Ottawa Shores E.N.T. Associates, P.C.
1445 Sheldon, Suite 304 Grand Haven, MI 49417
616-935-6966 phone 616-935-6967 fax

Consent to Treat & Financial Responsibility

Date________________________

I (acting for myself or on behalf of ___________________________ (Birthdate) ___________) consent and authorize Ottawa Shores E.N.T. Associates, P.C. and/or Mark D. Wilson, M.D. to administer such medical care as they deem appropriate (consent).

I understand that:

- Absent emergency or extraordinary circumstances, no substantial procedures are performed unless there is a discussion of the treatment with the physician or other health care professional.
- Each patient or appropriate patient representative has the right to refuse consent for treatment.

____
Signature of Patient or
Responsible Party

I understand that I am responsible for the terms and conditions of my individual insurance plan. Due to the vast number of different insurance policies Ottawa Shores E.N.T. Associates, P.C. personnel will try to stay within my managed care guidelines, but suggest that I verify referral information and coverage with my carrier prior to any continued treatment.

I authorize my insurance benefits be paid directly to Ottawa Shores E.N.T. Associates, P.C.

I authorize Ottawa Shores E.N.T. Associates, P.C. to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim.

I have read, understand, and agree to the above Financial Policy. I understand that charges not covered by my insurance company, as well as applicable co-payments and deductibles, are my responsibility.

__________ ______________________________ _______________________
Date Signature Printed Name

(The following does not apply to patient's with health care insurance.)

I have no health care insurance and I understand that I am personally responsible for any medical services rendered by Ottawa Shores E.N.T. Associates, P.C.

____Signature of Patient or Responsible Party