ANDROS ENT
EAR NOSE THROAT & SLEEP CENTER

General Consent and Authorization Form

Consent to Treat: I consent to and authorize the physicians, nurses and other healthcare providers at Andros ENT & Sleep Center to perform appropriate healthcare examinations, treatment, and diagnostic testing or medication administration as deemed medically necessary by their professional judgment. I know that there are some risks with all medical treatments and procedures and I understand that no one can guarantee how well treatments or procedures will work.

☐ Agree ☐ Disagree

Assignment of Benefits/Payments for Services: I authorize payment of any and all benefits to Andros ENT & Sleep Center. I know that I must pay for any charges for my care that are not covered by my insurance, health plan, or government programs. I realize I must cooperate with Andros ENT & Sleep Center to get payment for my care. If I am eligible for payment from more than one type of coverage, Andros ENT & Sleep Center will return any extra payments to the payor. If I have an unpaid bill at Andros ENT & Sleep Center, any refunds due to me will be put on my unpaid bill. If there is money left over after the bill is paid, I will get a refund from Andros ENT & Sleep Center. I authorize the release of my protected health information included medical records if requested by and to my health insurance carrier for the purpose of claim processing, prior authorization, medical billing audits, and claim appeals.

☐ Agree ☐ Disagree

Release of Information I consent to the release and use by Andros ENT & Sleep Center of my protected health information to the extent permitted by law to and for the following:

- To a healthcare provider, including your primary care provider, another treating provider, or another healthcare provider being advised or consulted in connection with my treatment or care
  ☐ Agree ☐ Disagree
- To a health plan, insurer, third party payer, third party administrator or other organization providing me with health benefits, for the purposes of claims payment and benefit determinations, fraud investigations, or quality of care studies or reviews,
  ☐ Agree ☐ Disagree
- To a person or organization in connection with Andros ENT & Sleep Center's healthcare operations. These operations may include interdisciplinary care conferences, quality improvement activities, performance evaluations, business management and other related activities.
  ☐ Agree ☐ Disagree
- To receive or sharing information through an Electronic Health Information Exchange such as prescribing medication, medical record transfers, health record locators to identify where a patient has received care, patient referrals (to another organization or from another organization)
  ☐ Agree ☐ Disagree
- To leave medical, billing or scheduling information on this voice mail/answering machine number:
  ( ) _____ - _____.

Other Individuals Authorized to Release Information: In addition to myself, (if minor any other legal guardians of the patient), the following persons are authorized to speak to my provider or have access to medical record.

Name:	Relationship to patient:
1._____	_____
2._____	_____
3._____	_____

Release of Information for Research Purposes [Optional] I consent to and authorize the release of my protected health information for medical and scientific research purposes. ☐ Agree ☐ Disagree

Patient Rights and Privacy Practices: You and your family's rights and our privacy practices are posted in main areas within Andros ENT & Sleep Center. Your signature acknowledges receipt of our Notice of Privacy Practices. If you have any questions concerning your rights and/or our privacy practices, please contact your care provider of Andros ENT & Sleep Center's Privacy Officer, Adam Dunham.

Other Individuals Authorized to Consent to Treatment: In addition to the legal guardians of the patient, the following persons are authorized to consent to recommended medical care for me: name and relationship to patient (e.g., significant other, spouse, grandma, grandpa, daycare provider, etc.)

Name:	Relationship to patient:
1._____	_____
2._____	_____
3._____	_____

My signature here means I have read this information and understand it. This consent is valid until revoked in writing.

Patient Name:_____ Date of Birth: _____

Signature:_____ Relationship to patient: _____

Print name:_____ Date: _____

Name of Interpreter (if used): _____

Interpreter Phone Number: _____