Richard D. Orgill, MD ENT
Ear, Nose, and Throat Specialist

NORTH LOCATION:
10958 N May Ave
Oklahoma City, OK 73120

SOUTH LOCATION:
1601 SW 89th St Ste C500
Oklahoma City, OK 73159

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize Richard D. Orgill, MD, PC to disclose my protected health information as described below to:

Name and relationship to recipient(s):_____

I understand that:

1) THIS AUTHORIZATION IS VOLUNTARY AND I MAY REFUSE TO SIGN THIS AUTHORIZATION WITHOUT AFFECTING MY HEALTH CARE OR THE PAYMENT FOR MY HEALTH CARE

2) I have the right to request a copy of this form after I sign it as well as inspect or copy any information to be used and/or disclosed under this authorization (if allowed by state and federal law. See 45 CFR 164.524)

3). I may revoke this authorization at any time by notifying the office of Richard D. Orgill MD in writing as set forth in the Notice of Privacy Practices. However, it will not affect any actions taken before the revocation was received or actions taken in reliance Theron, or if the authorization was obtained as a condition of obtaining insurance coverage and other applicable law provides the insurer with the right to contest a claim under the policy.

4). Richard D. Orgill MD PC agrees to maintain the confidentiality of my protected health information, however if the person or organization authorized to receive the information is not a health plan, health care clearinghouse or health care provider, fewer law (HIPAA) requires me to be advised that information used or disclosed pursuant to this authorization my be subject to re-disclosure and may no longer be protected by HIPAA rules.

Information to be disclosed:
( ) Entire Medical Record. ( ) Office Chart Notes ( ) Billing Statements. ( ) Laboratory Reports ( ) Radiology Reports
( ) Other _____

_____ _____
Signature of Patient or Legal Representative. (If applicable) Date

_____. _____
Printed Name of Patient or Legal Representative (if applicable) Date

OFFICE POLICIES

APPOINTMENTS AND NO-SHOW POLICY

We make every attempt to schedule patients at the earliest possible availability. Should you need to cancel or reschedule, it is very important you give us at least 24-hour advance notice so that we can offer the appointment to another patient. In an event you are running late, please contact our office. If you are more than 15 minutes late to your scheduled appointment, you may be asked to reschedule. Many of our patients have complex diagnostic problems - although our staff tries to stay on schedule, a patient's condition may require additional time which may create delays in our schedule. We do ask for your patience and understanding in these instances.

We have a “no show” policy in which if a patient does not give the required 24-hour notice to change or cancel an appointment they will be charged a $50 “no show” fee. Patients with multiple cancellations or missed appointments may be discharged from our practice.

Any applicable “no show” fee is billed directly to the patient or the credit card on file will be charged. This charge is not reimbursable by your insurance and must be paid prior to rescheduling the appointment and/or surgical procedure at the discretion of the provider.

FINANCIAL POLICY

All patients are responsible for payment at the time of service. We do accept Cash, Checks, MasterCard, Visa, Discover and AMEX. There will be a $30.00 charge for all returned checks and a $25.00 charge for all debit/credit card chargebacks.

The office of Richard D. Orgill MD PC is a contracted provider with many insurance plans and may accept assignment of benefits. As a courtesy, we will file all claims, including secondary insurance, to the plans with which we participate. Please inform us of any special requirements in your plan. You are responsible to provide us with the correct insurance information at the time of your visit. If your insurance changes, notify our office immediately. Failure to provide the correct insurance information at the time of your visit may result in your having to pay the full cost of the visit or surgery if your insurance denies your claim.

You are responsible to pay for any co-payments, estimated deductibles, and past due balances at the time of each visit. If you have not yet met your yearly deductible, and/or you have a high deductible plan, you will, at the time of your visit, be responsible to pay the estimated cost of your visit at the time of service. If your plan specifies a co-payment amount for a specialist, you will be responsible for that amount. If you are having surgery, you will be notified of the estimated co-insurance prior to that surgery and in order for you to be scheduled, you will be responsible to pay that estimated amount for surgery. After your insurance reconciles your visit through your explanation of benefits, you will be billed for any remaining amount beyond what was collected at the time of visit per our office policy. All outstanding balances, copays, and estimated cost of your visit must be paid at the time of your service. In the case that your insurance company reimburses our office above what you have paid, we will refund that amount upon receipt of the insurance overage payment. You are required to pay the deductible or co-insurance amounts designated by your insurance company. If your insurance denies your claim, you are held financially responsible.

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In the event your health plan determines a service to be “not covered” or missing authorization and/or coordination of benefits, you will be responsible for the total charge. We encourage our patients to understand their policy and to contact their insurance company for clarification of benefits prior to services being rendered. You must inform the office of all insurance changes, authorization and/or referral requirements, e-mail changes, phone number changes, and address changes. In the event the office is not informed before care is rendered, you will be responsible for any denied charges.

Patients outstanding balances must sign a credit card on file agreement and make payment arrangements prior to being seen and future appointments being made. Patients who have questions about their bills or would like to discuss a payment plan option may contact our billing office at (405) 676-9300. Recent changes in healthcare markets and payment processes have altered insurance coverages to shift more of the cost of care to our patients and as such, we require that previous balances, copays, and estimated costs for visits are paid at the time of service in order to protect our patients from incurring further financial burden. As a service to our patients, you can securely keep a credit card on file.

In cases of divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those charges. If the divorce decree requires the other parent to pay all or part of the costs, it is the authorizing parent’s responsibility to collect from the other parent.

NON-VISIT RELATED FORMS

We charge $25 per non-visit related form to be completed, and without exception the money must be prepaid at the time the form is left with our office. FMLA forms are charged at $40 per form, and again, we require this to be prepaid at the time the form is left with our office. We require 5 business days to complete the forms. Patients may come by to retrieve their form, or they may provide our office with a stamped, self-addressed envelope and it will be forwarded as indicated.

_____(Initials) I have signed the Patient Authorization for Use and Disclosure of Protected Health Information from the office of Richard D. Orgill MD PC.

_____(Initials) I have received the office and financial policies from the office of Richard D. Orgill MD PC.

_____(Initials) I have received the Appointments and No-Show Policy and agree to its terms.

_____(Initials) I understand any co-payments, including payments towards co-insurance or deductibles, as outlined in our financial policy, are due at the time of service as specified by these terms.

_____(Initials) With my consent, the office of Richard D. Orgill MD PC may e-mail or text any items that assist in the practice carrying out treatment, payment and healthcare operations, such as appointment reminder cards, correspondences, and billing statements.

By signing below, I acknowledge, with my initials above, I have received, read, and understand the office and financial policies, and I agree to be bound by its terms. I understand and agree such terms may be amended in the future by the practice.

_____ _____

Signature of Patient or Legal Representative (If applicable) Date