Total Care ENT

Name: _____ Date: _____

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I consent to the use or disclosure of my protected health information by ***Total Care ENT, Inc.*** for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bills or to conduct healthcare operation of ***Total Care ENT, Inc.*** I understand that diagnosis or treatment of me by: ***Robert S. Pema, D.0.*** may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. ***Total Care ENT, Inc.*** is not required to agree to the restrictions that I may request. However, if ***Total Care ENT, Inc.*** agrees to a restriction that I request, the restriction is binding on ***Total Care ENT, Inc.*** and ***Robert S. Pema, D.O.***

I have the right to revoke this consent, in writing, at any time, except to the extent that ***Total Care ENT***, Inc. has taken action in reliance to this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a healthcare clearinghouse.

This protected health insurance relates to my past, present or future physical or mental health or condition and identifies me or there is a responsible basis to believe the information may identify me.

I understand I have a right to review ***Total Care ENT, Inc.*** Notice of Privacy Practice prior to signing this document. The ***Total Care ENT***, Inc. Notice of Privacy Practices is available to me in the waiting area. The Notice of Privacy Practices describes the types of uses and disclosure of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operation of the ***Total Care ENT***, Inc. The Notice of Privacy Practices of ***Total Care ENT, Inc.*** is also provided in the waiting room. This notice of Privacy Practices also describes my right and the ***Total Care ENT, Inc.*** duties with the respect to my protected health information.

Total Care ENT, Inc. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised note of privacy practices by assessing ***Total Care ENT, Inc.***, by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

I have read this and I do not feel it is necessary to include a complete copy of the Notice of Privacy Practices in my chart when I can review a copy in the waiting room and I can request a copy.

Signature of Patient or Personal
Representative: _____ Date: _____

Total Care ENT
4488 West Broad Street • Suite 3
Columbus, OH 43228

P: 614-853-1950
F: 614-853-1951
totalcareent.com