PATIENT REGISTRATION FORM (PLEASE PRINT)

PATIENT INFORMATION

Referred By: ______________________ Primary Care Physician: ______________________

Patient's Legal Name: ____
Last First MI

Social Security #: ______________________ Date of Birth: ______________ Sex/Race ________

Marital Status: (circle one) Minor Single Married Widow(er) Divorced Separated

Home Address: ____
Street City State Zip

Mailing Address (If Different From Above): ______________________________

Home Phone #: ( )______________________ Work Phone #:( )______________________

Cell Phone #: ( )______________________ Cell Phone Carrier: ______________ Text Mssg Auth________

Email Address: ____

Patient's Occupation: ______________________ Employer:______________________

Pharmacy: ______________________ Pharmacy Phone #: ( ) ______________________

Name of Spouse: ______________________ Spouse's Date of Birth: ______________________

Spouse's Social Security #: ______________________ Spouse's Phone #: ( )______________________

RESPONSIBLE PARTY INFORMATION

Name of Person Responsible for this Account:______________________ Relationship: ______________

Date of Birth: ______________ Social Security #: ______________ Best Phone #:( )______________

Address (If Different From Above):____

INSURANCE INFORMATION

Primary Insurance: ______________________ Policy #: ______________ Group #:______________

Name of Insured: ______________________ Date of Birth: ______________________

Secondary Insurance: ______________________ Policy #: ______________ Group #: ______________

Name of Insured: ______________________ Date of Birth: ______________________

EMERGENCY CONTACT

Name: ______________________ Relationship: ______________ Best Phone #: ( )______________

Authorization & Release

I hereby authorize ENT Bessemer, LLC to release any and all information acquired in my examination and treatment to my insurance carriers and other treatment physicians. **All deductibles, co-payments, and co-insurance are due at the time of service.** If I am covered by Blue Cross, Medicare, and/or Medicaid, I will furnish my insurance card and signature. If I am covered by other insurance, I will furnish the necessary forms to this office. I hereby assign and authorize all payment directly to ENT Bessemer, LLC any medical and surgical benefits otherwise payable to me. Should and insurance payment be received that is less than the physician's usual charge for the services provided, I will be responsible to the difference. I also agree to pay all cost of collection, including but not limited to, reasonable attorney's fees, and waiver all claims of exemption under the law of the state of Alabama. **I acknowledge that all information regarding my identity is correct and accurate to my knowledge. By signing this document I understand that I am held accountable for any false information which could result in a fine or penalty and should notify ENT Bessemer, LLC if any of my information should change or if my identity is compromised or stolen.**

X____ Date: ______________________

Signature of Patient (Or Parent/Guardian if Minor)

Medical History Form

Patient Name:______________________________ Primary Care Doctor: ____________________

Age:____________ Sex: Male / Female Height: __________ Weight: ____________

Please circle yes or no if you use any the following and list if not shown:

*Aspirin or aspirin containing products? (goody's, stanback) Y / N ________________________

* Blood thinning medication (Coumadin etc.) Y / N ______________________________________

*Anti-Inflammatory agents? (motrin, advil, ibuprofen, other) Y / N _________________________

*Decongestant nose sprays? (afrin, Neosynepherin) Y / N ________________________________

*Caffeine? Y / N

*Do you currently smoke? Y / N *Previous smoker? Y / N How long ago? _________

*Do you use smokeless Tobacco? Y / N

*Any significant alcohol or recreational drug use? Y / N

*Are you a diabetic? Y / N ***If yes**, what was your last A1C reading? ___________

*Do you currently take medications? Yes / No If yes, please list below with dosage:

____

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____

____

____

*Do you have any allergies or drug reactions? Y / N If yes, please list below.

____

* Have you had any operations? Y / N If yes, please list below.

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* Do you have any personal history of the following, please circle yes or no:

Free Bleeding: Y / N	Cancer: Y / N	Arthritis: Y / N
Diabetes: Y / N	Stroke: Y / N	Esophageal Reflux: Y / N
High Blood Pressure: Y / N	Heart Disease: Y / N	Thyroid: Y / N
Asthma: Y / N	Seizures: Y / N	Kidneys: Y / N
Emphysema: Y / N	Hepatitis: Y / N	Anesthesia Complications: Y / N
Sleep Apnea Y / N		

Other: ____

*Family history: Please check those that apply

	Mother	Father	Sibling	Grandparent
*Allergies :	______	______	______	______
*High Blood Pressure:	______	______	______	______
*Cancer:	______	______	______	______
*Bleeding Disorders:	______	______	______	______
*Diabetes:	______	______	______	______
*Heart Disease:	______	______	______	______
*Hearing Loss:	______	______	______	______

Do you have a living will? Y / N

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ENT Bessemer LLC Patient Financial Agreement

Thank you for choosing us as your otolaryngologist. We are committed to providing you with quality and affordable health care. We ask all patients to review and sign this policy, asking questions as necessary. A copy will be provided to each patient upon request.

1) Insurance: We accept assignment and participate in most insurance plans. If your insurance is not a plan we participate in, payment in full is expected at each visit. Knowing your insurance benefits is your responsibility. Please contact your insurer with any questions you may have regarding your coverage to receive the maximum benefit.
2) Patient payment: All copayments are to be paid at the time of service. This arrangement is part of your contract with your insurance company.
3) Registration: All patients must complete our patient information form, which will be entered into our computer to maintain accurate information for proper billing. We must obtain a copy of your driver's license and current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information, or your insurance changes and you fail to notify us in a timely manner, you may be responsible for the balance of a claim. Most insurance companies have time filing restrictions; if a claim is not received within 60 days of the date of service, it can be rendered ineligible for payment and you will be responsible for the balance that remains.
4) Claims: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may not accept information from our office and may need information from you. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether your insurance company pays or not. Your insurance benefit is a contract between you and the insurance company; we are not party to that contract.
5) Uninsured patients: We offer a discounted rate to our patients who do not have insurance. Please be advised that the full payment is due prior to seeing the physician.
6) Credit and collection: If your account is more than 90 days past due, you will receive a letter stating that you have 30 days to pay your account in full. Partial payments will only be accepted if the account is in good standing. Please be aware that if a balance has remained unpaid, it will be sent to a collection agency. If an account is sent to collections, it is our policy not to see you for future visits until a payment is made on your account.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

I have read and understand the financial policy and agree to abide by its guidelines.

X ____

Date____________________

ENT Bessemer, LLC

985 Ninth Ave. S.W., Ste. 308
Bessemer, AL 35022
(205) 481-7780

This is an authorization under the Privacy Rules of the Health Insurance Portability and Accountability Act of 1996. It authorizes ENT Bessemer, LLC to disclose and/or discuss my medical records to/with any authorized family members or agents, such as a spouse, family member or friend. This information would include prescription requests, appointment reminders, notification of test results, etc.

Please list all authorized persons

____

____

____

This authorization is valid until

____

Under the Privacy Rules, I have the right to revoke this authorization at any time and ENT Bessemer, LLC, must cease using this authorization. However, ENT Bessemer, LLC may complete any actions it initiated prior to my revocation and which rely on my medical records for completion.

I understand that by disclosing my medical records, ENT Bessemer, LLC cannot guarantee the recipient will use or disclose in violation of Privacy Rules.

I must revoke this authorization in writing and send the revocation to ENT Bessemer, LLC, 985 Ninth Ave. S.W., Ste. 308, Bessemer, AL 35022

Please print name______________________________

Signature ______________________________

Date ______________________________

NOTICE OF PRIVACY PRACTICES

We care about the privacy of your medical information. We are required by law to maintain the privacy of that information and to provide you with this notice of our legal duties and our privacy practices. **Unless you give us a <u>WRITTEN</u> <u>AUTHORIZATION</u>**, we will only disclose your medical information for treatment, payment, or health care operations or when we are otherwise required to do so.

TREATMENT- We may disclose medical information about you to your personal doctor or to other healthcare providers who take care of you. For example, we may notify your personal doctor about treatment you receive in your office. We might use health information about you to manage your health care by suggesting ways to improve your health.

PAYMENT- We may use and disclose information about you so that the medical services you receive can be properly billed and paid for. For example, we may ask a hospital emergency department for details about your treatment before we bill your care.

HEALTH CARE OPERATIONS- We may use and disclose medical information about you for operations. For example, we may use medical information about you to review the quality of medical services you receive.

AUTHORIZATIONS- If you give us WRITTEN AUTHORIZATION to do so, we may use and disclose your medical information. If you give us WRITTEN AUTHORIZATION, you have the right to change your mind and revoke that authorization.

COPIES OF NOTICE- You have the right to receive additional copy of this notice at any time.

CHANGES TO THIS NOTICE- We reserve the right to revise this notice. A revised notice will be effective for medical information we already have about you as well as any information we may receive in the future. We are required by law to comply with whatever Privacy Notice is currently in effect.

YOUR RIGHT TO INSPECT AND COPY- Upon WRITTEN REQUEST, you have the right to inspect the health information we maintain about you and to have copies of that information. An initial copy to a provider's office is provided at no charge, but additional copies will be subject to a charge.

YOUR RIGHT TO AMEND-If you feel that the medical information about you which we have is incorrect or incomplete, you can make a WRITTEN REQUEST for us to amend that information. We can deny your request for certain limited reasons, but we must give you a written basis for our denial.

YOUR RIGHT TO A LIST OF DISCLOSURE- Upon WRITTEN REQUEST, you have the right to receive a list of our disclosures of your medical information, except when you have authorized those disclosures, or if the disclosures were for treatment, or healthcare operations. We are not required to give you a list of disclosure prior to April 14, 2003.

YOUR RIGHT TO REQUEST RESTRICTIONS- Upon WRITTEN REQUEST, you have the right to request restrictions on the medical information we may use or disclose about your. We are not required to agree to such a request.

YOUR RIGTH TO REQUEST CONFIDENTIAL COMMUNICAITONS- You have the right to request that we communicate about your medical matters with you in a certain way or at a certain location. Your request MUST BE IN WRITING. For example, you can ask that we only contact you at work, or only at a certain phone number, or only by mail.

HOW TO USE YOUR RIGHTS UNDER THIS NOTICE- If you want to use your rights under this notice, you may write or call us.

COMPLAINTS TO THE FEDERAL GOVERNMENT- If you believe your privacy rights have been violated, you have the right to file a complaint with the Federal Government. You may write to: Office of the Secretary, Department of Health and Human Services, 200 Independence Ave., S.W., Washington, D.C. 20201. You will not be penalized for filing a complaint with the federal government.

COMPLAINTS AND COMMUNICATIONS WITH US- If you want to exercise your rights under this Notice, of if you wish to file a complaint with us, you can write to us at: Chief Privacy Officer, ENT Bessemer, LLC, 985 9th Ave., Suite 308, Bessemer, AL 35022.

Revised 10/2012

NOTICE OF PRIVACY PRACTICES

I agree that I have read and/or received a copy of this Office's Notice of Privacy. I acknowledge that I understand the above information.

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Patient Signature

Date _______________________