JANNING CENTER
EAR NOSE & THROAT

PATIENT NAME: _____

Consent for Treatment, Payment, and Healthcare Operations

I authorize Janning ENT Center, LLC, to use and disclose my protected health information (PHI), or the PHI of my minor child for whom I am legally authorized to provide consent, as necessary for treatment, payment, and healthcare operations.

These activities may include:

- **Treatment:** Providing, coordinating, or managing my healthcare or the healthcare of my minor child.
- **Payment:** Billing insurance companies and processing payments for healthcare services.
- **Healthcare Operations:** Activities such as quality improvement, reviewing patient care, and managing the practice.

I understand that my protected health information includes personal, demographic, and medical information related to my past, present, or future physical or mental health, treatment, or payment for healthcare services that identifies me or could reasonably be used to identify me.

I understand that I may request restrictions on how my health information is used or disclosed. Janning ENT Center, LLC, is not required to agree to every requested restriction. If the practice agrees to a restriction, it will follow that restriction as required by law.

I understand that I may revoke this consent in writing at any time. Revocation will not affect actions already taken in reliance on my consent before the revocation was received.

By signing below, I acknowledge that I have read and understand this consent and authorize the use and disclosure of my protected health information as described above, subject to applicable federal and Minnesota law.

Patient Name: _____

Parent/Legal Guardian Name (if applicable): _____

Relationship to Patient: _____

Patient or Parent/Legal Guardian Signature: _____

Date: _____

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Patient Financial Responsibility and Consent

Co-Payments

All co-payments required by your insurance plan are due **at the time of service**. Depending on your insurance coverage and the services provided, multiple co-payments may be required during your appointment.

Deductibles

A deductible is the amount you are responsible for paying before your insurance company begins covering certain services. An office visit with one of our providers includes a face-to-face consultation and evaluation. A co-payment may be required for the office visit. Additionally, some services and all procedures performed in the office may be subject to your insurance deductible before benefits are paid. If you have not met your deductible, you may be responsible for all or part of the cost of the services provided, depending on the terms of your insurance plan. Some in-office procedures may be classified by your insurance company in the same manner as surgical procedures and may be subject to your deductible and other applicable cost-sharing requirements. When a patient has an unmet deductible, the organization requests payment at the time of service equal to 50% of the estimated cost of the scheduled services. The amount collected will be based on available insurance eligibility and benefit information and represents an estimate of the patient's financial responsibility. Patients will be informed that the final amount owed may vary based on insurance processing and claim adjudication.

Diagnostic Procedure Consent

Your office visit may include a diagnostic procedure involving the insertion of a scope into your nose or throat. Your insurance company may classify this procedure as an invasive or surgical procedure for billing purposes. Depending on the terms of your insurance policy, your insurance company may cover all, part, or none of the cost of this procedure. You are responsible for understanding your insurance coverage and any applicable limitations before the procedure is performed. Any charges not covered by your insurance company will be your responsibility. You have the right to refuse the diagnostic procedure.

AI-Assisted Visit Consent

Janning ENT Center, LLC, may use artificial intelligence (AI) to assist with documenting and summarizing information discussed during my visit. I understand that my healthcare provider will review AI-assisted documentation for accuracy and remains responsible for my care. My health information will be handled in accordance with applicable privacy laws. I understand that I may decline or withdraw my consent to the use of AI without affecting my ability to receive care

Electronic Communications

I consent to receive electronic communications from Janning ENT Center, LLC, regarding my healthcare services. These communications may include appointment reminders, scheduling notifications, billing statements, payment reminders, and other relevant patient communications, including promotional campaigns. Communications may be sent via email, text message, or other approved electronic methods.

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Insurance Coverage and Eligibility

I understand that my insurance eligibility and benefits may not be verified at the time of my appointment. I choose to receive medical services from Dr. Janning, Dr. Mellema, Kara De Groot, NP-C, or Bethany Stevermer, PA. I understand that verification of my insurance eligibility or benefits does not guarantee payment by my insurance company, even if I am eligible for benefits on the date of service. If it is determined that I am not eligible for coverage or that the services provided are not covered by my insurance plan, I understand that I will be responsible for payment of all applicable charges. I understand that I am responsible for providing accurate and current information for all primary and secondary insurance coverage at the time of my visit.

Guarantee of Payment for Services & Assignment of Benefits

I authorize my insurance benefits to be paid directly to the physician. I understand that I am responsible for all charges not covered by my insurance. I also authorize the release of necessary medical information to process insurance claims and obtain payment. I understand that I am financially responsible for all charges incurred, including office visits, procedures, co-payments, and deductibles, whether or not my insurance pays. An annual finance charge of 8% may be applied to unpaid balances, as permitted by law. If my account is sent to collections, I will be responsible for collection costs, including attorney's fees and court costs, as permitted by law. I authorize the release of information necessary to obtain payment and collect outstanding balances, as permitted by law.If payment arrangements have not been made after four monthly billing statements, I authorize Janning ENT Center, LLC, to charge my credit card for the outstanding balance, subject to applicable law and credit card authorization requirements.

Referral Waiver

I understand that if my insurance requires a referral for my visit, I am responsible for obtaining it from my primary care physician before my appointment. If the required referral is not received by the day of my appointment, I understand that I may be responsible for the cost of all services provided during that visit, subject to my insurance plan and applicable requirements.

By signing below, I acknowledge that I have read and understand the financial responsibilities and insurance coverage terms outlined above.

Patient Name: _____

Parent/Legal Guardian Name (if applicable): _____

Relationship to Patient: _____

Patient or Parent/Legal Guardian Signature: _____

Date: _____

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No-Show and Appointment Cancellation Policy

We schedule appointments to ensure each patient receives the appropriate time and attention from our physicians and staff. We ask you to arrive on time and keep your scheduled appointments.

As a courtesy, Janning ENT Center sends appointment reminder messages in advance of your scheduled visit.

If you are unable to make your appointment, please contact our office as soon as possible to cancel or reschedule. We ask that you provide at least **24 hours' notice** so we can offer the appointment to another patient.

Appointments canceled or rescheduled for less than 24 hours' notice, or missed without notice, may result in a **$50 no-show fee**. This fee is not covered by insurance and will be billed directly to you. This fee must be paid prior to scheduling another appointment.

After two consecutive missed appointments, Janning ENT Center may consider ending the patient-provider relationship, consistent with applicable laws and professional guidelines.

Patient Name: _____

Parent/Legal Guardian Name (if applicable): _____

Relationship to Patient: _____

Patient or Parent/Legal Guardian Signature: _____

Date: _____