Central Park
ENT

Physician Assistant
Consent for Treatment

This facility has on staff a physician assistant to assist in the delivery of medical care.

A physician assistant is not a doctor. A physician assistant is a graduate of a certified training program and is licensed by the state board. Under the supervision of a physician, a physician assistant can diagnose, treat and monitor common acute and chronic diseases as well as provide health maintenance care.

"Supervision" does not require the constant physical presence of a supervising physician, but rather overseeing the activities of and accepting responsibility for the medical services provided.

A physician assistant may provide such medical services that are within his/her education, training and experience. These services may include:

- Obtaining histories and performing physical exams
- Ordering and/or performing diagnostic and therapeutic procedures
- Formulation a working diagnosis
- Developing and implementing a treatment plan
- Monitoring the effectiveness of therapeutic interventions
- Assisting at surgery
- Offering counseling and education
- Supplying sample medications and writing prescriptions (where allowed by law)
- Making appropriate referrals

I have read the above, and hereby consent to the services of a physician assistant for my health care needs.

I understand that at any time I can refuse to see the physician assistant and request to see a physician.

Name:	Date
Signature:	Witness: (optional)

CENTRAL PARK ENT CONSENT FORM FOR ePRESCRIBE PROGRAM

ePrescribing is way for doctors to send electronically an accurate, error free, and understandable prescription from the doctor's office to the pharmacy. The ePrescribe Program also includes:

• Formulary and benefit transactions - Gives the health care provider information about which drugs are covered by your drug benefit plan.

• Medication history transactions - Provides the health care provider with information about your current and past prescriptions. This allows health care providers to be better informed about potential medication issues and to use that information to improve safety and quality. Medication history data can indicate: compliance with prescribed regimens; therapeutic interventions; drug-drug and drug-allergy interactions; adverse drug reactions; and duplicative therapy. The medication history information would include medications prescribed by other health care providers involved in your care and may include sensitive information including, but not limited to, medications related to mental health conditions, venereal diseases/sexually transmitted diseases, abortion(s), rape/sexual assault, substance (drug and alcohol) abuse, genetic diseases, and HIV/AIDS. As part of this Consent Form, you specifically consent to the release of this and other sensitive health information.

Consent

By signing this consent form you are agreeing that your provider at the practice may request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

You may decide not to sign this form. Your choice will not affect your ability to get medical care, payment for your medical care, or your medical care benefits. Your choice to give or to deny consent may not be the basis for denial of health services. You also have a right to receive a copy of this form after you have signed it.

This consent form will remain in effect until the day you revoke your consent. You may revoke this consent at any time in writing but if you do, it will not have an effect on any actions taken prior to receiving the revocation.

Understanding all of the above, I hereby provide informed consent to the practice to enroll me in this ePrescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

○ Accept ○ Reject (Print Patient Name)_____

Signature _____ **Date:** _____

Central Park Ear, Nose and Throat

Dear Patient:

It is the responsibility of the patient to read their coverage documents for information regarding benefits, limitations, and exclusions. It is also your responsibility to be aware of your co-payments, deductibles, and co-insurance amounts. In an effort to help educate our patients regarding copays, deductibles and coinsurance please note that most managed care insurance companies consider your office visit applicable to your copay which is a separate charge from the procedures or tests listed below. We will be happy to provide you with our office visit fees per your request.

Listed below are the most common tests and procedures that are performed in our office. Please note this is not an all-inclusive list. Procedure costs vary according to each individual insurance plan.

Procedure	
30300	Removal foreign body, nose
30903	Nasal Cautery
31231	Nasal endoscopy, unilateral or bilateral
31237	Nasal/sinus endoscopy, debridement
31575	Laryngoscopy, flexible fiberoptic
69200	Removal foreign body, ear
69210	Removal impacted cerumen (Wax removal)
69220	Debridement of mastoid cavity
69433	Myringotomy with tube
92557	Audiometry (Hearing Test)
92567	Tympanometry

Many managed care plans may cover these procedures or tests but apply them toward a deductible and/or co-insurance instead of your office visit co-pay. Some plans may consider any of these procedures as non-covered services. If your plan applies a test or a procedure toward your deductible, co-insurance or considers it as a non-covered service, you will be responsible for payment.

I understand that the benefits quoted to the provider are not a guarantee of payment by my insurance company. I understand and agree that I am responsible for any charges related to procedures and /or tests that are performed and are not reimbursed by my insurance company.

If you have any questions, please request to speak with a member of our business office.

Patient or Legal Guardian Signature _____ Date _____

Medical Consent for Treatment

Being at least 18 years of age and of sound mind, I, _____, the undersigned patient/responsible party consent to treatment considered necessary for _____(name of patient)and any extension of this treatment or procedure, whether or not currently anticipated, that the attending physician may consider necessary during the course of such procedure in order to correct an immediate medical problem, and that such treatment and procedures (i.e. Labs, Vaccinations) will be performed by physicians who are staff members of Central Park ENT. The undersigned hereby consents and grants authorization for such treatment and procedures and certifies that no guarantee or assurance had been made as to the results that may be obtained. (The undersigned further consents to the disposal in accordance with applicable laws of body tissue or body parts that may be removed during the course of this procedure.)

The undersigned agrees to pay for the service rendered by Central Park ENT on the release of the patient.

I do hereby assign any hospital benefits of liability of and payable by any third party for the herein-named patient to Central Park ENT unless I pay the amount in full on the release of the patient.

Statement of Financial Responsibility:

All services rendered are the payment responsibility of the patient. As a courtesy, we will bill your insurance carrier. The patient is responsible for all fees, regardless of insurance coverage or the usual and customary fees provided by your insurance company. It is customary to pay for services when rendered unless other arrangements have been made in advance. I understand that I will be responsible for any costs incurred as a result of my account having been turned over to a collection agency or attorney.

Financial Responsibility Statement:

If your account is placed with a collection agency, a collection-fee of up to 30% may be added to your account and shall become a part of the total amount due. You will be responsible for any and all reasonable collection fees including collection fees, reasonable attorney fees and court cost.

You agree, that for us to service your account or to collect any amounts you may owe, we and our collection agencies may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges for you. We and our collection agencies may also contact you by sending text messages or emails, using an email address you provide to use. Method of contact may also include pre-recorded / artificial voice messages and/or use of an automatic dialing device as applicable.

Patient: _____ Date: _____

Relationship to Patient: _____

Central Park ENT

Central Park ENT

Acknowledgement of Notice of Privacy (HIPAA) and Consent to Use/Disclose Health Information

I acknowledge that I have received a copy of Central Park ENT's Notice of Privacy Practices. I understand that as part of my healthcare, Central Park ENT originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future treatment. I understand this information serves as:

- A basis for planning my care and treatment
- A means of communication among the health professionals who contribute to my care
- A means of which insurance companies can certify that services billed were actually provided
- A source of information for applying my diagnosis and surgical information to my bill
- A tool for routine health care operations, such as assessing quality and reviewing the competence of the healthcare professionals

Appointment Messages:

____Home ____Cell

Medical Messages:

____Home ____Cell

Before signing this form, you should understand the following:

By signing this form, I authorize the use and /or disclosure of my protected health information

I understand that if my protected health information is disclosed to someone who is not required to comply with the federal privacy regulations, then such information may be re-disclosed and would no longer be protected

I authorize the release of any medical or other information necessary to process the insurance claim resulting from this service. I also request payment of government benefits either to myself or to the party who accepts assignment below

I understand that I have a right to revoke this authorization at any time. My revocation must be in writing. I am aware that my revocation is not effective to the extent that persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization.

I understand that I do have the right to inspect and copy my protected health information to be used or disclosed (in accordance with the requirements of the federal privacy protection regulations found under 45.C.F.R. Section 164.524.)

Authorized for Access (please include name/phone number of person/s you are authorizing access)

_____

_____

_____ _____

Signature of Patient/ Authorized Representative Date