

THANK YOU FOR CHOOSING EAR, NOSE & THROAT PLASTIC SURGERY CENTER. IN ORDER TO SERVE YOU PROPERLY WE REQUIRE THE FOLLOWING INFORMATION. ALL INFORMATION RECEIVED IS STRICTLY CONFIDENTIAL. PLEASE PRINT.

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TODAY'S DATE: \_\_\_\_\_

**PATIENT INFORMATION**

PATIENT NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ AGE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_

STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_ SEX: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_

SOCIAL SECURITY NUMBER: \_\_\_\_\_ MARTIAL STATUS: \_\_\_\_\_

CELL PHONE: \_\_\_\_\_ HOME PHONE: \_\_\_\_\_ ALT. PHONE: \_\_\_\_\_

**GUARANTOR INFORMATION (PARTY RESPONSIBLE FOR PAYMENT OF CHARGES)**

GUARANTORS NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_

STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_ SEX: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_

SOCIAL SECURITY NUMBER: \_\_\_\_\_ MARTIAL STATUS: \_\_\_\_\_

CELL PHONE: \_\_\_\_\_ HOME PHONE: \_\_\_\_\_ ALT. PHONE: \_\_\_\_\_

**EMERGENCY CONTACT**

NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_ RELATION: \_\_\_\_\_

**PRIMARY CARE PHYSICIAN**

NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

**INSURANCE INFORMATION**

PRIMARY INSURANCE: \_\_\_\_\_ PHONE: \_\_\_\_\_

SUBSCRIBER: \_\_\_\_\_ ID#: \_\_\_\_\_ GROUP#: \_\_\_\_\_

COPAY AMOUNT: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ SOCIAL SECURITY NUMBER: \_\_\_\_\_

SECONDARY INSURANCE: \_\_\_\_\_ PHONE: \_\_\_\_\_

SUBSCRIBER: \_\_\_\_\_ ID#: \_\_\_\_\_ GROUP#: \_\_\_\_\_

COPAY AMOUNT: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ SOCIAL SECURITY NUMBER: \_\_\_\_\_

OTHER INSURANCE: \_\_\_\_\_ ID#: \_\_\_\_\_

EMAIL: \_\_\_\_\_

PHARMACY: \_\_\_\_\_

Video monitoring is conducted only in areas of our offices, such as but not limited to, entrance and exit doors, lobbies, hallways and other open areas.

Monitoring is not conducted in areas where employees and patients have a right to expect privacy, such as restrooms and treatment rooms. Because we are sensitive to the legitimate privacy rights of our employees and patients, we make every effort to guarantee that all workplace monitoring is always done in an ethical and respectful manner.

**GUARANTORS' SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_**  
(SIGNATURE REQUIRED)

IF THERE IS ANY PROBLEM FILLING OUT THIS FORM, PLEASE ASK FOR ASSISTANCE

Name: \_\_\_\_\_

Date: \_\_\_\_\_

**REASON FOR SEEING DOCTOR:** \_\_\_\_\_

**FAMILY HISTORY:** (Has any blood relative had any of the following diseases?)

	<u>Please circle</u>	<u>Who</u>		<u>Please circle</u>	<u>Who</u>
Cancer	no    yes		High Blood Pressure	no    yes	
Tuberculosis	no    yes		Bleeding Problems	no    yes	
Diabetes	no    yes		Hearing Loss	no    yes	
Heart Trouble	no    yes		Malig. Hyperthermia	no    yes	

**PERSONAL HISTORY:** (Have you ever had any of the following illness?)

Mumps	no    yes	Kidney Disease	no    yes
Chickenpox	no    yes	Liver Failure	no    yes
Scarlet Fever	no    yes	Gonorrhea or Syphilis	no    yes
Pneumonia	no    yes	Jaundice at Birth	no    yes
Heart Attack: When? _____	no    yes	Hepatitis	no    yes
Angina	no    yes	Epilepsy or Seizures	no    yes
Heart Failure	no    yes	Migraine Headaches	no    yes
Stroke	no    yes	Tuberculosis	no    yes
Arthritis	no    yes	Diabetes- How Long? _____	no    yes
Connective Tissue Disease	no    yes	Cancer- of What? _____	no    yes
Neck: Neuritis or Sciatica	no    yes	High Blood Pressure, Medicated	no    yes
Meningitis	no    yes	Nervous Breakdown or Disorder	no    yes
Enlarged Thyroid or Goiter	no    yes	Drug Abuse, Past or Present	no    yes
Bleeding Disorders	no    yes	Asthma	no    yes
Anemia - Chronic or Current	no    yes	Emphysema	no    yes
HIV Infection/Exposure	no    yes	Enlarged Lymph Glands of Neck or Elsewhere	no    yes
Heart Murmur (i.e. mitral valve prolapse)	no    yes		

**ARE YOU CURRENTLY PREGNANT?**                      **Yes    No**

**If you are currently pregnant please verbally tell your physician as this may affect your treatment options.**

**HABITS:**

Alcoholic Beverages: Never \_\_\_\_\_ Barely \_\_\_\_\_ Moderate \_\_\_\_\_ Daily \_\_\_\_\_

Caffeinated Beverages: Never \_\_\_\_\_ Barely \_\_\_\_\_ Moderate \_\_\_\_\_ Daily \_\_\_\_\_

Tobacco: Cigarettes \_\_\_\_\_ packs per day \_\_\_\_\_ number of years: Cigar \_\_\_\_\_ Pipe \_\_\_\_\_ Chewing Tobacco \_\_\_\_\_ Snuff \_\_\_\_\_

Prior Smoker? \_\_\_\_\_ Quit, how long ago? \_\_\_\_\_

Is the environment in which you work loud or noisy?                      no    yes

Have you been exposed to any loud or unusual noises?                      no    yes

Are you exposed to chemicals or have you been?                      no    yes

Have you been in the military service?                      no    yes

**CURRENT MEDICATIONS:** (List all including aspirin, hormones, diet pills, etc)

**ALLERGIES:** (Medications, foods, etc)

**YES or NO (Please list them)**

**SURGERY:**

**YES or NO (List all operations)**

**HOSPITALIZATIONS:** (What illnesses have you been hospitalized for?)

**DO YOU CURRENTLY USE A CPAP MACHINE? YES or NO**

Additional medical problems not noted above:

**GUARANTORS' SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_  
**(SIGNATURE REQUIRED)**

- A. We currently have an enormous number of patients with outstanding balances. Therefore, our accounting department has implemented a 7% monthly interest rate for all account balances not paid within 30 days.
- B. Please note that due to unforeseen circumstances you may not be seen at your scheduled appointment time. This may result in prolonged wait times. We understand that your time is valuable. Please feel free to reschedule your appointment for a later time if you desire to do so.
- C. I understand that I have been given the opportunity to read and/or receive a copy of Ear, Nose & Throat Plastic Surgery Center's privacy practices/ HIPAA rules.
- D. **MEDICAID PATIENTS ONLY:** I understand that Medicaid pays for only 12 office visits per calendar year. I understand that I will be financially responsible for any visits in excess of these 12 visits.
- E. **HEARING AID PATIENTS:** At this time I have not made a decision to purchase hearing aid(s). I have been made aware if any hearing aid(s) orders are placed over the phone, and I cancel the order after it has been placed, there is a minimum \$250 non-refundable deposit fee (per hearing aid).
- F. **EAR, NOSE AND THROAT PLASTIC SURGERY CENTER WILL BILL YOUR SECONDARY INSURANCE CARRIERS FOR YOU IF COMPLETE ACCURATE INFORMATION IS PROVIDED AT THE TIME OF THE INITIAL APPOINTMENT ONLY.**

**SINCE YOUR AGREEMENT WITH YOUR INSURANCE CARRIER IS A PRIVATE MATTER, WE DO NOT ROUTINELY RESEARCH WHY AN INSURANCE CARRIER HAS NOT PAID. IF AN INSURANCE CARRIER HAS NOT PAID WITHIN 60 DAYS OF BILLING, FEES OR ANY BALANCES ARE DUE AND PAYABLE IN FULL BY YOU. WE WILL FURNISH YOU WITH APPROPRIATE PAPERWORK SO THAT YOU MAY THEN SEEK REIMBURSEMENT FROM YOUR CARRIER.**

- G. By signing below I acknowledge and consent to Ear, Nose and Throat Plastic Surgery Center et al, charging a \$1.00 convenience fee for credit card transactions under \$50.00 and charging a \$3.00 convenience for credit card transactions over \$50.00.

**BY SIGNING BELOW I AM STATING THAT I FULLY UNDERSTAND THE ABOVE INFORMATION.**

**Signature of Patient or Guardian: \_\_\_\_\_ Date: \_\_\_\_\_**

## **ACCESS BY INDIVIDUALS TO THEIR PROTECTED HEALTH INFORMATION**

**Effective Date: January 2004**

Access to Your PHI: You have the right to review and copy your PHI we maintain. All requests to access your PHI must be made in writing. The designated privacy officer will respond to your request and tell you when and where you can review your PHI in our possession. Please contact us during our normal business hours and bring a valid government approved form of identification. If you would like a hard copy of the information we have please write to the office or come in to sign a records release with the designated privacy officer. Please allow 30 days. If you are requesting a copy, please note that we will an administrative fee for postage and copying of your PHI to the extent permitted by applicable state law. If your file contains medical records from an outside physician or facility, those files will also be made available but you will incur an additional certification fee. All fees shall be collected in advance or your request may be delayed. If we deny your request for review or copy of your PHI, we will explain it to you in writing. If we do not have your PHI, but know who does, we will tell you whom to contact.

**Please note the following disclaimer, we do not accept responsibility for any errors or mistakes in the medical records received from an outside entity. Should you have any questions or concerns regarding those files, please contact the original entity that provided the care.**

**Signature Of Patient or Guardian: \_\_\_\_\_ Date: \_\_\_\_\_**

## **INFORMATION SHEET**

### **72 HOUR NOTICE IS REQUIRED FOR PROCESSING MEDICAL RECORDS**

#### **THE PATIENT IS RESPONSIBLE FOR:**

- 1. Contacting the PCP and requesting a REFERRAL.**
- 2. Providing the Medical Records Department with the needed information to obtain copies of Medical Records.**
- 3. Authorize release of medical records.**
- 4. Picking up any X-rays, CT scans, MRI's, and any other films.**
- 5. Making sure that the specialist you are being referred to is covered under your Insurance Plan. (You may contact your member services by using the number listed on the back of your Insurance card if you are unsure.)**
- 6. Payment for all services is due at the time of services rendered.**
- 7. Failure to comply with the requested information may cause your appointment to reschedule.**

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

# EAR, NOSE AND THROAT PLASTIC SURGERY CENTER

## FINANCIAL LIABILITY

I understand that I am financially liable for my services that are rendered by Ear, Nose and Throat Plastic Surgery Center. I understand that the office will file my insurance on my behalf. I give permission to Ear, Nose and Throat Plastic Surgery Center to render medical care to me. I understand that even though I have insurance coverage, I will be responsible for any amount of the bill that is not covered by my insurance company. In the event that my condition is a pre-existing condition, I understand that I am financially liable for this bill. I understand that I will follow the protocol set up by my insurance company and will obtain any necessary referrals. If this is not done within the insurance company's guidelines, I understand I will be financially liable for this bill. I understand that I will not be seen without a current valid referral if this is a requirement of my insurance plan. I understand that if I choose to be seen without a required referral I will be considered a self-pay patient. I understand that it is my responsibility to make sure all necessary pre-certifications or prior authorizations are done prior to the services being rendered.

## SELF-PAY AND COSMETIC PATIENTS

You are responsible for payment in full prior to the services being rendered.

## WORKER'S COMPENSATION

You are responsible for assisting us in obtaining authorization from your case manager or adjuster for all services rendered. We will bill your employer or worker's compensation insurance plan. You are only responsible for payment if your claim is controverted.

## MEDICARE PATIENTS

I understand that Medicare will not make a coverage decision unless I receive these services and the claim is submitted to Medicare for them. I understand that you may bill me for services and that, under State law, I might have to pay for services while Medicare is making its decision. If Medicare decides that it will not pay for my services, I will have the right to appeal the decision. If Medicare decides not to pay for the services, Medicare will tell me how to make my appeal. Please note Federal Law requires us to collect your yearly deductible and co-insurance amounts. If you have a secondary insurance we will bill your secondary insurance for any deductible or co-insurance after Medicare pays. Please note your secondary insurance may also have a yearly deductible and co-insurance amount, in this case you will be responsible for that balance. If Medicare denies payment, I agree to be personally and fully responsible for payment.

## AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I authorize Ear, Nose and Throat Plastic Surgery Center to furnish to any source from which I claim benefits in the payment of my medical bill, when needed, such information from any medical record as may be reasonably necessary to establish my claim for benefits. I also authorize Ear, Nose and Throat Plastic Surgery Center to release any information necessary to the physicians, facilities, or hospitals involved in my care. This release shall not be revoked after services have been provided.

## PAY INSURANCE ASSIGNMENT TO BENEFITS

I hereby assign payment directly to Ear, Nose and Throat Plastic Surgery Center of the group benefits herein specified, including any major medical benefits payable and otherwise payable to me. I understand I am financially responsible to Ear, Nose, and Throat Plastic Surgery Center for charges not covered by this authorization.

## CREDIT CARD CONVENIENCE FEE

By signing below I acknowledge and consent to Ear, Nose and Throat Plastic Surgery Center et al, charging a \$1.00 convenience fee for credit card transactions under \$50.00 and charging a \$3.00 convenience for credit card transactions over \$50.00.

**By signing below I understand and agree to the terms as outlined above.**

**Signature of Patient or Guardian: \_\_\_\_\_ Date: \_\_\_\_\_**