DISCLOSURE AND CONSENT

You have the right, as a patient, to be informed about your recommended treatment so that you may make the decision whether to undergo treatment under the care of Aspire Allergy & Sinus. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so that you may give or withhold your consent to treatment.

____(initial) CONSENT TO TREATMENT

I consent to the performance of examinations, diagnostic procedures, and rendering of treatment by the medical provider at Aspire Allergy & Sinus and their designated medical office staff as is deemed necessary in the medical provider's judgment. I agree to be financially responsible for the costs of such diagnostic procedures. I authorize and consent to the disposal of materials/substances that would normally be removed during such diagnostic procedures and medical treatment. I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made to me as a result of treatments or examination. The opportunity has been provided for me to ask questions regarding the proposed allergy treatment and these questions have been answered to my satisfaction. ***I understand that I have the right to refuse any medical or surgical treatment that I do not want***.

_____(initial) Notice Regarding Insurance Claims/Payments

I authorize Aspire Allergy & Sinus to bill my services **(please circle one: to my insurance / as self-pay)** from dates of service on and after the signed date. This choice will remain into effect until services are complete or new disclosure and consent is signed. I will ensure authorizations and referrals are in order prior to billing insurance. If authorization is not obtained, I will be billed as self-pay. Aspire Allergy & Sinus will **not** change the billing preference of my services unless instructed by the patient. The documented decision will be kept in my patient file for confirmation and reference purposes. I will be responsible for out-of-pocket costs after claims are finalized which is due upon receipt of the statement. Should my account become a collection problem, I acknowledge financial responsibility for any additional fees incurred during the collection process. I must pay past due balances in full prior to making future appointments unless a payment arrangement has been established between Aspire Allergy & Sinus and myself.

____(initial) RECEIPT OF *NOTICE OF PRIVACY PRACTICES*

I have been given access to Aspire Allergy & Sinus' Notice ***of Privacy Practices,*** which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

____(initial) CONSENT TO DISCLOSE PROTECTED HEALTH INFORMATION

HIPAA allows individuals to designate a family member or other individual with whom my Protected Health Information be disclosed for purposes of communication results, findings, and/or care decisions. Uses and disclosures for treatment records, payment information and healthcare operations may be permitted without prior consent in an emergency. I authorize Aspire Allergy & Sinus to share my Protected Health Information with the following:

Name	Relationship	Contact Number

Patient may revoke or modify this specific authorization at any time, must be in writing.

____(initial) CONSENT TO OBTAIN PROTECTED HEALTH INFORMATION FOR CONTINUUM OF CARE

Practice is permitted by federal privacy laws to make uses and disclosures of my health information for the purpose of treatment, payment and health care operations. Protected health information is the information we create and obtain in providing services which include documenting symptoms, examination, test results and treatment.

I have read and understand the information above.

PATIENT NAME (PRINTED)_____

PATIENT SIGNATURE _____ DATE_____

PARENT/LEGAL GUARDIAN SIGNATURE_____ DATE_____

*As a parent/legal guardian, I understand that I must accompany my child throughout the entire procedure and visit.