# NATIONAL DIZZY & BALANCE CENTER
# PATIENT CONSENT FORM

**TO OUR PATIENTS:** Please read and sign the form below. Ask questions if you do not understand it. If you have a concern or complaint, please first discuss it with your medical health provider. If your concern remains unresolved, you may submit a written complaint.

**CONSENT FOR TREATMENT:** I consent and authorize my medical health provider to assess and treat me. I understand that my provider is available to explain the purpose of the assessment and treatment, and that I have the right to refuse the recommended treatment. No guarantee or assurance has been made to the results of any treatment.

**RELEASE OF MEDICAL RECORDS FOR MY MEDICAL CARE OR AS REQUIRED BY LAW:** I understand that it is important for my medical health providers to have access to my medical records, which will help them to safely manage my care. I consent to the release of my health records and other information related to my health care services for payment and healthcare operations purposes. I agree that my health care records and other information may be released to Medicare, my insurance company or health maintenance organization, other payers, other providers involved in my care, payer network organizations, including accountable care organizations in which my providers participate, and the contractors and third party administrators of any of these parties.

**NOTE: Records are automatically sent only to your referring provider. To request records be released to any other provider, please complete an Authorization to Release Medical Information.**

**BILL MY INSURANCE / ASSIGNMENT OF BENEFITS:** I request that a "Third Party Payor" pay the bills for my services at National Dizzy & Balance Center.

- I authorize NDBC to send bills for my medical care and treatment to my insurance company, other payor, and/or Medicare or Medicaid for payment, to the extent my insurance company, other payor, and/or Medicare or Medicaid is required to pay the bill under the terms of my insurance policy or by law.
- I request that my insurance company, other payor, and/or Medicare or Medicaid pay NDBC or the providers who are involved in my treatment.
- I consent to the release of my medical records by NDBC to my insurance company, other payor, and/or Medicare or Medicaid (and organizations working on their behalf) if necessary in order for my bills to be paid.
- I agree to pay for any charges not covered by any third party payor.
- Worker's Compensation Claims – Any bills associated with Worker's Compensation visits will be sent to the appropriate Worker's Compensation insurance company for reimbursement. I agree that my insurance can be billed if the claim is not payable by Worker's Compensation.
- I understand that NDBC may assess a 1.5% finance charge (18% annual percentage rate) to any patient account balance not paid within 91 days.
- **I understand that if I do not provide accurate insurance information, a bill will be sent directly to me for payment.**

**NDBC PRIVACY PRACTICES:** I understand that a copy of National Dizzy & Balance Center's Privacy Policy is available at my request. If I would like a copy in the future, I will ask for one. I also understand that a copy of NDBC's Privacy Policy is posted in the reception area. I understand that I have the right to revoke this consent, in writing, at any time, except where NDBC has already made disclosures in reliance on this consent. NDBC is not required to agree to all restrictions I may request. I understand that by refusing to sign this consent, or revoking this consent, this facility may refuse to evaluate and treat me as permitted by Section 164.506 of the Code of Federal Regulations. National Dizzy & Balance Center reserves the right to change its notice and privacy practices, in accordance with Section 164.520 of the Code of Federal Regulations.

**BY SIGNING BELOW, I AGREE TO THE ABOVE STATEMENTS.**

Signature of Patient/Authorized Representative _____ Date _____

Printed Name: _____ Patient Date of Birth: _____

If Authorized Representative, Relationship to Patient: _____


Revised 07/07/2014