PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Enticare P.C. takes your privacy seriously. We will not disclose your medical records (protected health information) to any party without your signed consent, except as stipulated in our Notice of Privacy Practices.

Name: ____ Date: ______________________________

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION INCLUDING HIV & AIDS RELATED INFORMATION

- I understand that neither Provider nor Recipient may condition treatment, payment, enrollment or eligibility for benefits on whether I sign this Authorization. In addition, I understand that Recipient may re-disclose the Records and that the Records may no longer be protected by the Federal privacy regulations.
- I acknowledge and agree that the protected health information authorized to be disclosed under this Authorization may include records for drug or alcohol abuse or psychiatric illness, and records of testing, diagnosis or treatment for HIV, HIV-related diseases and communicable disease-related information.
- With respect to any communicable disease-related information protected by State confidentiality rules and disclosed under this Authorization, Recipient is prohibited from making any further disclosure of this information unless further disclosure is expressly permitted by me pursuant to a separate written authorization or is otherwise permitted by applicable law.
- Further, with respect to any drug and alcohol abuse treatment information disclosed under this Authorization, this information has been disclosed from records protected by Federal confidentiality rules (42 C.F.R. Part 2). The Federal rules prohibit the recipient of this information from making any further disclosure of this information unless further disclosure is expressly permitted by me pursuant to a separate written authorization or is otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

RIGHT OF REFUSAL

- I acknowledge that I have had the opportunity to review Enticare P.C.'s Notice of Privacy Practices, which is displayed for public inspection at its facility and on its website. This Notice describes how my protected health information may be used and disclosed, and how I may access my health records.
- I understand that I have the right to refuse to sign this authorization and that I do not have to sign this authorization to receive treatment at Enticare P.C. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the Federal Health Insurance Portability and Accountability Act (HIPAA). I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Enticare P.C. Privacy Officer at 3420 S. Mercy Road, Suite 107 Gilbert, AZ 85297.

EXPIRATION

This Authorization will remain effective until the expiration date specified below or, if no date is set forth below, for one-year following the date of this signing, at which time this Authorization will expire. A photocopy of this Authorization will be considered effective and valid as the original.

Date authorization expires (if any): ______________________

Signed by: ____ ______________________

Signature of Patient or Legal Guardian — Today's Date

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Relationship to Patient

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PATIENT FINANCIAL POLICY

You will be responsible for payment of all services if any of the following circumstances apply:

- If you do not have insurance or failed to notify us that your insurance has terminated or changed;
- If you do not have a referral and/or authorization when required and have elected to be seen;
- If you are with an insurance company we are not contracted with; or,
- If a claim denial from the insurance company, for any reason, is not able to be resolved.

Valid Insurance: Insurance companies require the submission of all claims within a specified time limit. If you have changes in your insurance coverage, and you fail to inform us of the change within twenty-one days of your visit, you may be responsible for the charges. Denials often arrive after the filing limit has expired, thus preventing us from being able to re-file a new claim with your new carrier. To ensure that you are not responsible for the charges, please make sure that we always have up-to- date information regarding your insurance coverage. Again, any denied claims for lack of correct insurance information, will be applied to patient responsibility.

Referrals: If your plan requires a referral from your primary care physician, it is **YOUR** responsibility to obtain it prior to your appointment and have it with you at the time of your visit. If your plan requires a referral and you do not obtain one, you will be held responsible for the visit charges in full at the time of service.

Coverage: An attempt will be made to obtain and comply with insurance company requirements. However, it is ultimately YOUR responsibility as a patient to verify your plan benefits, and whether or not Enticare PC is a contracted provider, prior to having any services rendered. Any and all face-to-face encounters with an Enticare provider qualifies as an office visit and will result in a claim submission to your insurance carrier. Co-payment, co-insurance and deductible amounts will apply and are the responsibility of the patient.

Disputes: Co-payment, co-insurance, and deductible amounts MUST be paid at the time of service. Any account balances will also be collected at the time of your visit. Any unpaid or disputed balances must be resolved within 90 days from the date of service. Enticare PC reserves the right to turn accounts over to a third party collection agency after 90 days. The responsible party or guarantor of this account will be responsible for all collection fees, legal fees, and any other fees associated with the account. If you have any questions, contact Enticare PC's Billing Department at **Billing@enticare.com**.

A $35.00 fee will be applied to all returned checks or disputed credit card transactions.

Medical Records: A fee of $1.00 per page up to $25.00 will be charged to patients requesting medical records for personal use, disability or non-surgical reasons. A records request form must be signed and received by Enticare PC before any records are disbursed per HIPAA. Please allow up to 14 business days.

No Show / Late Cancellation of Appointments:

To avoid a $25 no show fee you must:

- Give at least 24-hour notice of your inability to make it to your clinical appointment.

To avoid a $150 no show fee related to scheduled sleep studies, allergy testing, and or hearing testing, you must:

- Give at least 72-hour notice of your inability to attend your study/test

To avoid a $150 no show related to surgery you must:

- Give at least 5 business days notice of your need to modify your appointment.

In the event you missed three separate appointments without giving us the required notice, Enticare PC has the ability to discharge you as an active patient from our practice. In the event that your insurance plan does not allow us to charge a no show fee, Enticare PC holds as recourse the ability to discharge you as an active patient due to your inability to keep scheduled appointments.

Dismissal from Practice: Enticare PC reserves the right to dismiss patients who are not compliant with any one of the following:

- Refusal to comply with recommendations from the provider;
- Does not comply with office policies;
- Refuses to cooperate with staff;
- Repeatedly disputes fees that are fair and are consistent with the services provided;
- Displays threatening, hostile attitude or behavior to physicians or staff;
- Continues to abuse prescription drugs or controlled substances after physician intervention;
- Refuses to pay outstanding balances;
- 3 no-shows or other non-compliance issues that interfere or jeopardize patient treatment or safety;
- Breakdown of communication with patient and/or family resulting in a lack of trust that makes it medically impossible to treat the patient

By signing this form, you agree to all the information listed above, authorize the release of any medical information necessary to process your claims and authorize payment of medical benefits to Enticare PC, or supplier for services rendered.

Signature of Patient, Parent, or Legal Guardian	Print Name	Date

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PROCEDURES IN OFFICE

Please be aware that certain procedures performed in our office are not included in the standard office visit. These procedures will be billed separately and in addition to office visit charges. We have become aware that some insurance carrier are classifying these procedures as "surgery" and applying the charges to your calendar year deductible. The result may be insurance payment for an office visit but NOT a procedure. In such cases, payment for the procedure will be due from the patient. Be assured that we are following accepted billing and coding guidelines.

The providers of Enticare PC only perform these procedures when deemed medically necessary to best diagnose and treat our patients. If you are presenting with a sinus, throat/voice complaint, symptoms of allergies, or hearing loss there is a good chance the provider will need to perform one or more of the following procedures.

Examples of in-office procedures include but are not limited to:

- **CPT-31575 Flexible Laryngoscopy**
  This procedure involves passing a long thin flexible fiber-optic scope through the nasal cavity and into the throat. The fiber-optic scope enables the physician to visualize areas of the throat not readily seen using laryngeal mirrors.
- **CPT-31231 Nasal Endoscopy**
  This procedure uses the flexible or rigid scope attached to a light source to view areas of the nasal cavities that cannot be viewed by the physician using the standard nasal speculum and head mirror.
- **CPT-31237 Nasal Endoscopy with Debridement or Biopsy**
  This is the same procedure as above with removal of crusting or tissue.
- **CPT-92511 Flexible Nasopharyngoscopy**
  This involves examining both the tissues of the nasal passages AND the pharynx and larynx.
- **CPT-95004 Allergy Test**
  This procedure is an Allergy test that can help confirm or rule out allergies and consequently reduce adverse reactions and limit unnecessary avoidance and medications.
- **CPT 92567- Tympanometry**
- **CPT 92557- Audiometry**
- **CPT 92588- Otoacoustic Emissions (OAE)**
  These are the codes used for audiology services. Tympanometry is used to tell the pressure of the ear drums. Audiometry and OAE is considered a basic hearing test, it is used to tell if hearing is normal.

Please contact your insurance provider to verify benefits and coverage information prior to having any services rendered.

______________________________ ____________________
Signature of Patient, Parent, or Legal Guardian — Relationship

______________________________ ____________________
Print Name — Date

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MEDICATION HISTORY CONSENT FORM

By signing below I give permission for **Enticare, PC** to access my pharmacy benefits data electronically through RxHub. This consent will enable **Enticare, PC** to:

- Determine the pharmacy benefits and drug co pays for a patient's health plan.
- Check whether a prescribed medication is covered (in formulary) under a patient's plan.
- Display therapeutic alternatives with preference rank (if available) within a drug class for medications.
- Determine if a patient's health plan allows electronic prescribing to Mail Order pharmacies, and if so, e-prescribe to these pharmacies.
- Download a historic list of all medications prescribed for a patient by any provider.

In summary, we ask your permission to obtain formulary information, and information about other prescriptions prescribed by other providers using RxHub.

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Patient Name (Print)

______________________________ ______________
Patient Signature Date

COMMUNICATION CONSENT FORM

By signing below, I give Enticare PC permission to communicate with me via the e-mail given on the new patient paperwork. I understand that the purpose of any such communication will be for educational information, access to our portal, and for news related to our practice and or your provider that may affect you.

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Patient Name (Print)

______________________________ ______________
Patient Signature Date