General Consents and Acknowledgements

_____ _____

Patient Name **Date of Birth**

Authorization and Consent for Healthcare

I hereby authorize Oregon Ear, Nose & Throat Center and affiliated or other providers to release any information acquired in the course of my treatment to my Insurance company, employer, or third party payer as required for claims field, quality assurance, health plan administration, or complaints /grievances. I understand that the specific information to be released may include, but is not limited to history, diagnosis and/or treatment of all related illnesses including HIV virus and Acquired Immune Deficiency Syndrome (AIDS). I authorize direct payment to be made to Oregon Ear, Nose & Throat Center or other providers for all medical or surgical services rendered. I understand that if any services or charges are not covered, or if Oregon Ear, Nose & Throat Center is unable to verify eligibility, that I am responsible for all charges incurred for services rendered. I understand that my Doctor is an Attending Physician at hospitals that may be out of network with my insurance plan. I understand that I have the option to get my care at either an in network or an out of network facility and that if I have any questions regarding this, I can ask my Doctor or contact Oregon Ear, Nose & Throat Center Billing Department for further information. I hereby voluntarily consent to such healthcare encompassing diagnostic procedures and treatment by my physicians, and my physician's associates, assistants, and healthcare providers, as may be necessary in my physician's judgement. I have relied on my physicians for information in this regard and acknowledge that no warranty or guarantee has been made to me as to the result or cure. This form has been fully explained to me, and I certify that I understand its contents.

_____ (please initial)

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this Office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____ (please initial)

Consent For Review of Prescription History from External Sources

I grant permission to Oregon Ear, Nose & Throat Center to view my prescription history from external sources. This authorization will remain in effect until such time the patient or personal representative notifies Oregon Ear, Nose & Throat Center in writing of a change in release of information.

_____ (please initial)

Text Communication Consent

I grant permission to Oregon Ear, Nose & Throat Center to communicate with me via text message to my mobile phone. Communications may include appointment reminders and financial information.

_____ (please initial)

Telemedicine

By signing below, I acknowledge that telemedicine (defined as the use of medical information exchanged from one site to another via electronic communications for the health of the patient, including consultative, diagnostic, and treatment services) may be employed to facilitate my medical care. All electronic transmission of data will be restricted to authorized recipients in compliance with the Federal Health Insurance Portability and Accountability Act (HIPAA) and applicable state privacy laws.

Photography

I grant permission for photographs or videos to be taken and may be used in my medical record or for authorization purposes.

Patient Name **Date of Birth**

Consent for Communication of Protected Health Information
I give my consent to Oregon Ear, Nose & Throat Center to release Protected Health Information to the people or facilities listed below. This is to include any results of lab, diagnostic and/or therapeutic testing, including HIV testing, or my medical condition. PLEASE LIST THE FULL NAME OF THE PERSON(S), PHONE NUMBER AND THEIR RELATIONSHIP TO YOU BELOW: (If you do not want your information released, please write "do not release".)

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Name	Relationship	Phone number

No Show Fee
You may be charged $35 if you do not notify Oregon Ear, Nose & Throat within 24 hours of your scheduled appointment that you will be unable to attend. If you are enrolled in a government funded health plan, you are exempt from this policy.

Notice to Patients
Medical doctors are licensed and regulated by the Medical Board of Oregon. To check up on a license or to file a complaint go to https://www.oregon.gov/omb, email info@omb.oregon.gov, or call (877) 254-6263.

Acknowledgement and Signature:

Patient or Guardian Signature Date