Dubuque ENT

HEAD & NECK SURGERY PC
Advanced, personal care from our family to yours
535 Cedar Cross Road, Dubuque, IA 52003
(563)588-0506 or (800)848-7507
Online: www.DubuqueENT.com

BY SIGNING THIS FORM YOU ARE SIGNING FOR THE FOLLOWING ITEMS:

1. **Acknowledgement of Review of Privacy Notice and Disclosure of "Phi"**

- I hereby acknowledge review of Dubuque ENT Head & Neck Surgery P.C.'s Privacy Notice. Any "PHI" (Protected Health Information) about the below listed patient, **SHOULD NOT** be discussed with or released to the following person or people **(Please list name(s) on line at bottom of page)***

2. **Statement of File Signature & Assignment of Benefits:**

- I authorize release of information to my insurance companies, employer, and work comp carrier, Medicare or Medigap.
- I understand that I am fully responsible for my bill.
- I authorize my insurance companies, Medicare & Medigap, work comp carrier and/or employer to issue payment directly to my physician.
- I authorize use of this form on all of my claims submissions
- I authorize Dubuque ENT to intercede on my behalf in helping me secure payment of any and all claims.

3. **Consent to Obtain External Prescription History:**

- I authorize Dubuque ENT Head & Neck Surgery, P.C., and its affiliated providers to view my external prescription history via the RxHub service or other prescription history service. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years. By signing this form I am certifying that I have read and understand the scope of my consent and that I authorize the access.

4. **Consent to Photograph:**

- I understand that photographs or other images may be recorded to document my care, if applicable. By signing this form I am certifying that I have read and understand the scope of my consent. I understand that these images will be stored in a secure manner that will protect my privacy required by law.

*Person/people who **<u>should not</u>** be allowed to discuss patient record:_____

Print Patient Name:_____ DOB:_____

Signature of Patient or Guardian_____ Date:_____