



## AUTHORIZATION TO RELEASE INFORMATION

I/We authorize Lake Mary E.N.T. & allergy to release medical, psychiatric and substance abuse information contained in my/the patient's records to insurance carrier(s), physicians or other healthcare practitioners. Unless checked ( ) below, medical records release may include diagnostic and therapeutic information:

( ) HIV/AIDS ( ) Mental Health ( ) Substance Abuse ( ) Pregnancy ( ) Sexually Transmitted Disease  
Please check the list of other people your medical records and information may be provided to : ( )  
Spouse ( ) Partner ( ) Caregiver ( ) Case Mgr. ( ) Attorney  
( ) Other \_\_\_\_\_

## NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT FORM

Our notice of Privacy Practices provides information about how we may use and release protected health information about you. You have the right to review our Notice before signing this form. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy by writing our practice or requesting a copy from our front desk staff.

At all times, you retain the right to revoke this consent. Such revocation may be submitted to the Practice in writing. The revocation shall be effective except to the extent that the Practice has already taken action based on prior consent.

The Practice may refuse to treat you if you ( or an authorized representative) do not sign this consent form and then revoke it, the Practice has the right to refuse to provide further treatment to you as of the time of revocation( except to the extent that the practice is required by law to treat individuals).

## PAYMENT POLICY

I/We understand that payment is due at the time of service. All patients are responsible for their co-payments and deductibles. We accept cash, personal checks, Mastercard, Visa. There is a \$35.00 fee for returned checks. I/We will be ultimately responsible for my bill. I also understand that I am responsible for knowing my Insurance Plan and Provisions. I also understand that I may receive services that will not be covered by my insurance plan, and I will be held responsible to pay for those services (this includes Medicare patients as well)

Missed appointments fee: Failure to cancel an appointment without notifying our office within 24 hours will result in a \$ 50.00 charge. This also applies to patients who call for sick appointments and miss them in the same day. If you do not receive a reminder phone call from our office regarding your appointment, you will still be responsible for the charge. Failure to make a payment on your account within 120 days of receiving bill for services, will result in collection fees and/or attorney fees. I also understand that if my account is sent to collections, I will be discharged from this practice and will also have to find a new physician.

By signing below, I acknowledge and understand the information on this document. I also permit a copy of this to be used in place of the original.

\_\_\_\_\_  
Patient/Guarantor Name

\_\_\_\_\_  
Patient/ Guarantor Signature

\_\_\_\_\_  
Date