



TALLAHASSEE EAR, NOSE & THROAT - HEAD & NECK SURGERY, P.A.

Consent to Use/Disclose Information for Treatment, Payment of Healthcare Operations, and Behavior Policy

Patient's Name

Patient's Date of Birth

I, the patient (or authorized representative), understand and consent to the terms of the Patient Privacy Notice from Tallahassee Ear, Nose & Throat-Head & Neck Surgery, P.A. made available to me printed, and/or available on the website for my review. I understand that my Protected Health Information may be used for treatment, payment and general practice operation.

I have the right to revoke this consent. Such revocation must be submitted to the Privacy Officer in writing. The revocation shall be effective except in the extent that Tallahassee Ear, Nose & Throat has already acted in reliance within the guidelines of the consent. If the consent is not signed or is terminated after signature, Tallahassee Ear, Nose & Throat may refuse to treat me or continue to treat me (except as required by law to treat individuals) as consent is required for general practice operation.

I understand Tallahassee, Ear, Nose & Throat-Head & Neck Surgery, P.A. may send letters, emails, texts, voicemails, billing statements, or communication through the secure patient portal to the guarantor on my account. I acknowledge that email, voicemail, text, and cell phones are not secure forms of communication. It is my responsibility, as the patient, to provide accurate and current demographic information including mailing address, phone numbers, and private personal email address for communication. I understand photographs, audio, videotapes, digital and/or other images may be made/recorded for treatment and payment purposes only. Audio and transcripts are never stored or saved to ensure privacy and security.

To provide the highest quality medical care, our practice requires that patients give their full attention during medical appointments. Accurate diagnosis and effective treatment depend on clear communication, careful listening, and focused interaction between the patient and physician. During your visit, patients are expected to refrain from using cell phones, tablets, smartwatches, laptops, or other electronic devices for activities such as texting, phone calls, internet browsing, social media, or gaming. These activities can distract both the patient and the provider, interfere with important medical discussions, and may impact the physician's ability to properly assess symptoms, identify underlying conditions, and recommend the most appropriate course of treatment.

If a phone/electronic device must be used for a medically relevant purpose such as reviewing medication lists, medical records, photos of symptoms, or participating in a medically necessary call please inform the provider or staff member in advance. Failure to comply with this policy may result in the appointment being paused, rescheduled, or ended to ensure that care is delivered safely and effectively.

We expect our patients to respect the privacy of other patients. If you obtain information about another patient, you are to notify us immediately so that we can take corrective action. **We expect our staff and physicians to treat you in a respectful manner. We ask that you conduct yourself in a manner that is respectful as well. If at any time your behavior is demeaning or disrespectful we reserve the right to discharge you from the practice.**

Patients under the age of 18: parent or legal guardian must be listed on this form for all visits in our office.

I give permission for the contacts listed below to be given information regarding my medical conditions and diagnoses (including treatments, financial account, and healthcare options) with:

If no one, please check here: ☐

•Name: _____ DOB: ____/____/____ Phone: (____)-____-____ Relationship: _____

•Name: _____ DOB: ____/____/____ Phone: (____)-____-____ Relationship: _____

•Name: _____ DOB: ____/____/____ Phone: (____)-____-____ Relationship: _____

I understand that if I need to change my contacts it is my responsibility to request it in writing to the Privacy Officer. A copy of this form can be provided upon request.

Patient or Guardian Signature Required _____

Processed by: _____ Date: _____

H001-22- July 2026



TALLAHASSEE EAR, NOSE & THROAT - HEAD & NECK SURGERY, P.A.

www.TallyENT.com



Patient Name: _____ **DOB:** _____

Please be advised there are times when our providers need to perform an in-office procedure to correctly diagnose and treat problems. **Procedures performed in our office are not included in the standard visit but are in the best interest of patient care.** Procedures will be billed separately and will be in addition to a regular office visit charge.

Insurance carriers classify these procedures as “surgery” and apply the charges to your surgical deductible, copayment, and/or co-insurance amount.

We are providing this information to notify you in advance so you are not surprised when you receive your explanation of benefits from your insurance and it states a “surgical procedure” was performed.

There may be a difference in the estimated amount collected at check-out after your visit and the amount your insurance determines is patient responsibility.

Amounts collected at the time of service are simply an estimate. The final balance will not be known until after review by your insurance company.

Examples of procedures include, but are not limited to, the following:

Fiberoptic laryngoscopy (Scope of Throat): A long, thin, fiberoptic scope (either rigid or flexible) will be passed through the nasal cavity or into the throat. The fiberoptic scope enables the physician to visualize areas of the throat not readily seen using any other means.

Nasal endoscopy (Scope of Nose): A scope attached to a light source will be used to view areas of the nasal cavities that cannot be viewed by the physician using the standard nasal speculum or visual inspection.

Tympanogram: This is an examination used to test the condition of the middle ear and mobility of the eardrum (tympanic membrane) and the conduction bones by creating variations of the air pressure in the ear canal.

Other procedures: Ear cleanings, hearing tests, CT scans and ultrasounds

When recommended, the above procedures are necessary to properly diagnose and treat your medical condition, and if not performed, may limit our ability to provide an appropriate treatment or surgical solution.

If you have additional questions, please feel free to speak to our staff and/or contact your insurance carrier for more information.

By signing below, I acknowledge that in-office procedures are separate from the office visit and understand that I am responsible for any balance that my insurance company applies to the deductible/copay/coinsurance according to my individual policy.

Patient/Guardian Signature: _____ Date: _____