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

PATIENT REGISTRATION FORM

LEGAL PATIENT NAME _____

SSN _____ **DOB** _____ **FEMALE** **MALE** **OTHER**

ADDRESS OR PO BOX_____

CITY _____ **STATE** _____ **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**

PATIENT EMPLOYER _____ **OCCUPATION** _____
EMPLOYER ADDRESS _____ **WORK PHONE** _____

RELATIVE/EMERGENCY CONTACT _____ **PHONE** _____
☐ **SPOUSE** ☐ **PARENT INFORMATION (* If parent information, fill both name sections out completely)**

NAME _____ *** NAME** _____

ADDRESS _____ *** ADDRESS** _____

CITY _____ **ST** _____ **ZIP** _____ *** CITY** _____ **ST** _____ **ZIP** _____

PHONE _____ **SOC. SEC #** _____*** PHONE** _____ **SOC. SEC #** _____

BIRTH DATE _____ ***BIRTH DATE** _____

EMPLOYER _____ *** EMPLOYER** _____
EMPLOYER PHONE_____ *** EMPLOYER PHONE** _____

PRIMARY INSURANCE	**SECONDARY INSURANCE**
NAME OF INS _____	**NAME OF INS** _____
POLICY HOLDER NAME _____	**POLICY HOLDER NAME** _____
POLICY HOLDER BIRTHDATE _____	**POLICY HOLDER BIRTHDATE** _____
POLICY ID/GRP # _____	**POLICY IF/GRP #** _____

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 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**

Notice Of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our office is dedicated to protecting the privacy rights of our patients and the confidential information entrusted to us. The commitment of each employee to ensure that your protected health information (PHI) is never compromised is a primary concept of our practice as well as a federal requirement in the Health Insurance Portability and Accountability Act (HIPAA). We may amend our privacy policies and practices but will always inform you of any changes that might affect your rights. We reserve the right to call or contact you electronically to confirm or reschedule your appointment.

PROTECTING YOUR PERSONAL HEALTHCARE INFORMATION

We may use and disclose your PHI for:

- The care and treatment provided for health care services to you.
- To pay your health care bills and to support the operations of your physician's practice such as coordinating your care.
- As required by law and will be limited to the relevant requirement of the law.
- Tio the public health authorities for public health activity's purpose that are permitted by law such as preventing or controlling disease, injury, disability and exposure to a communicable disease or risk of contracting or spreading a disease or condition.

DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION

- Agencies authorized by law for audits, investigations, and inspections such as government agencies who oversee health care system, government benefit programs and other civil rights laws.
- Public health authority authorized by law to receive reports of child abuse or neglect. In addition, we may disclose PHI if we believe that you have been a victim of abuse, neglect or domestic violence to the government entity or agency authorized to receive such information.
- Authorized person or company by the Food and Drug Administration for the purpose of quality, safety, or effectiveness of FDA-regulated products or activities such as tracking products, enable product recalls, or conduct post marketing surveillance as required by law.
- Any judicial or administrative proceeding in response to an order of a court or administrative tribunal, or conditions to a subpoena.
- Law enforcement for the purposes of locating a suspect, fugitive, material witness or missing person.
- A funeral director, coroner, or medical examiner for identification purposes, determining cause of death or to perform duties authorized by law.
- Research regulated and approved by an institutional review board.
- Appropriate conditions such as: for individuals who are Armed Forces personnel, as deemed necessary by appropriate military command authorities; by the Department of Veterans Affairs; to foreign military authorities if you are a member of that foreign military service; for the purpose of conducting national security and intelligence activities including provisions of protective services to the President or others legally authorized.
- Comply with workers' compensation laws.
- Your provider of care if you are an inmate of a correctional facility.

PATIENT RIGHTS

- Other use and disclosure of your PHI will be made only with your written authorization unless otherwise permitted or required by law.
- You may revoke this authorization in writing at any time. If you revoke your authorization, we will not use or disclose your PHI for the specifications of the written agreement.
- You have the right to inspect and copy your PHI for as long as we maintain the PHI. You may not inspect or copy psychotherapy notes, information complied in anticipation of a civil or criminal proceeding, laboratory results that are subject to law that prohibits access if you signed your authorization rights due to a trial program. As permitted by federal law, we may charge you a reasonable copy fee for a copy of your records.
- You have the right to request a restriction of your PHI for the purpose of treatment, payment, or health care operations when payment for the treatment has been made in full form out of pocket expense. You may also request PHI not be disclosed to family members or friends who may be involved in your care. Your physician is not required to agree to a restriction that you may request.
- You have the right to request to receive confidential communication by alternative means or locations.
- You have the right to have your physician amend your PHI, in certain cases we may deny your request for amendment.
- Your PHI cannot be used for marketing products and services without authorization from you.
- You have the right to receive an accounting of certain disclosure, for participating physicians who consult or assist with your care, for national security or other law enforcement disclosures.
- You have the right to complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer. We will not retaliate against you for filing a complaint.

Signature: _____ Date: _____

PATIENT MEDICAL HISTORY

Patient Name_____ **DOB** _____

Primary Care Physician _____

LIST ALL MEDICATION ALLERGIES:

_____

_____

LIST ALL PREVIOUS SURGERIES:

_____

_____

PAST MEDICAL HISTORY (CIRCLE YES OR NO):

DIABETES: YES NO **ASTHMA:** YES NO **HEART DISEASE:** YES NO

IRREGULAR HEARTBEAT: YES NO **STROKE:** YES NO **CANCER (SPECIFY):** _____

KIDNEY DISEASE: YES NO **LUNG DISEASE:** YES NO **HIGH BLOOD PRESSURE:** YES NO

OTHER MEDICAL PROBLEMS: _____

SOCIAL HISTORY (CIRCLE YES OR NO):

SMOKE TOBACCO: YES NO **E-CIG:** YES NO **ALCOHOL:** YES NO

MEDICATIONS (IF YOU HAVE A LIST THIS CAN BE ATTACHED):

DATE	NAME OF MEDICATION	DOSAGE	NUMBER OF TIMES YOU TAKE THE MEDICATION