Audubon Medical Campus
3030 N. Circle Dr, # 300
Colorado Springs, CO 80909

COLORADO ENT & ALLERGY

St. Peregrine Pavilion
6031 E. Woodmen Rd, # 300
Colorado Springs, CO 80923

Tel 719 867 7800
Fax 719 867 7899
ColoradoENT.com

PATIENT CONSENT FORM & FINANCIAL POLICIES

Use and Disclosure of Protected Health Information

With my consent, Colorado ENT & Allergy (also referred to as "the Practice" within this form) may use and disclose protected health information (PHI) or individually identifiable health information (IIHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to the Practice's Notice of Privacy Practices for a more complete description of such users and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent.

With my consent, Colorado ENT & Allergy may call my home or other designated location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care.

With my consent, Colorado ENT & Allergy may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

I authorize Colorado ENT & Allergy to contact me in the following ways (check all that apply):

Call me:	☐ at home	☐ on cell	☐ at work
Leave voicemail:	☐ at home	☐ on cell	☐ at work

I authorize Colorado ENT & Allergy to release my protected health information to other individuals:

☐ No
☐ Yes _____ (Name of individual(s) to whom information may be released)

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

Consent for Treatment

By signing this form, I am giving my permission for the physicians and staff of Colorado ENT & Allergy to treat me, including the performance of testing and/or procedures, as deemed necessary in the exercise of their professional judgment. This consent is given for both in-person visits and telehealth visits.

Medicare Consent

I certify that the information given by me in applying for payment under Title SVIII and /or Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediary carriers any information needed for this or a related Medicare or Medicaid claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services. I understand that I am responsible for my health insurance deductibles and coinsurance.

(Continued on reverse side)

Please initial_____

Audubon Medical Campus
3030 N. Circle Dr, #300
Colorado Springs, CO 80909

COLORADO ENT & ALLERGY

St. Peregrine Pavilion
6031 E. Woodmen Rd, #300
Colorado Springs, CO 80923

Tel 719 867 7800
Fax 719 867 7899
ColoradoENT.com

Payment for Service

I understand I am responsible for paying the full amount for all services on the day of service, unless the physician or Practice has an agreement with my insurance carrier. If I am insured, I authorize the Practice to release all information necessary to secure payment. I further understand my share of the cost of the services, e.g., co-payments, co-insurance, and deductibles, will be collected upon check-out.

Insurance Claims

As a courtesy, the Practice will file insurance claims with your insurance carrier. Your insurance company, in lieu of reimbursing you directly, will pay to the physician or Practice any benefits for services rendered. Your medical insurance carrier may pay less than the actual bill for services, so you may be responsible for payment of all services rendered. You are responsible for making available
complete insurance information for accurate filing of claims. To meet this end, we will request your current insurance card at each visit. Reduction or rejection of your claim by your insurance company does not relieve the financial obligation you have incurred. It is your responsibility to know and understand your medical insurance coverage. Not all services are a covered benefit in all contracts. Additionally, some services we provide will be billed separately from the office visit and may require a separate co-pay or be applied to your co-insurance/deductible. Please call your insurance company to verify your benefits. You will be responsible for all fees not paid by your insurance company.

Referrals and Authorizations

As a specialist, some insurance companies (particularly HMOs and TRICARE) require that prior to any visit you must obtain an authorization or referral from your primary care physician. It is your responsibility to know if this is required by your insurance and, if so, to obtain the referral. If this is not done by the day of your appointment, you will be asked to either reschedule your
appointment or pay the full amount for all services on the day of service If your insurance company rejects a claim because a valid
authorization or referral was not in place, the full cost of the visit will be your responsibility.

Workers Compensation

We require the workers compensation carrier's name and address prior to your visit. If the information is not provided, you are
responsible for paying the full amount for all services on the day of service. Additionally, if your workers compensation claim is
denied, you are responsible for all charges incurred.

Financial Assistance

For patients with financial need, we offer extended payment plans. Please ask to speak with one of our financial representatives to discuss your options.

Scheduling Fees

If you are unable to keep your scheduled appointment, please contact our office at least 24 hours in advance. We reserve the right to charge for any appointment which is not canceled with proper notice.

Unpaid Account Balances

In the event that you fail to make payments for services rendered, your account may be turned over to a collection agency. You will be responsible to pay the collection agency's fees that may be incurred in the collection of any outstanding balance.

Agreement: I have read the above form and policies and agree to the terms stated.

Name (printed)_____Email_____

Signature_____Date_____