James L. Masdon, M.D.
Board Certified
Hannah Nixon, Au.D., Doctor of Audiology

WELCOME TO MASDON ENT!

We are thankful that you have chosen us to provide you with Ear, Nose, and Throat care. Please CAREFULLY read the following office policies, **initial**, **sign**, and **date**. If you would like a copy, please ask. Thank you!

(INITIAL)___________ We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may give your health plan information about you so that they will pay for your treatment.

(INITIAL)___________ Payment for all copays, deductibles, and non-covered services, etc. is due at the time of service. Patients who are uninsured are expected to pay the balance in full at each visit. For your convenience, we accept cash, checks, VISA, MasterCard, and Discover. (If check is returned there will be a $30.00 processing fee.)

(INITIAL)___________ I understand that a copay up-front for an office visit may not cover additional testing deemed necessary during my visit, and that I may owe additional copay/coinsurance amounts that I will be asked to pay prior to leaving the office.

(INITIAL)___________ ANY & ALL NON COVERED CHARGES will be the patient's responsibility. If patient is a minor, the parent or legal guardian will be responsible for payment. This includes office & surgery charges.

(INITIAL)___________ PAST DUE ACCOUNTS – Any patient with a financial past due account may be denied a future appointment until balance is paid in full.

(INITIAL)___________ NO SHOWS – Patients that no show for their appointment three times or more may be discharged from the practice.

(INITIAL) ___________ I give Dr. Masdon and his staff permission to take photos necessary for medical, surgical, or insurance purposes.

(INITIAL)___________ I understand that I should not drive or operate any heavy machinery while taking any narcotic/anxiety prescriptions that are given to me by Dr. Masdon. I also agree, for quality care, that Dr. Masdon may obtain my medication history.

I HAVE READ AND AGREE TO THE ABOVE GUIDELINES. I UNDERSTAND THAT NONCOMPLIANCE IS GROUNDS FOR DISMISSAL. I UNDERSTAND THAT MASDON ENT MAY, AT ITS DISCRETION, CHANGE THE TERMS AND CONDITIONS OF THIS NOTICE.

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PATIENT'S NAME (PLEASE PRINT) **PATIENT'S DATE OF BIRTH**

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SIGNATURE **TODAY'S DATE**