



**Hoover**  
**Ear, Nose and Throat**  
**Associates, P.C.**  
 2116 Data Park  
 Hoover, AL 35244  
 205-733-9595  
 205-733-9599 Fax



**Hoover Hearing Clinic**  
 A division of  
 Hoover ENT Associates, P.C.  
 2116 Data Park  
 Hoover, Alabama 35244  
 205-733-9694 Tel  
 205-733-9599 Fax

## **PATIENT CONSENT TO TREAT**

### **CONSENT FOR TREATMENT, RELEASE OF MEDICAL INFORMATION, AND FINANCIAL RESPONSIBILITY**

I voluntarily consent to the medical examinations, diagnostic tests, and treatments deemed necessary by the healthcare providers at **Hoover ENT Associates** and **Hoover Hearing Clinic**. I understand that if invasive or additional procedures are recommended I may be asked to sign a separate informed consent form, depending on the specific service provided.

### **ASSIGNMENT OF BENEFITS / FINANCIAL RESPONSIBILITY**

I acknowledge that I am responsible for all charges not covered by my insurance, including copays, coinsurances, and deductibles. I authorize the release of any medical information necessary to process insurance claims on my behalf. I further acknowledge full financial responsibility for any services rendered and understand that payment of charges incurred in the office is due at the time of service.

### **FEES FOR MISSED APPOINTMENTS**

I understand there will be a **\$25 fee** if I do not show up for a scheduled appointment or if I do not cancel my appointment at least 48 hours prior to the scheduled appointment time. This fee will be collected from the card on file (if available) or will have to be paid before an appointment is rescheduled.

### **PRESCRIPTION REFILLS**

I understand that prescriptions from other physicians will not be refilled by this office. If I have not seen the physician within one year, no refills will be given. To provide accurate and excellent medical care, I understand that the physician's office utilizes software that can obtain some information regarding past medications I have been prescribed or taken. I understand this information is obtained from the pharmacies I have used and a prescription clearing house service used by the pharmacies. This information will be used in facilitating my medical care and will be considered protected health information just like all the other health information I provide. I agree to allow the physician's office to obtain this information electronically.

### **HIPAA PRIVACY ADKNOWLEDGMENT**

I acknowledge that I received a copy of the Physician Office's Notice of Privacy Practices or know where I can view a copy of the notice. A copy of the notice can be found on the office website ([www.hooverent.com](http://www.hooverent.com)). I consent to the use and disclosure of my protected health information (PHI) for the purposes of treatment, payment, and healthcare operations.

### **REVOCAION OF CONSENT**

I understand that this consent remains in effect until I revoke it in writing. I have the right to discontinue services at any time.

\_\_\_\_\_  
*Printed Name of Patient*

\_\_\_\_\_  
*Date of Birth*

\_\_\_\_\_  
*Patient or Legal Representative Signature*

\_\_\_\_\_  
*Date of Signature*