ENT PHYSICIANS, INC.

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Print patient's name (and legal guardian's name if patient is under 18 years old)

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• In an effort to better serve our patients in a timely manner, we feel it is important to enforce our missed appointment policy. If you are **unable to keep your appointment**, please give us at least **24 hours notice**. If we are notified in less than 24 hours, or you fail to show for your scheduled appointment leaving us unable to schedule someone in your time slot, you will be charged a **$35.00 fee**. Your signature below indicates that you understand the late cancellation policy and associated fee.

• Notice of Privacy Practices for ENT Physicians Inc. for protected health information (HIPPA) acknowledgment of receipt of privacy practices. I understand that my **protected health information may be used by the practice as described within the notice**. Your signature below indicates that you understand that your protected health information may be used only as described within the policy.

• ENT Physicians' microphone equipped exam rooms allow medical assistants to listen and transcribe your visit into your electronic health record. This courtesy allows us to more accurately record your visit and allows your physician to focus on you. A temporary audio recording may be made for accuracy and quality control purposes, which will deleted after entry into the permanent record. Your signature below indicates that you understand that your **visit may be recorded or typed into my record by remote assistant**.

• We apologize for the extra time involved in checking in as a new patient. For **follow-up appointments, we ask that patients check in 15 minutes before** your scheduled appointment time. If you realize that you are going to be late, please let us know as soon as possible. If you **arrive more than 15 minutes late, your appointment may be canceled** and rescheduled.

• We do our best to authorize or verify coverage for office visits and testing ordered through our office. However, it is your responsibility to verify coverage for office visits or any testing that our providers may order. Our staff will provide you with any information necessary to confirm coverage for testing, but it is ultimately the **patient's responsibility to verify coverage** by contacting your insurance company’s customer service center.

• I hereby authorize the doctors of ENT Physicians Inc, to consult, exam and perform necessary tests or studies appropriate for diagnosis or treatment of the patients problem. I authorize and request my insurance benefits to be paid directly to ENT Physicians Inc, for any care I receive. The doctor or insurance company may release any information required to process and pay any claims from my health care here. I understand I am financially responsible for all charges incurred by me or my dependent.

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Signature Today’s Date