SACRAMENTO
EAR | NOSE | THROAT

Patient Information

Please print neatly and fill out every item as accurately as possible. Ask a staff member if you require assistance in filling out this form.

Name: _____
First Middle Last

Date of Birth: _____ ☐ Male ☐ Female
mm/dd/yyyy

Artificial Intelligence (AI) Consent

We are employing technology that uses artificial intelligence to assist us during your encounter(s). This is provided by a third-party service that temporarily records the visit and generates a clinical note based on your conversation for the provider to review and sign.

Your privacy is our utmost priority. We have appropriate agreements in place with all service provider(s) to ensure the confidentiality and security of your protected health information, and the technology adheres to applicable regulations such as HIPAA. All documentation is reviewed, edited, and approved by your provider to ensure the accuracy and completeness of your medical record.

If you choose not to participate in the audio recording, you will still receive treatment. You may also choose to start and/or stop the recording at any time during the visit.

Do you consent to recording the audio of your visit and the use of this technology? Yes _____ No _____

Medicare/Medi-Cal Lifetime Signature on File:

I request that payment of authorized Medicare/Medi-Cal benefits be made on my behalf to Sacramento Ear, Nose & Throat Surgical and Medical Group, Inc., for any services furnished me by the physician. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information to determine these benefits payable for related services.

Private Insurance Authorization for Assignment of Benefits/Information Release:

I, the undersigned, authorize payment of medical benefits to Sacramento Ear, Nose & Throat Surgical and Medical Group, Inc., for any services furnished me by the physician. I understand that my agreement with my insurance company is a separate agreement between myself and my insurance company and that I am financially responsible for any amount not covered by my contract. I also authorize you to release my insurance company, or their agent, information concerning health care advice, treatment or supplies provided to the patient. This information will be used for the purpose of evaluating and administering claims of benefits.

As part of your visit you may have additional services performed to enable a thorough assessment. Additional services during your visit will result in additional charges for those procedures. By signing below you confirm that you have read and understand this statement.

_____ _____
Signature Date

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Notice of Acknowledgement
Advance Directive

Name: _____
First Middle Last

Date of Birth: _____
mm/dd/yyyy

An advanced directive is a legal document allowing a person to give directions about future medical care or to designate another person(s) to make medical decisions if he or she should lose decision making capacity. Advance Directives are the following written instruments: The Living Will and The Durable Power of Attorney for Health Care. The instrument may be revoked and a notation of the date and time must be made to the patient's medical record.

Do you have an Advance Directive?

A. Directive to Physicians (Living Will) Yes _____ No _____

B. Durable Power of Attorney for Health Care Yes _____ No _____

Is it up to date? Yes _____ No _____

Where is a copy located? _____

Principal Agent: _____

Address: _____

Phone #: _____

_____ _____
Signature of Patient or Representative Date

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Appointment Cancellation No Show Policy

Thank you for trusting your medical care to Sacramento Ear, Nose and Throat and The Allergy Center. When you schedule an appointment with use we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment please contact our office as soon as possible. This gives us time to schedule other patients who may be waiting for an appointment. Please see our Appointment Cancellation/No Show policy below:

Office Visits

Effective March 1, 2025, any patient who fails to show or cancels/reschedules an appointment less than **48 hours prior** to the appointment will be considered a No Show or in violation of our Cancellation Policy.

Upon the first No Show or violation of our Cancellation Policy, a $50 fee will be charged to the patient (we do not bill the insurance) (the fee does not apply to Medi-Cal patients) and will need to be paid **prior to** rescheduling.

Upon a second No Show or violation of our Cancellation Policy, if an established patient, the patient may be **dismissed** from the practice. If a new patient, the referral will be **redirected back to the PCP/referring doctor for a referral to another ENT/Allergy practice.**

Surgery

If a patient scheduled for surgery fails to show, cancels or reschedules their surgery less than **1 week prior** to the scheduled surgery, the patient will be charged $100 to be paid prior to rescheduling the surgery.

I have read and understand the Appointment Cancellation/No Show policy and agree to its terms.

Signature (Patient/Parent/Legal Guardian)	Patient Name (if minor)/Relationship to patient
Print Name	Date

Sacramento Ear, Nose & Throat Surgical Medical Group, Inc., and S.E.N.T. Hearing Aid Center (Collectively "SacENT") recognizes and respects the fact that all patients have the right to inspect and obtain a copy of their own record containing their Protected Health Information ("PHI"). I understand I have the right to review SacENT's Notice of Privacy Practices prior to signing this form. SacENT reserves the right to revise its Notice of Privacy Practices at any time.

Consent:

With this consent, SacENT may use and disclose any PHI about myself (or my child) to carry out treatment, payment (including collection of payments), and healthcare operations. Please refer to SacENT's Notice of Privacy Practices for a more complete description of such uses and disclosures.

With my consent, this office may mail to my home or other designated location or leave a message on voicemail or in person in reference to any items that assist the practice in carrying out treatment, payment or other healthcare operations, such as appointment reminders, insurance items, payment items, and any other information regarding my (or my child's) healthcare as long as they are marked "Personal and Confidential". With my consent, SacENT may e-mail any information regarding my (or my child's) health care, treatment, payment and appointments to me.

For informational purposes only, a link to the federal Centers for Medicare and Medicaid Services (CMS) Open Payments web page is provided here. The federal Physician Payments Sunshine Act requires that detailed information about payment and other payments of value worth over ten dollars ($10) from manufacturers of drugs, medical devices, and biologics to physicians and teaching hospitals be made available to the public at **https://openpaymentsdata.cms.gov**.

Notice to Patients:

Medical doctors are licensed and regulated by the Medical Board of California. To check up on a license or to file a complaint go to **www.mbc.ca.gov**, email: **licensecheck@mbc.ca.gov**, or call **(800) 633-2322**.

I understand I have the right to request that SacENT restricts how it uses and discloses my health care information to carry out treatment and payment. SacENT is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing below, I acknowledge receiving the above information.

That SacENT may also disclose, in it professional judgement, my health care information to such persons directly involved with my health care or payment thereof:

Authorized Persons:

First Name	Last Name	Phone Number	Relationship

I have read and received a copy of the Notification Privacy Practices.

Patient's Name _____ Patient's Date of Birth _____

Signature of Patient/Parent or Legal Guardian _____ Date _____

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Healthcare Communications Authorization Form

Please indicate below your preferred communication method(s) for _____
Patient Name

Text Message

By signing below, I authorize Sacramento Ear, Nose & Throat and The Allergy Center to send appointment reminders and other healthcare communications electronically via text message to my mobile phone. I understand this service is free of charge. However, standard text messaging rates from my mobile carrier may apply. Message frequency may vary depending on your interaction with us.

You can opt out at any time by replying STOP. For assistance, reply HELP. Your consent is not a condition of receiving care or services. View our Privacy Policy: https://sacent.com/policies.

Please activate text message communication for the following mobile phone number:

_____ _____
Mobile # Mobile Carrier

Email

By signing below, I authorize Sacramento Ear, Nose & Throat and The Allergy Center to send

appointment reminders and other healthcare communications electronically via email to the following email address:

_____
Email Address (Please print clearly)

Voice Message

By signing below, I authorize Sacramento Ear, Nose & Throat and The Allergy Center to contact me for appointment reminders and other healthcare communications via phone and voice message at the numbers provided upon registration. If I am unavailable to answer the telephone, I give Sacramento Ear, Nose & Throat and The Allergy Center permission to leave a message on my voice mail, answering machine or with the person answering the telephone. By providing additional telephone number(s) below, I give permission for same communications and permissions at this/these number(s).

_____ Please circle: Work Home Cell
Telephone #

_____ Please circle: Work Home Cell
Telephone #

_____ _____
Patient Signature Date

Or

_____ _____
Parent or Legal Guardian Signature Date