

PATIENT INFORMATION SHEET

Patient Name _____ PCP _____		Must Have for Medicare
Address _____		Referred by _____
City, State _____	<input type="checkbox"/> Physician Name _____	
Zip Code _____	<input type="checkbox"/> Friend	<input type="checkbox"/> Yellow Pages <input type="checkbox"/> Internet
Home Phone # _____	<input type="checkbox"/> Other _____	
Social Security # _____	Patient Employer _____	
Patient Sex M <input type="checkbox"/> F <input type="checkbox"/> Marital Status _____	Address _____	
Birth Date _____ Age _____	Work Phone # _____	
Student Yes <input type="checkbox"/> No <input type="checkbox"/> Part Time <input type="checkbox"/> Full Time <input type="checkbox"/>	E-mail address _____	
Spouse's Name _____	Spouse's Social Security # _____	
Spouse's Employer _____	Address _____	
Work Phone # _____		
IN CASE OF EMERGENCY CONTACT _____		
Home Phone # _____	Work Phone # _____	
Relationship to patient _____		
Reason for Today's Visit _____		
GUARANTOR INFORMATION (for signature listed below)		
Guarantor Name _____	Employer _____	
Address _____	Address _____	
City, State _____ Zip _____	City, State _____	Zip _____
Phone # _____	Phone # _____	
Birth Date _____ Sex M <input type="checkbox"/> F <input type="checkbox"/>	Social Security # _____	
INSURANCE INFORMATION		
Referral Required Yes <input type="checkbox"/> No <input type="checkbox"/>	Policy holder's date of birth _____	
Name of Insurance Company _____		
Address _____	Phone # _____	
Name of policy holder _____	Relationship to patient _____	
Address _____	Phone # _____	
Employer of policy holder _____		
Policy # _____	Group # _____	Effective Date _____
<p>Our office will file insurance claims for you; however, office visit co pays and deductibles are payable on the day you are seen. Please remember you are responsible for all fees, regardless of insurance coverage. All HMO's, IPA's and EPI's require authorization. This is your responsibility. If we do not receive the authorization, payment is due at the time of service. I authorize the release of medical information necessary to process this claim and to Health Care Professionals requesting consultation and third party payers responsible for all or part of the physician's fees. I authorize payment of the medical and surgical benefits to Northside Ear, Nose and Throat Associates, P.C.</p>		
Signature of Patient or Legal Guardian _____		Date _____

MEDICAL HISTORY INFORMATION

PLEASE MARK EACH ITEM THAT APPLIES. ADD ANY ITEMS THAT ARE NOT LISTED

	Yes	No
CHILDHOOD ILLNESSES		
Measles _____		
Mumps _____		
Whooping Cough _____		
Other _____		
MEDICAL ILLNESSES		
Hearing Loss _____		
Ringing in ears _____		
Dizziness _____		
Noise exposure _____		
Diabetes _____		
TB _____		
Hepatitis _____		
Pneumonia _____		
Other Chest Problems _____		
Hypertension (BP) _____		
Heart Disease _____		
Cancer _____		
Disorder of Digestion _____		
Ulcers _____		
Heartburn _____		
HIV _____		
Diarrhea Frequent _____		
Constipation - Chronic _____		
Urinary Tract Problems _____		
Seizures _____		
Stroke _____		
Depression _____		
Anxiety _____		
Difficulty with Clotting _____		
TRAUMA (Injuries)		
Fractures _____		
Severe Lacerations _____		
Auto Accidents _____		
Injuries on the Job _____		
ALLERGIES		
Hayfever _____		
Asthma _____		
Frequent Injections _____		
Other Allergies _____		

SURGERY (List all Surgery)

OTHER HOSPITALIZATIONS:

CURRENT MEDICATIONS: (List)

Are you allergic to any medications: (List)

Tobacco History Use:

HEIGHT: WEIGHT:

ANESTHESIA COMPLICATIONS: _____

LIST OTHER ILLNESSES: _____

PATIENT NAME: _____ **DATE:** _____

NORTHSIDE ENT, P.C.
FINANCIAL POLICY

Patient Name _____

Chart/Account # _____

We are committed to meeting your healthcare needs. Our goal is to keep your insurance or other financial arrangements as simple as possible. In order to accomplish this in a cost effective manner, we ask that you adhere to the following guidelines.

1. You are ultimately responsible for payment of charges for services you receive from our office. Any check payment dishonored by your bank will result in a **\$35.00 return check charge** being added to your account.
2. It is your responsibility to provide us with your current address, telephone number, and insurance information.
3. It is your responsibility to contact your insurance carrier to confirm that our physicians participate in your plan. If you see a doctor that is not currently on your plan, you will be responsible for payment in full.
4. If your plan requires a referral, it is your responsibility to obtain this prior to being seen by the doctor.
5. All co-payments are due at the time of service.
6. If you miss your appointment, you may be charged a **NO-SHOW fee of \$25.00** for each appointment missed. 24 Hour notice is required should you need to cancel or reschedule your appointment.
7. All medical records requests must be in writing and received in our office 72 hours prior to the date needed. Records over 10 pages will only be mailed not faxed, and all medical records requests will have a fee based on the number of pages. The range of fees for this service is from \$10.00-\$50.00.
8. Our office collects an optional **Administrative Services Fee (ASF) of \$10.00 per year** at your first visit of the year. These administrative fees are intended to cover the cost of certain administrative services we provide that are not covered by your insurance. You are not required to pay the ASF; however, if you choose not to pay the optional ASF, you will be charged for all non-covered administrative services, as needed. Completion of all forms, to include but not limited to, that you will pay for on an "as requested" basis are: FMLA, disability forms, school forms, patient requested generated reports, such as claims, statements, payment histories. These "as requested" forms will be charged at \$50.00 per form.
9. Attention Medicare Part A or Part B patients: hearing aids or examinations for the purpose of prescribing, fitting, or changing hearing aids are excluded from coverage. Therefore, examinations in our office for audiology testing that are found to not be medically necessary are expected to be paid in full at the time of service.
10. In the event the balance of your account becomes 60 days delinquent after insurance payments, your account may be sent to our collection agency. You would be responsible for the collection fees incurred.

_____ I accept the financial policy that includes payment of the Administrative Service Fee, (ASF).

_____ I accept the financial policy but choose not to pay the Administrative Service Fee (ASF). I understand the services listed in item number 8 are included in the ASF. I understand that if I elect not to pay the ASF I will pay for the services as I need them at the fee listed.

Patient Signature _____

Date _____

NORTHSIDE ENT, PC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

We are required to provide you with a copy of our Notice of Privacy Practices, which stated how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of the office's Notice of Privacy Practices.

Please print your name here

Signature

Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- A. The patient refused to sign
- B. Due to emergency situation it was not possible to obtain an acknowledgement.
- C. We were not able to communicate with the patient.
- D. Other. Please provide specific details

HIPAA Acknowledgement of Receipt of the Notice of Privacy Practices
This form does not constitute legal advice and covers only federal, not state law.