FINANCIAL POLICY AND AGREEMENT FOR
BREVARD EAR, NOSE AND THROAT CENTER

In order to provide the best service to you, our patients, we have answered some of the
most commonly asked questions below:

PAYMENT FOR SERVICE IS DUE AT THE TIME SERVICES ARE RENDERED:
We accept cash, personal checks and major credit cards (Discover, Master Card and
VISA.)

INSURANCE: The doctor’s service is provided directly to you and not to an insurance
company. We cannot render service on the assumption that the charges will be paid for
you by the insurance company. If we participate with your insurance, we will file your
services directly to them. You will be expected to pay any deductible and/or co-pay as
outlined in your policy when you check in on your appointment day. We must emphasize
that, as your medical providers, our relationship and concern is with you and your health,
not your insurance company. All charges are your responsibility from the date services are
rendered. We expect payment from either your insurance company or from you within 45
days. You must then collect from your insurance company if they did not pay.

AUTHORIZATION FOR SERVICES: The patient is responsible for all authorizations
for services before services are rendered. If we do not have an authorization number at the
time of your visit, you can either pay for services in full, or reschedule your appointment.
Patients are also responsible for letting us know which lab their insurance requires us to
use for any laboratory work. We will not be held responsible.

MEDICAL RECORDS: Please be advised it may take up to ONE week for records to be
sent out. Charges: Any records required sooner than ONE week will be subject to a
charge of $1.00 per page.

Thank you for taking the time to read this policy statement. We hope it answers your
questions. If you have more, please let us know.

(PLEASE INITIAL THE NEXT THREE STATEMENTS,
AND SIGN THE FOURTH STATEMENT IF DESIRED)

I authorize release of any medical information and payment of medical benefits to Drs.
Burk, Whitley, Holt and Crain.

I understand that even though I have some type of insurance coverage I am responsible for
payment of services.

I authorize release of my medical records to other health care professionals involved in my
care.

I authorize release of any medical information to ______________________

Method of Payment: ☐Cash ☐Check ☐Credit Card

SIGNATURE ___________________________ DATE: ___________________________
BREVARD ENT CENTER AND PRIVACY PRACTICES ACKNOWLEDGEMENT

Patient Consent For Use And Disclosure Of Protected Health Information

With my consent, Brevard ENT center may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to Brevard ENT Center's notice of privacy practices for a more complete description of such use and disclosure.

I have the right to review the notice of privacy practices prior to signing this consent. Brevard ENT Center reserves the right to revise its notice of privacy practices at any time. A revised notice of privacy practices may be obtained by forwarding a written request to Brevard ENT Center, Privacy Officer, 1099 Florida Ave., Rockledge, FL 32955.

With my consent, Brevard ENT Center may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any other call pertaining to my or my child's clinical care, including lab results, among others.

With my consent, Brevard ENT center may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

I have the right to request that Brevard ENT Center restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Brevard ENT Center's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Brevard ENT Center may decline to provide treatment to me.

________________________
Patient's Name

________________________
Signature of Patient/ Parent or Legal Guardian          Date

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

________________________
Signature

________________________
Date
e-Prescribing/Medication History Download Consent Form

e-Prescribing is defined as a physician’s ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the point of care. Congress had determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. E-Prescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an e-Prescribe program. These include:

- **Formulary and benefit transactions** – gives the prescriber information about which drugs are covered by the drug benefit plan.
- **Medication history transactions** – provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.
- **Fill status notification** – allows the prescriber to receive an electronic notice from the pharmacy telling them if patient’s prescription has been picked up, not picked up, or partially filled.

By signing this consent form you are agreeing that BREVARD EAR, NOSE AND THROAT CENTER can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payers for treatment purposes.

Understanding all of the above, I hereby provide informed consent to BREVARD EAR, NOSE AND THROAT CENTER to enroll me in the e-Prescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

__________________________________________  ____________________________
Name                                                Date of Birth

__________________________________________
Signature of Patient or Guardian

__________________________________________
If guardian, relationship to patient
PATIENT CONSENT AND AGREEMENT

- I consent to participation in the facility Patient Portal (Portal), and understand that my personal health and individually identifying information is made available to me in the Portal.

- I understand that the use of the Portal is for non-emergency purposes.

- I understand that I have the ability to provide Portal access to my Authorized Representatives (Representatives) and that those Representatives may have the ability to perform all of the functions I am able to perform, including viewing, downloading and transmitting my health and individually identifying information.

- I understand there are risks associated with web-based applications, and that I am responsible for safeguarding my access information.

- I understand that my e-mail address is required to initiate Portal access, and will be used for communications related to the Portal. I agree to communicate my e-mail address changes.

- I have read and understand the terms and Conditions of Use, and I have been provided with an opportunity to ask questions.

- I understand that my access to the Portal requires my acceptance of the Terms and Conditions of Use. If I refuse to sign at this time, I understand that I may change that decision in the future and can contact the Facility to obtain access to the Portal.

- I understand that failure to follow the Terms and Conditions of Use may result in termination of access to the Portal.

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<th>Patient Name</th>
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☐ Patient Refused Access to the Portal

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Brevard Ear, Nose & Throat Center

Office Procedure – Patient Information Sheet:
Potential Additional Costs

During your visit certain tests / procedures may need to be performed that may incur an additional charge above and beyond the office visit charge (see examples below). This may appear as a surgical/diagnostic procedure on your statement from your insurance company. Depending on your insurance contract, you may be required to pay additional fees for co-insurance, deductible and/or co-pay.

Examples (most common):

**Endoscopy** – Insertion of a small flexible or rigid lighted scope into your nose or mouth to better visualize either your nose or your throat.

**Microscope** – Use of a microscope to visualize the ear canal and drum.

**Ear Wax Removal** – Removal of impacted cerumen (earwax)

**Hearing Services** – Diagnostic testing for hearing and dizziness

Patient Name:_________________________   Acct#__________

Patient Signature:_________________________

Any questions call our Billing department at 321-639-0155
Patient Name: _______________________________________
Date: ____________________________________________

**Hearing Health Questionnaire**

(Please circle yes or no)

1. Seem to hear better in one ear than the other?  YES  NO
2. Have trouble hearing in chrch or at other large gatherings?  YES  NO
3. Avoid or feel withdrawn at meetings or social gatherings?  YES  NO
4. Difficulty following conversation between the front and back seat of the car?  YES  NO
5. Have trouble understanding some women or children when they speak?  YES  NO
6. Have ringing in the ears or other head noises (buzzing, crickets, etc.)?  YES  NO
7. Do you currently wear hearing aids?  YES  NO
   
   If so, how old are your current hearing aids?_________________