

***CENTRAL JERSEY OTOLARYNGOLOGY***  
***OFFICE POLICY*** ***PATIENT RESPONSIBILITY***

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
(please print)

I understand that it is my responsibility to know my insurance policy regarding doctor participation, referrals, and what is covered by my insurance company.

I understand that additional charges will be incurred for procedures performed by the doctor at the time of my visit.

I understand that if I require surgery, it is my responsibility to get any necessary referrals, if needed, and to also call my insurance company to see what my responsibilities are.

I understand that if my insurance company requires a referral, and I do not have one, I am responsible for full payment at the time of my visit.

I understand that referrals will not be accepted after the time of my visit.

I understand that insurance contracts are made between me and the insurance company.

***Central Jersey Otolaryngology*** does not render service on the assumption that the charges will be paid by my insurance company. Payment of any charges are presumed to be my responsibility.

I hereby authorize ***Central Jersey Otolaryngology*** to furnish information concerning my illness and treatment to my insurance company, attorney, school, or other treating physician. I understand that I am responsible for any amount not covered by insurance.

I understand that ***Central Jersey Otolaryngology*** requires payment at the time of treatment unless prior arrangements have been agreed upon.

I understand that there will be a \$25.00 charge for all returned checks.

\_\_\_\_\_  
Signature of responsible party

\_\_\_\_\_  
Date

Person who brings in patient, if patient is a minor, is responsible for payment.

**Attention:**

**IF YOU HAVE ANY CHANGES IN YOUR INSURANCE COVERAGE, PLEASE PROVIDE US WITH THIS INFORMATION SO WE MAY UPDATE OUR RECORDS.**

**IF COVERAGE HAS CHANGED AND WE ARE NOT AWARE OF THIS CHANGE, YOU ARE DIRECTLY RESPONSIBLE FOR ALL CHARGES.**

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE OF RESPONSIBLE PARTY

# Central Jersey Otolaryngology

## ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

By signing below I acknowledge that I have received a copy of the Notice of Privacy Practices

Name of Patient \_\_\_\_\_

Please list anyone that you give your permission to have your personal Health Information:

Signature of patient or personal representative: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If signed by personal representative, relationship to patient: \_\_\_\_\_

Date: \_\_\_\_\_

The Privacy Rule that is contained in HIPPA establishes a federal requirement that health care providers obtain a patient's written consent before using or disclosing the patient's personal health information to carry out treatment, payment, or health care operations (TPO). This must be obtained before information may be used or disclosed for TPO purposes, except in emergency situations.

The following information must be included in a medical record release form used by the Practice to be in compliance with HIPPA requirements.

I also authorize the release of "my results", such as laboratory results, X-ray results, clinical findings of consultations and the like, by phone to the following number \_\_\_\_\_.

This information may also be left on the answering machine at the same phone number  yes  no

### OFFICE USE ONLY:

Our practice will make a good faith effort to obtain a written acknowledgement of receipt of the Notice provided to the individual. If written acknowledgement is not obtained, our practice must document its good faith efforts to obtain such acknowledgement and record the reason why the acknowledgement was not obtained.

Refused to Sign

Physically unable to Sign

(Other) \_\_\_\_\_

Employee Signature: \_\_\_\_\_

Date: \_\_\_\_\_