The Hearing Center of Jackson

290 E. Layfair Drive, Flowood, MS 39232

Patient Name _____ Date of Birth_____ Chart # _____

Prior Express Consent Form

General Consent for Treatment _____(initial)

I request and authorize health care services by Jackson Ear Clinic (JEC) and his/her designee(s) as my provider may deem advisable and in my best interest. This may include routine diagnostic, radiology and laboratory procedures and medication administration.

Release of Medical Information _____(initial)

I consent to JEC's use of my protected health information related to the medical services provided for the following purposes: my treatment, obtaining payment for my treatment which includes submitting information to my insurance company for the purpose of processing claims for services rendered and for healthcare operations of other treating providers working with JEC, all as permitted under federal and state laws and regulations. This authorization will expire one year from the first date of service. I understand that I have a right to revoke this authorization at any time and must submit a written statement to Kathy Dehnke to obtain a revocation. I understand that the revocation will not apply to information that has already been released in response to this authorization and I will be responsible for any outstanding debt at the time of such revocation. The right to authorize disclosure of this health information is voluntary and I understand medical services will not be withheld if I chose to decline authorization, however I also understand that I will be expected to pay for all charges at the time of service if I decline to authorize the release of my protected health information.

Privacy Practices and Patient Rights and Responsibilities _____(initial)

Jackson Ear Clinic's "Notice of Privacy Practices" (Notice) provides information about how health information about patients may be used and disclosed. I, the patient, or his/her legal representative, acknowledge that I have been offered an opportunity to review the Notice before signing this form.

Payment _____(initial)

I assign and authorize payment, for any and all services rendered, directly to JEC from my insurance company or third party payer including, but not limited to Medicare, Medicaid, commercial health insurance plans, MS Vocational Rehabilitation and Workers' Compensation insurance.

In consideration of the health care services provided to me by JEC, I agree to pay all charges not covered by my insurance company or any applicable health benefit plan **at the time of service** including, but not limited to, deductibles, co-payments, co-insurance and non-covered services. If I am under 18, the parent/guardian requesting treatment and present with me is considered the Patient's Responsible Party.

If a payment is made on an account by check, and the check is returned as Non-Sufficient Funds (NSF), Account Closed (AC) or Refer to Maker (RTM), I (or the Patient's Responsible Party) will be responsible for the amount of the check plus a fee of $25.00 as a Service Charge.

Authorization to Leave Messages _____(initial)

I consent to receive calls from JEC about my protected health information and account information at the phone number(s) provided including my wireless phone account. I understand I may be charged for such calls by my wireless carrier and that such calls may be generated by an automated dialing system.

I further authorize JEC to leave messages regarding my treatment, appointments and account services which may include requests for assistance in obtaining payment from my health plan and/or courtesy reminders of past due balances.

With whom may we share information about your health, appointments, insurance or account. Please list below.

Name (s)	Relationship to You	Telephone Number
_____	_____	(____)_____
_____	_____	(____)_____
_____	_____	(____)_____
_____	_____	(____)_____

May we discuss diagnosis / treatment with the above listed contacts? ○YES ⊙NO only _____

May we discuss billing / account info with the above listed contacts? ○YES ⊙NO only _____

Is it okay to leave messages on your answering system? ○YES ⊙NO

NOTE: In order for JEC to disclose your Private Health Information, the representative listed above must be able to provide two (2) of the identifiers listed below:

1. Last 4 digits of patient's social security number
2. Patient's date of birth
3. Patient's zip code

I understand that it is my responsibility to update this list in order to keep accurate those authorized person(s) to discuss and use the patient's healthcare information. I understand that it is important for JEC to be able to communicate with me and have current information about me, my address and my phone number(s).

Consent to Treat / Authorization to Release Information

In consideration of JEC providing services to me, I consent and agree to the terms and conditions contained in the Prior Express Consent Form. I authorize the health care providers of Jackson Ear Clinic to provide treatment and consent to use of my protected health information to obtain payment from my insurance plan and to coordinate healthcare operations. I am responsible for payment of services rendered. Full payment is due at the time of service unless I am covered by an accepted third party plan. I understand that if my account should ever require action by a collection agency in order to collect delinquent debt, fees charged by the agents may be added to the balance due on my account.

_____ _____ _____

Signature of Patient Parent/Guardian (if under 18) Date