ENT Specialists 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**

_____

Signature of Patient or Legal Guardian Date

HIPAA Authorization Form

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

_____

_____

PRISMA is a data collection system we utilize at ENT Specialists to access your medical information from hospitals, physician offices and pharmacies. You are automatically opted in to PRISMA through our EHR system. If you want to opt out, please let the front desk know when you check in for your visit.

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

Cell phone: YES or NO Home phone: YES or NO Leave Message: YES or NO

Email: YES or NO Email Address: _____

(Office appointment confirmation calls will still be made)

Using artificial intelligence to document your vist: YES or NO

Primary Language: _____

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

_____

_____

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

_____

Signature of Patient or Legal Guardian Date