

Patient Name: \_\_\_\_\_

**EAR, NOSE and THROAT SURGEONS  
OF Western New England, LLC.**

**HIPAA / CONSENT FORM**

**ASSIGNMENT OF BENEFITS / CONSENT FOR Treatment, Payment & Health Care Operations**  
By signing below, I understand that I hereby authorize the Practice to disclose my medical information so that the Practice may treat, seek payment from third parties for such treatment, and generally carry on the Practice's health care operations. I understand that I am responsible for payment in full of all charges. I request that payment of authorized Medicare and other insurance benefits be paid directly to Ear, Nose & Throat Surgeons of Western New England, LLC. I also authorize Ear, Nose & Throat Surgeons of Western New England, LLC to release all information necessary for the processing of insurance claims to HCFA, its agents or any other insurance company to determine benefits payable for related services. SIGNATURE: \_\_\_\_\_ Date: \_\_\_\_\_

**INSURANCE STATEMENT OF UNDERSTANDING**

This office will gladly submit your private insurance claims for office/surgical services rendered. You must supply us with your current ID card. All efforts will be made to collect your insurance benefits. Your insurance coverage is a contract and is your responsibility. You are also responsible for any non-covered services as well as obtaining and maintaining a current referral and any services denied by insurance company. Co-payments are due at the time of your office visit.

**COPAY POLICY**

Many health insurance plans require a copay for services rendered which is expected at the time of service. If we must bill you for your copay, a \$ 25.00 service charge may be added. Thank you for your cooperation in this matter.

**"NO-SHOW" / CANCELLATION POLICY**

If you cannot keep your scheduled appointment, please call 24-hours in advance to avoid no show office charges. We reserve the right to charge for missed appointments if you do not honor this policy. If you repeatedly "NO SHOW and/or CANCEL your appointments, we reserve the right to discharge you from care.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**CONSENT TO DISCLOSE PROTECTED HEALTH INFORMATION  
TO FAMILY, FRIENDS, AND/OR OTHER REPRESENTATIVES**

By signing below, I have authorized Ear, Nose & Throat Surgeons of WNE, LLC to disclose my Protected Health Information to the following family members and friends:

Name	Relationship	Telephone#

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

Notice of Privacy & Acknowledgement Form given to patient: (date) \_\_\_\_\_