



NASAL & SINUS CENTER
of AUSTIN

ACKNOWLEDGEMENT/CONSENT FOR TREATMENT

PATIENT NAME (Please print)

(initial) RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have reviewed a copy of Capital Otolaryngology's *Notice of Privacy Practices*. (Also available at www.capoto.com)

(initial) CONSENT TO TREATMENT

I consent to the performance of examinations, diagnostic procedures, and rendering of treatment by the medical provider and their designated medical office staff as is deemed necessary in the medical provider's judgment.

I understand that I have the right to refuse any medical or surgical treatment that I do not want.

**(initial) FINANCIAL RESPONSIBILITY, RELEASE OF INFORMATION,
ASSIGNMENT OF BENEFITS, and AUTHORIZATIONS**

I understand that copays, deductibles/co-insurance will be collected at the time service. I further understand that I am financially responsible for all charges, and as a courtesy, my charges will be filed with my insurance carrier. I understand that my insurance may process certain services (e.g. nasal endoscopy, nasal debridement) as a **diagnostic** or **surgical procedure** and may be applied towards my deductible/coinsurance.

I authorize the release of any medical information necessary to process an insurance claim on my behalf. I request that my medical insurance carrier make payment directly to Capital Otolaryngology for services rendered to me. I understand I will be responsible for these charges if the claim is denied or is not paid in a timely manner.

Should my account become a collection problem, I understand I will be financially responsible for any additional fees incurred during the collection process. I also understand that all past due accounts must be paid in full prior to making any future appointments.

I understand, when required by my insurance plan, I am responsible for obtaining referrals from my Primary Care Physician prior to receiving treatment from a Capital Otolaryngology provider. If said referral is not on file with Capital Otolaryngology at the time of my visit, and I choose to proceed with treatment, I understand I am responsible for all charges incurred during that visit, payable at the time of service.

My signature below indicates that I have read and am in agreement with all statements that I have initialed above.

Signature of Patient (or Guardian)

PRINTED Name of Patient (Guardian)

Date