ENT Specialists, Inc.

Consent Form

Name:

DOB:

Account #:

Financial Policy

I have reviewed the **Patient Financial Policy** provided to me by ENT Specialists and hereby agree to the terms outlined in the **Patient Financial Policy**.

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Signature of Patient or Legal Guardian Date

HIPPA Authorization Form

I authorize ENT to speak with the following people concerning my care.

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We may get an updated list of your medications as needed: YES or NO.

I authorize ENT to communicate with me through the following methods.

Cell phone: YES or NO Number: _______________________ Leave Message: YES or NO

Email: YES or NO Email Address: ____

(Office appointment confirmation calls will still be made)

Race: Native American Asian Black/African American White Hispanic Native Hawaiian

Ethnicity: Hispanic/ Latino YES or NO Primary Language: ___________________

I request the following restrictions to the use and disclosure of Health Information:

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I have reviewed the **HIPPA Authorization Form** provided to me by ENT Specialists and hereby agree to the terms and conditions outlined in the **HIPPA Authorization Form**.

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Signature of Patient or Legal Guardian Date