Ear · Nose · Throat & Sinus Center of Orlando

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CONSENT FORM

**AUTHORIZATION**

I certify that I (or my dependent) has insurance coverage as listed above and assign directly to ENT SINUS OF ORLANDO. I understand that I am financially responsible for all charges whether or not paid by insurance. I remain responsible for the payment of copayments, deductibles, non-covered services, and any other charges not paid by insurance within 30 days. I hereby authorize (ENT SINUS OF ORLANDO) to release all information necessary to secure payment of benefits. I authorize the use of this signature for all insurance claims.

**Signature:** _____ **Date:**_____

**CONSENT FOR TREATMENT**

Having voluntarily presented myself (or my dependent) ENT SINUS OF ORLANDO, I acknowledge recognition of the fact that the evaluation and treatment received, I also give ENT SINUS OF ORLANDO permission to discuss prescription history, advised or deemed necessary to be the judgment of the physician.

**Signature:**_____ **Date:**_____

**ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE (HIPPA)**

By signing below, I acknowledge that ENT SINUS OF ORLANDO has offered or provided a copy of its Privacy Notice Practices, which explains how your health information will be handled in various situations. *** A copy of this form is valid as original***

_____Initials: I have received a copy of the Privacy Notice of ENT SINUS OF ORLANDO.
_____Initials: ENT SINUS OF ORLANDO has offered me a copy of the Privacy Notice which I have declined and has given me the chance to discuss my concerns and questions about the privacy of any health information.

**Signature:**_____ **Date:**_____

**ADDITIONAL PERSON(S) AUTHORIZED TO MAKE THE USE OR DISCLOSURE OF MY PHI**

We at ENT SINUS OF ORLANDO value and do everything in our power to protect your privacy. Your medical information will not be given to any individual (including spouses, parents, children or any significant others without your consent). If you want anyone other than your referring physician to have access to your medical information, please list their name, address, relation, and phone number below. (NOTE: Uses and disclosures may be permitted without prior consent in an emergency.

Name: _____ Relation:_____

Name: _____ Relation:_____

Name: _____ Relation:_____

Signature: _____ Date:_____

**PATIENT PORTAL AUTHORIZATION**

By signing below, I acknowledge that I have read and understood the consent form. It is my responsibility to notify ENT Sinus Of Orlando if there is a change in my email account or I feel my secure password has been breached. I have asked questions related to this consent agreement and believe all of my questions have been answered with clarity.

Patient/Guardian Signature: _____ Date: _____