ACKNOWLEDGEMENT OF PRACTICE POLICIES

THE BARRANCO CLINIC

RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____

Account #: _____

We are required by law to maintain the privacy of protected health information and to provide individuals with this Notice of our legal duties and privacy practices with respect to protected health information.

We are required to abide by the terms of our Notice of Privacy Practices currently in effect.

We reserve the right to change the terms of the Notice of Privacy Practices and make the Notice of Privacy Practices provisions effective for all protected health information that we maintain. We will provide individuals with revised Notice of Privacy Practices on the first visit to the clinic after the revision is published. You then have the right to object or withdraw as provided in this Notice.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices.

_____
Patient Signature

_____
PATIENT'S PARENT OR LEGALLY APPOINTED GUARDIAN'S SIGNATURE (IF PATIENT IS LESS THAN 18)

_____
Date

_____
RELATIONSHIP OF PATIENT

AI-167 (09/15)

ENT VISIT POLICY

Please know that your ENT visit today may include some or all of the following commonly performed parts of an ENT examination. Depending on your disease process your exam may include FIBEROPTIC EXAMINATIONS of the nose and larynx/vocal cord, RADIOLOGICAL services and/or AUDIOLOGICAL testing. If such a procedure is performed a procedural fee will be submitted to your insurance carrier. You should know that YOUR INSURANCE CARRIER may refer to these routine parts of your specialist's consultation as PROCEDURES or even SURGICAL PROCEDURES. If our office participates with your insurance carrier you will only be obligated to pay for any deductibles, co-insurance and/or co-pays as agreed upon by you and your carrier.

Please know that the performance of these procedures by your specialist is important to give you the best and most comprehensive care available.

_____
Patient Signature

_____
PATIENT'S PARENT OR LEGALLY APPOINTED GUARDIAN'S SIGNATURE (IF PATIENT IS LESS THAN 18)

_____
Date

_____
RELATIONSHIP OF PATIENT

PERSONAL REPRESENTATIVE AUTHORIZATION FOR MEDICAL RELEASE

Patient Name: _____

Birth Date: _____ Phone: _____

I authorize The Barranco Clinic to speak to the following family members or my personal representative regarding:

- All medical information, including but not limited to records pertaining to examinations, treatments, consultations, appointments, billing records, x-rays and reports, history, laboratory findings, admissions and discharge reports, treatment records, diagnosis and prognosis records, nurse and doctor notes and any other non-medical information in my file.
- Only the following types of information:

_____

_____

_____

The above medical information shall only be released to the following persons:

Name of Personal Representative	Relationship	Phone #
_____	_____	_____
_____	_____	_____

I understand that I may terminate the Medical Authorization at any time. I must notify The Barranco Clinic in writing regarding termination and effective date.

This authorization shall remain valid (check one)

- Until revoked in writing.
- Until _____, 20_____.

_____
Patient Signature

_____
Date

_____
Witness Signature

Financial Policy

We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policy. Payment is due at the time of service unless arrangements have been made in advance by your carrier. We accept cash/checks. Visa, MasterCard, Discover, American Express and Care Credit.

I authorize the release of any medical information necessary to process an insurance claim for services rendered by The Barranco Clinic. I certify the information provided is correct. I authorize and assign payment of medical benefits to The Barranco Clinic for services rendered. This assignment will remain in effect until revoked by me in writing. A photocopy of this form is to be considered as valid and effective as the original.

We file insurance for Medicare and companies we are contracted with only. Your insurance is a method for you to receive reimbursement for the fees you have paid to the physician for services rendered. Having insurance is not a substitute for payment. Many companies have fixed allowance or percentages based on your contract with them, not with our office. It is your responsibility to pay the deductible, co-insurance, and any other balances not paid, or not covered by your insurance at each appointment. In the event your insurance plan determines a service to be "not covered," you will be responsible for the complete charge. It is your responsibility to monitor your insurance benefits, deductibles, authorizations, effective date and termination dates of coverage. We will assist you in receiving reimbursement as much as possible, but you are responsible for your bill. We will wait up to sixty (60) days for payment from your insurance company. If the insurance company has not paid within sixty (60) days, we will expect the balance in full from you at that time. If it is necessary that a second statement has to be sent to advise you of a balance on your account, there will be a $10 statement fee.

Returned checks are processed through Check Exchange or The Barranco Clinic. A service charge will be added and checks will not be accepted for future payments.

There will be a $50.00 "no show fee" charged after two consecutive missed appointments without 24 hours notice. For the following a $100.00 "no show fee" will be charged: any diagnostic testing including but not limited to: Allergy testing, CT scans and audiology testing. For those patients who do not show for a scheduled surgical procedure, a $150.00 "no show fee", or 10% of the surgical fee, whichever is greater, will be charged. These charges must be paid prior to scheduling any further appointments. This charge will not be billed to insurance.

In the event that any litigation is required to collect the sums due from you under this agreement. The Barranco Clinic shall be entitled to recover from you, all of its legal costs and expenses, including reasonable attorneys fees, before trial, at trial and in any appellate proceeding.

I AGREE TO BE FINANCIALLY RESPONSIBLE FOR ALL CHARGES. I HAVE READ THE STATED FINANCIAL POLICIES OF THE BARRANCO CLINIC AND AGREE TO ABIDE BY ITS TERMS. I ALSO UNDERSTAND AND AGREE THAT SUCH TERMS MAY BE AMENDED BY THE PRACTICE FROM TIME TO TIME.

_____
Guarantor of Account: (Parent or legally appointed guardian, if minor)

_____
Date

Witness _____