim, you agree to be responsible to pay the full balance. Claims not paid within 90 days will be made patient due; the patient will then need to contact the insurance company for further claims payment actions.

II. No Show/Cancellation Policy

ENT Specialists of Arizona requires a *minimum* of **24-hour notice** from our patients when canceling or rescheduling an appointment. Failure to cancel/reschedule before the 24 hour window will result in a **$50 FEE** per infraction (payable upon receipt of billing).

Telephonic reminders are made by our staff and/or automated system when time permits. However, it is ultimately the patient's responsibility to remember scheduled appointments. You may leave notice of cancellations/re-schedules via phone **480-894-5550 Tempe or 480-964-4415 Mesa**, but it must be at least 24 hours in advance of the appointment. Please assist us in maintaining good service through efficiency.

III. HIPAA (Health Insurance Portability and Accountability Act of 1996)

We disclose your protected health information to carry out treatment, payment, and health care operations. If you would like a more detailed description of such uses and disclosures, please refer to the *Notice of Privacy Practices*. You have the right to review the *Notice of Privacy Practices* before signing this consent form. The terms of the *Notice of Privacy Practices* may change from time to time. You can get a copy of the latest *Notice of Privacy Practices* by contacting our office. We also will post a copy of our current *Notice of Privacy Practices* in our office.

You have the right to request that we restrict how we use or disclose protected health information to carry out treatment, payment, or health care operations. We do not have to agree to such requests, but must honor the requests to which we agree. You have the right to revoke this consent in writing, and the revocation will become effective except to the extent that we acted in reliance on your consent.

My Acknowledgement

I have read and understand the financial and no show/cancellation policy described above. I agree to pay, promptly and in full, any amounts due to the provider, including co-payments, deductibles, and amounts due for non-covered or services that are not payable by my insurance.

_____ _____
Patient or legally authorized individual signature Date

_____ _____
Printed Name if signed on behalf of the patient Relationship (parent, legal guardian, personal representative, etc.)