

CYNTHIA CHROSNIAK, M.D.
HEATHER SCHWARTZBAUER, M.D.
NICHOLAS MEHTA, M.D.
OTOLARYNGOLOGY
HEAD AND NECK SURGERY
DIPLOMATS AMERICAN BOARD OF OTOLARYNGOLOGY

JANE COOKE, Au.D.
KATHI BALETSTINO-ESTS, Au.D.
AUDIOLOGY
HEARING SERVICES
AUDIOVESTIBULAR TESTING

CONDITIONS OF REGISTRATION

CONSENT FOR TREATMENT:

By signing below, I hereby consent to the administration of such medical treatment, diagnostic and/or therapeutic procedures and surgery as required by the physician rendering care for themselves and/or their child(ren).

REFERRALS AND AUTHORIZATIONS:

By signing below, I acknowledge that it is my responsibility, if I (we) have an insurance plan that requires any referrals, pre-certifications or authorization to receive any additional medical services, such as specialty care and diagnostic testing, to obtain such authorization from my (our) primary care physician (PCP) or insurance company prior to such non-emergency services being rendered. Additionally, if any aforementioned procedures are not done, I understand that this may cause reduced or rejected coverage for which I will be held responsible and that any of these aforementioned actions do not guarantee that my insurance company will pay for myself, spouse or my (our) child(ren)'s claims. Any denial of a claim is between the policyholder/subscriber and their insurance.

FINANCIAL AGREEMENT:

By signing below I agree that:

1. if for any reason a check is returned on my account I will be responsible for a \$25 returned check fee in addition to the original fees for service(s);
2. there will be a \$25 fee for any appointments not cancelled 24 hours prior to the date and time scheduled.
3. if this account is sent to an attorney for collections, I agree to pay any collection and reasonable legal fees, (30% is deemed reasonable) court costs and other expenses incurred as a result of said collection, all actions have a venue of Montgomery County, MD, other venues notwithstanding.
4. There will be a \$100 cancellation fee for all surgery scheduled at the hospital or surgery center if I cancel within five (5) business days of the scheduled procedure.

ACKNOWLEDGEMENT OF NOTIFICATION OF PRIVACY PRACTICES:

By signing below, I acknowledge the availability of the practice's Notice of Privacy Practices pamphlet, which provides information about how we may use and disclose your protected health information, and is compliant with the Health Insurance Portability and Accountability Act (HIPAA). We reserve the right to change the terms described, and should we do this we will post the changes in all of our offices and on our web site. You have the right to request restrictions on how your protected health information may be used or disclosed for treatment, payment or health care operations. We are not required to agree with your restrictions; but if we do, we are bound by our agreement with you.

SIGNATURE: _____

DATE: _____