# ENT Associates of Worcester

*Sinus • Hearing • Allergy*

**Christopher C. Charon, MD | Deirdre Monahan, PA-C**

145 Pomfret Street Putnam, CT 06260 Phone (860)928-7330 Fax (860)928-1907

## CONSENT FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS (TPO)

**I. CONSENT TO TREATMENT**

1. I give my permission to be treated. This may include examinations, tests and procedures, medical treatment and admission to facilities under the care of a doctor and/or care provider, which they or their authorized agent may think is necessary or the best course of action. I understand specific consent forms may need to be signed for specific procedures. If I have a religious objection to specific care to be provided, I may ask not to provide that care.
2. I understand and agree that my care may include taking photographs/video and making sound recordings that may be used for my care and/or for education, as well as health care operations purposes.
3. I understand and agree that others, under the direction of a doctor and/or care provider, may help with or take part in giving hospital and/or medical care to me. These may include doctors and/or care providers in training and medical/nursing students.
4. I give permission to properly dispose of any specimens/tissue taken from my body. I understand specimens/tissue may be used for educational or research purposes in accordance with state and federal law.
5. I understand that no guarantees have been made about the outcome or results of any examination or treatment, and I understand that I have the right to refuse treatment at any time.
6. I understand and agree that care or services may be provided through telehealth. The provider will decide whether the condition being diagnosed or treated can be properly managed through telehealth.
7. I authorize and consent to communicate by phone, email and/or text.

**II. FINANCIAL ARRANGEMENTS**

1. I also understand and agree that, to the extent permitted by my insurance or coverage, I am financially responsible for all charges, co-payments and deductibles remaining after insurance payments, and all ENT Associates charges that are not covered by my insurance or third-party payers.
2. I assign benefits and insurance proceeds to ENT Associates of Worcester for services provided.
3. **Medicare Patient Certification and Assignment of Benefit:** I certify that any information I provide in applying for benefit under Title XVIII (“Medicare”) or Title XIX (“Medicaid”) of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to ENT Associates by the Medicare or Medicaid program.
4. I acknowledge that I have received, read, and understand the Practice’s Appointment and No-Show Policy. I agree to comply with the policy, including providing required notice for cancellations or rescheduling. I understand that failure to provide adequate notice or failure to attend a scheduled appointment may result in a no-show or late cancellation fee, for which I am financially responsible.

**III. PATIENT VALUABLES**

I release ENT Associates of Worcester from responsibility for loss or damage to personal property I choose to keep with me.

**IV. AGREEMENT THAT ANY LEGAL ACTION WILL BE FILED IN A COUNTY IN WHICH CARE IS PROVIDED**

I understand and agree that any legal action related to my care must be filed in the county where care was provided.

**ACKNOWLEDGMENT**

I have read this Authorization/Consent for Treatment, Payment and Health Care Operations (TPO) form or have had it read to me and it has been explained to my satisfaction.

Patient Signature: ______________________________ Date: _____________

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## HIPAA NOTICE OF PRIVACY PRACTICES & CONFIDENTIAL COMMUNICATION

Patient Name: _________________________________ Date of Birth: ____________________

CONFIDENTIAL COMMUNICATION REQUEST

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have the right to request that we communicate with you about your health information in a specific way or at a specific location.

May we speak with someone other than you about your medical information?

**YES or NO** If YES, please complete below:

Name: ________________________________________________

Relationship: ___________________________________________

Phone: _________________________________________________

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that my protected health information may be used and disclosed for:

- Treatment, including coordination among healthcare providers
- Payment for services
- Healthcare operations such as quality review and administrative activities

I understand:

- I may request restrictions on certain uses and disclosures (in writing).
- If I pay in full out-of-pocket, I may request that information about that service not be sent to my insurance.
- Certain disclosures (such as psychotherapy notes or marketing use) require my written authorization.
- I will be notified in writing if a breach of my protected health information occurs.
- I may request a full copy of the complete Notice of Privacy Practices at any time.

Signature: ______________________________________________ Date: _______________

If signed by someone other than patient, relationship: ______________________________

## NO SHOW & APPOINTMENT POLICY

At ENT Associates, we are committed to providing timely, high-quality care to all patients. Keeping scheduled appointments allows us to serve you and others effectively.

**Cancellations & Rescheduling**

If you need to cancel or reschedule an appointment, please notify our office at least 24 hours in advance.

**Missed Appointments (No-Shows)**

A missed appointment occurs when a patient does not arrive for a scheduled visit and does not provide advance notice.

Missed Appointment Fee: **$200.00**

These fees are not covered by insurance and are the patient's responsibility. Fees may be waived for emergencies or reasonable circumstances. Medicaid and certain plans may not allow fees.

**Appointment Reminders**

We provide reminders via phone, text, or email. Please keep your contact information up to date.

**Repeated Missed Appointments**

Repeated missed visits may result in changes to scheduling or transfer of care in accordance with regulations.

**Acknowledgment**

By scheduling an appointment, you acknowledge this policy.