AMENDED

Acknowledgements And Permissions Form

Robert J. Sciacca, M.D.
J. Christopher Davis, M.D.

4515 Southlake Parkway _ Suite 300 _ Hoover, AL 35244 _ Phone: 205.985.7393 _ Fax: 205.987.1332

SECTION I—Acknowledgement of Receipt of *Notice of Privacy Practices*

Alabama ENT reserves the right to modify the privacy practices outlined in *The Notice of Privacy Practices*.

I have previously received a copy of the ***Notice of Privacy Practices for Alabama ENT***.

____

Name of Patient *(please print or type using blue or black ink)*

____

Signature of Patient or Patient Representative *(if patient is a minor or unable to sign this form)*. Date

Relationship of Patient Representative to Patient: ______________

SECTION II—Amended Permission to Leave Information

You have requested changes concerning who you wish to receive test results and/or other pertinent medical informaiton. In the event that we cannot reach you by phone, your permission is required to leave this information with a third party or recording device. Please read and complete the following:

______ *(Please initial)* I give Alabama ENT Associates permission to leave their office name and phone number at my home phone number.

______ *(Please initial)* I give Alabama ENT Associates permission to leave their office name and phone number at my work phone number.

______ *(Please initial)* I give Alabama ENT Associates permission to give test results and/or pertinent medical information to: *(please check all for which permission is given)*

- ☐ Spouse ☐ Answering machine/voicemail (home)
- ☐ Parent ☐ Answering machine/voicemail (work)
- ☐ Other:______________________________ Effective Date:________________

SECTION III—Acknowledgement and Acceptance of Cancellation Policies

The policies of Alabama ENT Associates for appointment and surgery cancellations are as follows:

_ Office visits must be cancelled within 24 hours of scheduled appointment time. ***Patient will be liable for a $35.00 scheduling fee*** for cancellations less than 24 hours in advance.

_ Scheduled surgeries must be cancelled 72 hours prior to scheduled surgery time. ***Patient will be liable for a $200.00 scheduling fee*** for cancellations less than 72 hours in advance.

By signing below, I certify that I have read and accept Alabama ENT Associates' Cancellation Policy. I realize that my insurance *will not* compensate me for these fees.

____

Signature of Patient or Patient Representative *(if patient is a minor or unable to sign this form)* Date