Otolaryngology Specialists of North Texas
Pediatric and Adult Ear, Nose, & Throat Specialists

Gregory N. Rohn, MD Bradford A Gamble. MD
6300 W Parker Rd, Suite G24 Plano, TX 75093
7515 Greenville Ave, Suite 410 Dallas, TX 75231

Authorizations and Releases

By signing this consent form, I acknowledge that I have read, understand and/or authorize the following:

Authorization of Treatment:
I certify that I am the patient or the parent/legal guardian of the patient, and I consent to the administration and cost of all medical and surgical procedures, x-ray and medication for myself and for my dependents.

Guarantee of Payment:
________ Initial if **SELF PAY**: I elect to pay for all services rendered in full on the date of treatment. I understand that my insurance will NOT be billed by Otolaryngology Specialists of North Texas (the "Practice").

________ Initial if **INSURANCE** – **Assignment of Benefits:** I authorize payment directly to The Practice for all benefits otherwise payable to me. I also acknowledge that the Practice will submit my bill to my insurance carrier as a courtesy; however, I am ultimately responsible for all charges incurred. I agree that I will pay my estimated balance today based on the best available information of my current policy and current contract with my insurance carrier. I understand this is only an estimate, and, after my visit is processed with my insurance company, I will be billed for any outstanding balance and/or refunded for any credit due to or by me. I understand he Practice cannot guarantee the accuracy of my bill until it has been fully processed by my insurance carrier and that I am ultimately responsible for all charges incurred.

Receipt of Financial Policy:
By signing this consent form, I acknowledge that a copy of the Financial Policy of the Practice is available to me upon request and can be downloaded at www.entkidsadults.com. I understand that a copy of this consent form may be used with the same effectiveness as the original.

Receipt of Privacy Practices/HIPAA & Release of Health Information:
By signing this consent form, I acknowledge that a copy of the Practice's Notice of Privacy Practices ("NPP") has been made available to me, I am entitled to receive a copy upon request and I may download the NPP at www.entkidsadults.com. I understand that a copy of this consent form may be used with the same effectiveness as the original.

I understand that the Practice may use and/or release my health information verbally, in writing, electronically or otherwise for treatment related functions, payment for services, for quality review purposes and any other purposes specifically permitted or required under HIPAA and as described in the Practice's NPP.

___**I request my health information be shared with** ______________________**Relationship to Patient**____________________

I authorize the Practice to leave messages for the patient about appointment reminders or instructions regarding patient care at the following **phone number**: ________________________.

Surgery Center Disclosure:
I understand that the physicians of the Practice are affiliated as owners with, and have financial interest in the following surgery centers or hospitals: Texas Institute of Surgery, Texas Health Center for Diagnostics and Surgery and Cook Children's Pediatric Surgery Center). The physicians may receive an indirect financial benefit if you are referred to any of these facilities. I understand that I have the option to use an alternate facility and the Practice will not treat me differently if I choose to use an alternate facility.

I may revoke consent for any or all of the above items at any time, in writing. I certify that all information provided to the Practice is correct.

____ ________________________
Patient Name Patient Date of Birth

____ ________________________
Patient/Responsible Party Signature Date