IMPORTANT NOTICE REGARDING
USE OF ENDOSCOPE

Dr LeLiever and Dr Lin feel that a patient presenting to our office with sinus, allergy, throat or voice complaints require a thorough examination of that specific area. In some cases, this can only be accomplished through the use of an endoscope. This examination is essentially painless, and in many cases, can be accomplished quickly. A procedural fee will be submitted to your insurance carrier for this procedure. In most cases we will accept your insurance company's allowance for this procedure. You will be obligated to pay only any deductible and/or copayments that are applied to this claim. (Please note, some insurance companies may list this diagnostic procedure as "surgery" on the insurance remittance advice you receive.)

These procedures have almost no risk and provide your physician with an excellent view of the areas involved. Please sign below to acknowledge that you have read the above and agree to undergo this procedure if needed.

IMPORTANT NOTICE REGARDING
DIAGNOSTIC TESTING

Our doctors frequently order medically necessary tests that are performed outside of our office. This includes lab tests, allergy testing, CT's, MRI's, ultrasounds, etc. It is the **patient's** responsibility to make sure these services are covered by their insurance company. You can obtain this information by calling the phone number located on your insurance card. At the time of your call, you may want to check benefits for this test(s) to see if you must meet a deductible, have a copayment, etc.

Our staff will obtain precertification if it is required by your insurance company. You will be notified prior to your appointment if there is a problem with the precertification.

CANCELLATION POLICY: I understand that if I do not call 24 hours in advance to cancel a scheduled appointment, my account will be charged a $75 NO SHOW fee. This fee will have to be paid prior to scheduling another appointment with our office.

I have read and acknowledge CCENT's Notice of Privacy Practices.

I authorize CCENT to release information including the diagnosis and records of any treatments or examinations rendered to me or my child to my insurance company as necessary to carry out treatment, payment and healthcare operations. I also authorize and request my insurance company to make payment of any medical benefits directly to the CCENT.

I have read and agree to abide by the above and give my consent for treatment.

Patient/Parent/Guardian Signature:_____ Date _____