**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**

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

I, the undersigned, consent to treatment necessary for the care of the patient named below. I hereby authorize release of any or all medical records to the referring physicians, my insurance carriers, and those involved in the payment of the patient’s account. I further acknowledge full financial responsibility for any services rendered by Hoover Ear, Nose and Throat Associates, P.C. (“Hoover ENT”) and/or Hoover Hearing Clinic (*a division of Hoover ENT Associates, P.C.*), and understand that payment of charges incurred in the office are due at the time of service. I also understand that charges not covered by insurance remain my responsibility, and I assign insurance benefits to Hoover ENT and/or Hoover Hearing Clinic. In the event an account is more than 90 days past due, I agree to pay all costs of collection including collection fees, attorney’s fees and hereby waive all rights of exemption under the Constitution of the State of Alabama.

# PRESCRIPTION REFILLS, MESSAGES, AND AFTER-HOUR CALLS

I understand that prescriptions from other physicians will not be refilled by Hoover ENT. If I have not seen a Hoover ENT physician within one year, no refills will be given. Unless there is a true emergency, no messages will be answered after 3:30

p.m. Dr. Boyd does not have after-hours call availability. If I have a true medical emergency, I understand that I am to dial the emergency 911 operator. No calls for Hoover Hearing Clinic will be answered or messages returned after 4:30 pm. Hoover Hearing Clinic does not have after-hours call availability.

In order to provide accurate and excellent medical care, I understand that Hoover ENT 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 of the other health information I provide to Hoover ENT. I agree to allow Hoover ENT to obtain this information electronically.

# FEES FOR MISSED APPOINTMENTS AND REQUESTS FOR MEDICAL RECORDS

There will be a $25 fee if you do not cancel your appointment at least 24 hours prior to your scheduled appointment time. There will be a $25 fee for rescheduling surgery from the original surgery date. There will be a fee for copying medical records according to the number of pages copied in addition to the cost for postage.

# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I received a copy of the Notice of Privacy Practices for Hoover ENT Associates, P.C. and/or Hoover Hearing Clinic. A copy of the Notice can be found on the websites ([*www.hooverent.com*,](http://www.hooverent.com/) [*www.hooverhearingclinic.com*](http://www.hooverhearingclinic.com/)).

# BY SIGNING I ACKNOWLEDGE AND AGREE TO THE ABOVE INFORMATION

Signature of Patient Date

Printed Name of Patient Date of Birth

Printed Name of Parent/Patient’s Representative (if applicable) Signature of Parent/Patient’s Representative (if applicable)

Revised 8/28/2018