Office Policies and HIPAA Acknowledgements

ACKNOWLEDGEMENT OR NOTICE OF PRIVACY PRACTICES

I have been provided with a copy of ENT of New Orleans, urgENT's, and Allergies Answered Notice of Privacy Practices. I understand I am entitled to a copy of this document.

NO SHOW POLICY

I understand that there may be a **$25 NO SHOW FEE** if I do not cancel my appointment within 24 hours prior to my scheduled appointment**.**

FAILURE TO CONFIRM or COMPLETE REGISTRATION

If I do not CONFIRM my appointment AND complete the required pre-registration process, my appointment time may not be available upon my arrival or may be rescheduled.

ELECTRONIC COMMUNICATIONS

I consent to allow the practice to provide me with information using the following communications methods: SMS TEXT MESSAGE, EMAIL, VIDEO CONFERENCING/TELEHEALTH and/or TELEPHONE.

I understand that delivery methods such as email and text messaging pose certain risks to the privacy and security of my protected health information. As such, I agree to assume personal responsibility for such communication risks and agree to not hold the practice responsible should such an event or incident occur.

MEDICATION HISTORY

I give my permission to allow my healthcare provider to obtain my medication history from my pharmacy, my health plans and other healthcare providers for use in my medical care or treatment.

TIME OF SERVICE PAYMENT

I understand that my appointment/procedure or testing **may be cancelled** if I do not fulfill my financial obligations. If I have a *deductible that has not been satisfied or a co-insurance applicable*, I will be asked to pay an estimated deposit before services will be rendered.

OUT OF POCKET CHARGES

I understand that some treatment, testing, and services are *not included* in my office copayment or coinsurance and may be subject to my insurance plan deductible.

Patient (or Guardian) Signature: _____ Date: _____