

PATIENT INFORMATION

What Physician requested this consultation: _____ Office Phone _____

Patient's Primary Care Physician: _____ Office Phone _____

Patient's Full Name _____

Date of Birth ____ / ____ / ____ Age _____ Sex: Male Female **Social Security #** _____ - _____ - _____

Patient's Home Address _____ Apt. # _____

City _____ State _____ Zip Code _____

Home Phone (_____) _____ Work Phone (_____) _____ Cell Phone (_____) _____

Email _____ Patient's Employer _____

Spouse's Full Name _____ Date of Birth ____ / ____ / ____

Spouse's Social Security # _____ - _____ - _____ Spouse's Work Phone (_____) _____

Spouse's Employer _____

Pharmacy Name _____ Pharmacy Phone (_____) _____

Pharmacy Address _____

RESPONSIBLE PARTY

If you are providing the information above for a patient under the age of 18 yrs. old, please complete the section below:

Father/Guardian's Name _____ **SSN** _____ - _____ - _____

DOB ____ / ____ / ____ Phone (_____) _____ Relationship to Patient _____

Address (if different from above) _____

Employer _____ Work Phone (_____) _____

Mother/Guardian's Name _____ **SSN** _____ - _____ - _____

DOB ____ / ____ / ____ Phone (_____) _____ Relationship to Patient _____

Address (if different from above) _____

Employer _____ Work Phone (_____) _____

INSURANCE INFORMATION

Insurance Company _____ Policy Holder ID# _____ Group# _____

Policy Holder Name _____ **DOB** ____ / ____ / ____

Address _____ Phone (_____) _____ Relationship to Patient _____

Co-Pay Amt. \$ _____ Deductible Amt. \$ _____

Secondary Insurance Company _____ Policy Holder ID# _____ Group# _____

Policy Holder Name _____ **DOB** ____ / ____ / ____

Address _____ Phone (_____) _____ Relationship to Patient _____

Co-Pay Amt. \$ _____ Deductible Amt. \$ _____

Is today's visit pertaining to a motor vehicle accident or a workman's comp injury? Yes No

If you answer yes, please fill out the following information:

Insurance Company Name _____

Agent Name/Contact Name _____ Phone (_____) _____

Claims/Billing Address _____

Claim # _____ Date of Accident or Injury? _____

OTHER INFORMATION

Name of Nearest Relative NOT LIVING with the Patient _____

Relation to Patient _____ Home Phone (_____) _____

Relative's Address _____ Apt. # _____

City _____ State _____ Zip Code _____

Relative's Employer _____ Work Phone (_____) _____

PATIENT ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY, NO SHOW & COLLECTION FEES

The following is our “no show” policy: A “no show” is when you do not provide 24 hr cancellation notice for follow up appointments scheduled with the physician or for specialized diagnostic testing with our in-house Audio, Allergy or Clinical departments. Specialized testing includes Auditory Brainstem Response (ABR), Electronystagmography (ENG) and/or Electocochleography (ECoG), Allergy Skin Test, Transnasal Esophagoscopy (TNE), Thyroid Ultrasound (US) or Video Stroboscopy. If you “no show” for your initial appointment we may require a credit card to hold your future rescheduled appointment. As long as you complete your rescheduled appointment there will be no charge to your credit card. If you are a “no show” for your next rescheduled appointment your credit card may be charged a \$25.00 no show fee for a follow up appointment scheduled with the physician or a \$75.00 no show fee for a specialized diagnostic testing appointment.

I understand that if I have not secured appropriate authorizations and otherwise complied with the terms of my health benefit plan, there may be a decrease in my coverage or no coverage at all for some or all of the services which I am about to receive, and that I will be financially responsible for the services not covered.

If we have to refer your account to a collection agency, you agree to pay the past due amount in addition to all collection costs (27% of the balance turned over). If we have to refer collection of the balance to a lawyer, you agree to pay all lawyers’ fees incurred plus all court costs. In case of suit, you agree the venue shall be in Jefferson County, (Louisville, Kentucky).

Advanced ENT and Allergy will charge a \$20 fee for all nonsufficient fund (NSF) checks.

Signature

Date

Printed Name of Patient or Personal Representative

Relationship to Patient

CONSENT FOR USE OR DISCLOSURE OF PATIENT INFORMATION FOR THE PURPOSES OF TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS

I hereby consent to ADVANCED ENT and ALLERGY using or disclosing my protected health information for the purpose of providing treatment to me, obtaining payment for health care services rendered to me or to carry out the Practice’s health care operations. I also consent to ADVANCED ENT and ALLERGY using or disclosing my protected health information for treatment activities provided by another health care provider, as well as the payment activities conducted by another health care provider or entity. I further consent to the disclosure of my protected health information in order for another provider or health care entity to conduct health care operations including quality assessment and reviewing the competence of health care professionals.

Signature

Date

NOTICE OF PRIVACY PRACTICES (HIPAA)

I acknowledge the Practice has provided me a copy of its Notice of Privacy Practices, which provides a detailed description of the uses and disclosures allowed by this consent, as well as other rights I have regarding my protected health information.

Signature

Date

SPECIFIC INFORMATION RELEASE (if applicable)

I specifically authorize release of the following information for the purposes of treatment, payment and health care operations. If it is a part of my protected health information: (INITIAL ANY OR ALL YOU AGREE TO AUTHORIZE FOR RELEASE)

_____ Chemical Dependency/Substance Abuse

_____ Sexually Transmitted Diseases

Signature

Date

IN-OFFICE PROCEDURE ACKNOWLEDGEMENT FORM

I have read and received a copy of the in-office procedure acknowledgement form.

Signature

Date