NORTHLAND EAR, NOSE & THROAT, P.C.

Where can we contact you to notify you of appointments and/or test results? _____
In accordance with patient confidentiality and privacy laws, we will need your written permission to discuss appointments, lab results, test results, medical records and your account with anyone other than yourself. Please list below those family members you give permission to access your information.
____NO ONE

_____ _____
Name Relation Phone Name Relation Phone

_____
Patient/Guardian Signature

LIFETIME CONSENT FOR CARE AND TREATMENT

I, the undersigned, do hereby agree and give my consent for Northland ENT to furnish medical care and treatment to _____considered necessary and proper in diagnosing or treating his/her physical and mental condition.

Patient/Guardian_____ **Date**_____

FINANCIAL POLICY STATEMENT

We bill your insurance carrier solely as a courtesy to you. You are responsible for the entire bill for services rendered. We require that arrangements for payment of your estimated share be made today. Copay is due at the time of service. If your insurance carrier does not remit payment within 60 days, the balance will be due in full from you. In the event that your insurance company requests a refund of payments made, you will be responsible for the amount of money refunded to our insurance company. In the event your company establishes and internal *usual and customary fee schedule*, you will be responsible for the difference remaining.

If any payment is made directly to you for services billed by us, you recognize an obligation to promptly remit same, with remittance advice, to **Northland ENT.**

The above does not apply for those patients that are considered Worker's Compensation. However, be advised if you claim W/C benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you.

Please also be advised that **Northland ENT** does not handle Attorney/Liability Insurance liens for medical services rendered. We do not await settlement to receive payment. Payment is expected when services are rendered.

In understand and agree that if I fail to make payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees. I also understand I am responsible for any amount not covered by insurance.

The above information has been read and explained to me. I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.

_____ _____ _____
Patient/Guardian/Responsible Party **Date** **Northland ENT Representative Witness Initials**