HIPAA Authorization Form

The Department of Health and Human Services has established a "Privacy Rule" to help ensure that personal health care information is protected. The rule was also created to provide a standard for health care providers to obtain their patients' consent for use and disclosure of health information to carry out treatment, payment, or health care operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel need your health care information to provide care that is in your best interests.

We support your full access to your personal medical records. We may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under the law, we have the right to refuse to treat you should you refuse to disclose your Personal Health Information (PHI). If you consent, then at some future time you may refuse part or all your PHI. You may not revoke actions that have already been taken which relied on a previously or currently signed consent.

If you have any objections, please ask to speak with our HIPPA compliance offices. You have the right to review our Privacy Notice and revoke consent in writing after you have reviewed our privacy notice.

Patient Financial Policy

ENT will bill your insurance company for telehealth visits, office visits, office procedures, and hospital procedures/surgeries. This could result in a copay, co-insurance, or deductible. We will bill the party responsible for any copay, co-insurance or deductible.

I understand that it is my responsibility to be familiar with my insurance plan and what benefits it provides. This includes what referrals, copayments and deductibles are required. I am required to sign the financial policy to be seen by ENT Specialists.

I understand that is my responsibility to provide ENT Specialists with accurate and up to date information about my insurance coverage at the time of my visit.

I understand that copayments and deductibles, required by my insurance company, are my responsibility. I understand that charges not covered by my insurance plan are my responsibility. This includes charges not covered by my insurance plan because I failed to provide the necessary information at the time of the visit that would have allowed for the proper adjudication of the insurance claim.

I understand that if I do not call at least 24 hours in advance of my appointment to cancel, I may be charged an administrative fee of $50.00. I understand that repeated missed appointments may result in the inability to make future appointments. Notification will be sent to my primary care physician in the event of dismissal from the practice.

I authorize my insurance plan to pay benefits directly to ENT Specialists Inc.

I authorize ENT Specialists to release pertinent medical information when requested by my insurance company to facilitate payment of a claim.

I request that payment of authorized Medicare and Medigap benefits be made on my behalf to ENT Specialists for any services provided to me by that provider. I authorize any holder on medical information about me to release to the CMS and its agents any information needed to determine these benefits or other benefits payable for related services. This authorization applies to all occasions of service and is in effect until I choose to revoke it.

If you have questions, please call our billing office at 781-769-3222