

Surgery Rescheduling, Cancellation Fee or Delinquent Accounts Service Charge

There will be a \$150.00 Surgery Rescheduling or Cancellation Fee charged for any scheduled surgery rescheduled or cancelled by patient due to any reason other than death in the family that can be verified or a medical condition that is documented and verified by note from the physician.

Self-Referral Disclosure Notice:

The physicians of ENT Associates are all, along with numerous other surgeons in Bloomington minority owners (2-5%) in the Southern Indiana Surgery Center. The Southern Indiana Surgery Center is a joint venture between local surgeons and Bloomington Hospital (50% owner). This is to notify you that our physicians do have an ownership interest in the facility and refer the vast majority of our patients in need of outpatient surgical procedures to this facility. We are happy to honor request for surgery to be done at a facility in which we do not have a financial interest (i.e. Bloomington Hospital, or other locations based on the individual surgeon's hospital privileges). Please let our surgery scheduling department know of your preferences regarding the location at the time that you are scheduled for your surgery.

The physicians of IU Health/ENT own a CT Scan machine within our office. This is to notify you that our physicians do have an ownership interest in this machine and refer the vast majority of our patients in need of a CT Scan within our own facility. We are obligated to inform our patients that you have other locations for this testing to be done, including Bloomington Hospital, SIRA, IMA and Monroe Hospital. We have no control over the price, interpretation or excessive radiation exposure you may receive at these other locations. Please inform our staff if you wish to do your testing at another facility.

The physicians of ENT sell Hearing Aids within our office. This is to notify you that our physicians do have an ownership interest in this service and refer the majority of our patients to our Audiology Department. We are obligated to inform our patients that you have other locations for this service. Please inform our staff if you wish to do this service at another facility.

Signature:

I have reviewed this consent form and give my permission to IU Health/ENT to disclose my health information in accordance with it. I acknowledge responsibility for payment for medical service rendered on my behalf or my dependent. If for any reason the account should become delinquent, I agree to pay for all collection and legal fees.

Signature of Patient or Patient Representative

Date