PATIENT REGISTRATION FORM

PATIENT NAME ____
(LAST) (FIRST) (MI) (SOC SEC #)

STREET OR BOX NO ______________________ CITY ______________________ ST ________ ZIP ________

HOME PHONE ______________________ CELL PHONE ______________________ EMAIL ______________________

HOW DO YOU PREFER TO BE REMINDED OF UPCOMING APPOINTMENTS?

Please Circle ONE: Call Home Phone Email Call Cell Phone Text Cell Phone

☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ F ☐ M BIRTHDATE ______________

PATIENT EMPLOYER ______________________________ OCCUPATION ______________________

EMPLOYER ADDRESS ______________________________________ WORK PHONE ______________

RELATIVE/EMERGENCY CONTACT ______________________________ PHONE ______________________

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☐ SPOUSE ☐ PARENT INFORMATION (* If parent information, fill both name sections out completely)

NAME ______________________________ * NAME ______________________________

ADDRESS ______________________________ * ADDRESS ______________________________

CITY ______________ ST ________ ZIP ________ * CITY ______________ ST ________ ZIP ________

HM PH ______________ CELL ______________ * HM PH ______________ CELL ______________

SOC. SEC # ______________ BIRTH DATE ______________ * SOC. SEC # ______________ BIRTH DATE ______________

EMPLOYER ______________________________ * EMPLOYER ______________________________

EMPL ADDRESS ______________ PH ______________ * EMPL ADDRESS ______________ PH ______________

PRIMARY INSURANCE

NAME OF INS ______________________
ADDRESS ______________________
CITY ______________ ST ________ ZIP ________
PHONE ______________ EFFECTIVE DATE ________
POLICY HOLDER NAME ______________________
POLICY HOLDER BIRTHDATE ______________________
POLICY ID/GRP # ______________________

SECONDARY INSURANCE

NAME OF INS ______________________
ADDRESS ______________________
CITY ______________ ST ________ ZIP ________
PHONE ______________ EFFECTIVE DATE ________
POLICY HOLDER NAME ______________________
POLICY HOLDER BIRTHDATE ______________________
POLICY IF/GRP # ______________________

PRIMARY CARE PHYSICIAN/REFERRING DOCTOR ____

ASSIGNMENT OF INSURANCE BENEFITS AND FINANCIAL RESPONSIBILITY AGREEMENT: I hereby authorize my signature on all insurance claim forms at the office of Midwest Ear, Nose, and Throat Surgery for payment directly to him/her for service rendered to me/patient. I authorize this office to make and send copies of medical records that may be needed to file my insurance claims. I understand that I/patient are responsible for charges incurred regardless of whether my insurance pays or not. I also understand I am responsible for any attorney fees and or court costs incurred in collecting any unpaid balances for services I/patient received. I authorize Midwest Ear, Nose, and Throat Surgery and any of its agents to contact me by telephone, at any of the numbers provided including any wireless number for me and/ or my spouse which could results in charges to me/us. Furthermore, I also authorize methods of contact may include using pre-recorded and/ or artificial voice messages and/ or automatic dialing devices, as applicable. ALL CO-PAYMENTS, DEDUCTIBLES OR COINSURANCE ARE DUE AT TIME OF CHECK IN. THERE WILL BE A $10 LATE FEE ADDED PER MONTH ON ALL BALANCES OVER 30 DAYS UNLESS PAYMENT ARRANGEMENTS HAVE BEEN APPROVED.

SIGNATURE ____ DATE ______________________

Message to our Patients

We file your insurance as a courtesy to you; **but you are expected to pay your co-insurance/co-payments/deductibles on the day of service. We accept cash, check, and credit cards.** Should incorrect insurance be presented, you may be given appropriate HCFA forms to file your medical claims. PATIENT IS RESPONSIBLE FOR PAYMENT.

All patients under the age of eighteen (18) will need a parent in attendance or **legal guardian** with written authority to treat patient at the appointment before medical care can be provided.

If your insurance company requires **prior authorization** for you to see a specialist, please contact your insurance company or referring doctor, whichever is applicable, before your appointment and bring your prior authorization form if required.

Medicare- We participate with Medicare using their guidelines. If you do not have a Medicare supplement the remaining **20% coinsurance** will be collected at the time of visit.

Returned checks have a $50 handling fee added to the account.

Forms – There is a fee for filling out forms. This includes FMLA forms.

It is the patient's responsibility to know what facilities and which physicians are providers of their insurance company network. You need to verify with your insurance company **whether a referral or pre-certification is necessary.** We will be happy to assist you as well to pre-certify a surgery; however it is your responsibility to know if it is actually a covered benefit with your member services.

We understand that information about you and your health is personal and we are committed to protecting the privacy of that information. Because of this commitment, we must obtain your special authorization before we may use or disclose your protected health information to communicate with you about the products and services available through our office. This form provides that authorization and helps us make sure that you are properly informed of how this information will be used or disclosed.

The information to be disclosed will relate to problems of the ears, nose, and throat and their treatment options.

By signing below, I authorize Midwest Ear, Nose, and Throat Surgery to contact me via mail and/ or email regarding information as described above.

SIGNATURE ____________________ DATE ____________________

DO YOU HAVE A COMMUNICABLE DISEASE TO REPORT TO THIS PHYSICIAN?

☐ **YES** ☐ **NO**

MIDWEST EAR NOSE AND THROAT SURGERY
MEDICATION LIST FORM

Name:	Address:
Phone Number:	
Birth Date:	
Allergic To /Describe Reaction:	Allergic To /Describe Reactions

LIST ALL MEDICINES YOU ARE CURRENTLY TAKING: Prescription and over-the-counter medications (examples: aspirin, antacids) and herbals (examples: ginseng, gingko). Include medications taken as needed (example: nitroglycerin).

DATE	NAME OF MEDICATION:	DOSAGE:	HOW MANY TIMES DO YOU TAKE THE MEDICATION:

Midwest Ear, Nose & Throat Surgery, PSC

HIPAA RELEASE FORM

Patient Name: ______________________ Patient DOB: __________

By signing this authorization, I authorize Midwest Ear, Nose & Throat Surgery, PSC to use and/or disclose certain medical and financial information to the people listed below. Privacy regulations require us to have a release signed by our patients so we may speak with family, friends, and other relations regarding your medical and patient financial information.

Please print each person's name, relationship to you, and a good contact number to reach them if we have any questions and are unable to reach you. Please check mark if you would like them to have medical or financial information access or that they are able to obtain both medical and financial information.

Name	Relationship	Phone Number	Medical	Financial
			☐	☐
			☐	☐
			☐	☐

Expiration of authorization – Provide a date or event that this authorization will expire. If you do not want this to expire select the option of never.

☐ NEVER ☐ Date: ______________________

This authorization gives **Midwest Ear, Nose & Throat Surgery, PSC** permission to use and/or disclose protected health information (PHI), including medical records and billing statements, (an authorization is not required for the purposes of treatment, payment or healthcare operations).
Right not to sign: You may refuse to sign this authorization. However, Midwest Ear, Nose & Throat Surgery, PSC cannot complete or release any forms without a signed authorization. Refusal to sign this authorization will not affect your ability to obtain treatment by Midwest Ear, Nose & Throat Surgery, PSC except in the case of care/evaluation that would be required for completing the requested forms to be disclosed to a third party (for example, a pre-employment physical, disability forms, etc.). In those instances, we may require a signed authorization prior to care/evaluation/consultation with a provider.
Right to revoke: You may revoke this authorization at any time except to the extent that we have relied on the authorization. To revoke this authorization, please submit a written revocation to the following address: Midwest Ear, nose & Throat Surgery, PSC, Attn: Privacy Officer, 1020 Professional Blvd, Evansville, IN 47714.
Re-disclosure: Health information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient, which we cannot be responsible.

______________________ Signature

__________ Date

Midwest Ear, Nose & Throat Surgery, PSC

Receipt of Notice of Privacy Practices
Written Acknowledgement Form.

I, ______________have been made available a copy of

Midwest Ear, Nose & Throat Surgery, PSC's Notice of Privacy Practices.

______________________________   ____________________
Signature of Patient   Date