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 CONFIDENTAL. **PLEASE PRINT**.

****

TODAY'S DATE: _____

PATIENT INFORMATION

PATIENT NAME: _____ DATE OF BIRTH: _____ AGE: _____

ADDRESS: _____ CITY: _____

STATE: _____ ZIP CODE: _____ SEX: _____ EMPLOYER: _____

SOCIAL SECURITY NUMBER: _____ MARTIAL STATUS: _____

PRIMARY PHONE: _____ 2ND PHONE: _____ 3RD 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: _____

PRIMARY PHONE: _____ 2ND PHONE: _____ 3RD 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: _____

HOW DID YOU HEAR ABOUT US? ☐ **TV COMMERICIAL** ☐ **PHYSICIAN REFERRAL** ☐ **FRIEND**

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?)

	Please circle		Who		Please circle		Who
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		
Heart Murmur (i.e. mitral valve prolapse)	no	yes	or Elsewhere	no	yes

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)

SURGERY: (List all operations)

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

Additional medical problems not noted above:

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. **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.

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 authorization 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.

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

Signature of Patient or Guardian: _____ Date: _____