FLORENCE EARS, NOSE & THROAT, PC

1594 FREEDOM BLVD., STE 206

FLORENCE, S.C. 29505

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT, & HEALTHCARE OPTIONS

I consent to the use or disclosure of my protected health information by Drs. Farrell/Mckay for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations. I understand that diagnosis or treatment of my by Drs. Farrell/Mckay may be conducted upon my consent as evidenced by my signature of this document.

I understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of this practice. Drs. Farrell/ Mckay are not required to agree to the restrictions that I may request. However, if Drs. Farrell/Mckay agree to a restriction that I request, the restriction is binding.

I have the right to revoke this consent, in writing, at any time, except to the extent that Drs. Farrell/ Mckay has taken action in reliance on this consent.

My “protected health information” means health information, including my demographic information, collected from me and created or received by physician, another health care provider, a health plan, my employer or a healthcare clearing house. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand that I have a right to review Drs. Farrell/Mckay Notice of Privacy Practices prior to signing this document. Drs. Farrell/Mckay Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the type of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performing of healthcare

operation of Drs. Farrell/Mckay. This Notice of Privacy Practices also describes my rights and Drs. Farrell/Mckay duties with respect to my protected health information.

Drs. Farrell/Mckay reserves the right to change the privacy practices that are described in the Notice Of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent to me in the mail or asking for one at the time of my next appointment.

ASSIGNMENT OF BENEFITS: Drs. Farrell/Mckay agrees to furnish information concerning my illness and treatment necessary to process my insurance claims. If insurance assignment is accepted I hereby assign to the physician all payments for medical services rendered to my dependent or myself. I understand that I am responsible for any amount not covered by my insurance.

My protected health information may be shared with: (check all that apply)

\_\_\_Spouse \_\_\_Mother \_\_\_Father \_\_\_Grandmother \_\_\_Grandfather \_\_\_Other(Specify)\_\_\_\_\_\_\_\_\_\_

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Name Of Patient or Personal Representative Signature Of Patient/Personal Representative