St. Cloud Ear, Nose, Throat-Head & Neck Clinic
Authorization to Release Information and Consent for Treatment

Patient Name: _____Date of Birth: _____ACCT #:_____

Release of Information: I authorize St. Cloud Ear, Nose, Throat-Head & Neck Clinic (St. Cloud ENT Clinic) to disclose any or all of the information in my medical record to:

- Any person, corporation or agency responsible for all or part of St. Cloud ENT Clinic who may be responsible for determining the necessity, appropriateness, payment or other matters related to St. Cloud ENT Clinic treatment for services:
- This includes but is not limited to, referring physicians, insurance companies, health maintenance organizations, preferred provider organizations, workers compensation carriers, welfare funds, the Centers for Medicare and Medicaid Services (CMS) or its intermediaries or carriers.
- Myself, as patient, or as the parent / legal guardian of a minor child (patient) for the purpose of continuing medical care, insurance purposes or personal review.

Medicare Patients: I authorize St. Cloud ENT Clinic to obtain information from the Social Security Administration regarding my entitlement and health insurance claim numbers.

Authorization for Disclosure (Optional): I give permission to discuss the following information with the individual(s) I have listed below: (please check the appropriate box)

Name: _____Relationship: _____Phone #:_____
- ☐ Any aspect of my health care
- ☐ Medical information ONLY
- ☐ Financial information ONLY

Name: _____Relationship: _____Phone #:_____
- ☐ Any aspect of my health care
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Name: _____Relationship: _____Phone #:_____
- ☐ Any aspect of my health care
- ☐ Medical information ONLY
- ☐ Financial information ONLY

I give express permission to disclose information to a caregiver who is accompanying me. I understand that I am responsible for notifying this office, in writing, of any changes to this authorization to disclose my personal health information.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES FORM: The Notice of Privacy Practices of St. Cloud ENT Clinic sets forth the ways in which my personal health information may be used or disclosed by St. Cloud ENT Clinic, and outlines my rights with respect to such information.
I acknowledge that on _____ (Date),
- ☐ I was provided a copy of the St. Cloud ENT Clinic Notice of Privacy Practice
- ☐ I declined a copy of the St. Cloud ENT Clinic Notice of Privacy Practice

CONSENT FOR TREATMENT: As a patient of St. Cloud ENT Clinic, I agree, request and authorize my attending physician to administer such treatment as is necessary. This includes their associates and / or assistants. Treatment may include such services, care, diagnostic procedures, and / or medical treatments, as the physician(s) deems reasonable and necessary. This would also include, but not be limited to, the performance of services involving pathology and radiology.

Signature: _____ Date: _____

Relationship to Patient: _____

PLEASE COMPLETE BOTH PAGES

St. Cloud Ear, Nose, Throat – Head & Neck Clinic
Statement of Patient Financial Responsibility

Patient name: _____Acct #: _____

The physicians and staff at St. Cloud Ear, Nose, Throat – Head & Neck Clinic (St. Cloud ENT Clinic) appreciate the opportunity to provide outstanding otolaryngology medical care to the Central Minnesota area. It is our obligation to provide the most responsive and high quality care in a cost-effective manner. The service(s) you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. We will bill your insurance carrier on your behalf; however, you are ultimately responsible for payment of your bill. You are responsible for payment of any deductible, co-payment and/or co-insurance amount as determined by your contract with your insurance carrier. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer.

Co-Pay Policy: Some health insurance carriers require the patient to pay a co-pay for services rendered. It is expected and appreciated that co-pays will be paid at the time of service at *each visit.*

Assignment of Benefits: I authorize my insurer to pay any benefits due me under my policy(s), managed care plan, HMO plan, Centers for Medicare and Medicaid and its intermediaries on their behalf directly to St. Cloud ENT Clinic the full and entire amount of bill incurred by me or the above named patient. I authorize the provider to release all medical information necessary to process this claim.

Self-Pay Patients without Insurance: I agree to assume **all** financial responsibility for services rendered by provider on behalf of myself or the above named patient.

Minor Patients: The clinic will not become involved in any way in disputes between divorced parents of a minor child receiving treatment. If I bring the child in for treatment, I am responsible for providing the correct insurance information to the office. I understand that I am responsible for any co-pay or coinsurance that is due. I understand that the clinic will not bill both parents. I understand the clinic will provide extra copies of my child's bill should I need it.

Accounts in Collections: Patients who have an account with the St. Cloud Ear, Nose and Throat Clinic that has been placed with a collections agency will be unable to schedule an appointment until that balance is paid in full.

I understand that I am financially responsible for **all** charges regardless of any applicable insurance or benefit payments.

I have read and understand the above information, and I agree to the terms described:

Patient / Guarantor Signature _____

Date: _____

PLEASE COMPLETE BOTH PAGES