

Metropolitan ENT

& Facial Plastic Surgery

Cancellation Policy/No Show Policy For Doctor Appointments and Surgery

1. Cancellation/ No Show Policy for Doctor Appointment

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly “full” appointment book.

If an appointment is not cancelled at least 24 hours in advance you will be charged a fifty dollar (\$50) fee; this will not be covered by your insurance company.

2. Scheduled Appointments

We understand that delays can happen however we must try to keep the other patients and doctors on time.

If a patient is 15 minutes past their scheduled time we will have to reschedule the appointment.

3. Cancellation/ No Show Policy for Surgery

Due to the large block of time needed for surgery, last minute cancellations can cause problems and added expenses for the office.

If surgery is not cancelled at least 10 days in advance you will be charged a seventy five dollar (\$75) fee; this is will not be covered by your insurance company.

4. Account balances

We will require that patients with self pay balances do pay their account balances to zero (0) prior to receiving further services by our practice.

Patients who have questions about their bills or who would like to discuss a payment plan option may call and ask to speak to a business office representative with whom they can review their account and concerns.

Patients with balances over \$100 must make payment arrangements prior to future appointments being made.

Print Name Patient

Signature Patient/Guardian

____/____/____
Date

Patient Account # _____
(Office Use Only)

Authorization for Release of Information

Name of Patient _____ Date of Birth ____/____/____

Metropolitan ENT is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Entity To Receive Information. Check each person/entity that you approve to receive information.	Description of information to be released Check each that can be give to person/entity on the left in the same section.
<input type="checkbox"/> Voice Mail	<input type="checkbox"/> Results of lab tests/x-rays <input type="checkbox"/> Other _____
<input type="checkbox"/> Spouse _____	<input type="checkbox"/> Financial <input type="checkbox"/> Medical as follows below: _____
<input type="checkbox"/> Parent (provide name) _____	<input type="checkbox"/> Financial <input type="checkbox"/> Medical as follows below: _____
<input type="checkbox"/> Other (provide name) _____ _____	<input type="checkbox"/> Financial <input type="checkbox"/> Medical as follows below: _____

Patient Information:

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or discloses as a result of this authorization maybe subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.
 THIS AUTHORIZATION SHALL IN BE EFFECT UNTILL REVOKED BY PATIENT.

Date ____/____/____

(Signature of Patient or Personal Representative

Description of Personal Representative's Authority (attach necessary documentation)

Revised October 2009