NEW PATIENT INFORMATION

Patient's Name: _____

Address: _____

City_____ State: _____

Zip: _____ Home Phone #: _____

Cell Phone _____Work Phone: _____

How would you like to receive appointment reminders

☐Morning ☐ Afternoon ☐ Evening

☐ Text ☐ Voice mail ☐ Email

RESPONSIBLE PARTY INFORMATION

(Complete Only If Other Than Patient for a Minor this will be the Parents Info.)

Responsible Party: Name: _____

DOB: _____SSN:_____

Phone_____

Email_____

Sex: M ☐ F ☐

INSURANCE INFORMATION

Primary Insurance

Insurance Company Name: _____

ID #_____Group#_____

Policy Holder Name: _____

DOB: _____

Secondary Insurance:

Insurance Company Name: _____

ID #_____Group #_____

PCP: _____

Referring Provider: _____

DOB: _____ Sex: M ☐ F ☐

Marital Status: Married ☐ Single☐ Divorced☐

Patients SSN: _____

Patient's Employer: _____

Employment Status: ☐ Full time ☐ Part time ☐ Not

Employed ☐ Self Employed ☐ Retired ☐ Active Duty

Emergency Contact

Relationship to Patient: _____

☐ Guardian ☐ HIPAA Contact

Name: _____

Address_____

Phone: _____

ADDITIONAL INFORMATION

How did you hear about us?

☐ Our Website ☐ Insurance Provider Directory

☐ Yellow Pages ☐ Yellow Book ☐ Existing Patient

☐ Internet search ☐ Social Media _____

Friend _____ Other: _____

Do we have permission to leave messages on your voicemail? ☐Yes ☐ No ☐Home ☐Cell

Race (Optional):_____Ethnicity_____

Primary Language Spoken: _____

Pharmacy Name: _____

Street: _____

Phone: _____

Do you give ENTSON consent to obtain a list of your medication from your pharmacy ☐Yes ☐ No

ASSIGNMENT, RELEASE AND FINANCIAL AGREEMENT

I certify that the information above is correct and honest. I authorize treatment of person named above and agree to pay all fees for such treatment. I hereby authorize my insurance benefits to be paid directly to the provider of service and I am financially responsible for non-covered services. I also authorize release of medical information to my insurance company for claims processing.

Print Name: _____ Date: _____

Signature _____ Relationship to Patient _____

Patient Name: _____ DOB: _____ Gender: M/F Date: _____

Medication History:

Are you taking any diet medications, herbal preparations, vitamins, or any other over the counter medications (i.e., Ginseng, Tylenol, Advil, Aspirin, Visine eye drops, Multivitamins, etc.)? _____ Yes _____No

List any medications you take at home including oral meds, insulin, inhalers

Medication Name	Strength	Frequency	Reason for taking	Last Time Taken
I.E Omeprezole	30mg	1 tab twice a day	GERD	7AM

List any known food and drug allergies

Allergy	Reaction

Conditions of Treatment

Patient Name: _____ DOB: _____

Permission for Treatment: Permission is hereby granted for physicians, residents, employees, or agents of Ear Nose & Throat Specialists of Nashville (collectively, the "Provider") to render the patient named above such medical and surgical treatment as is deemed necessary. _____ (Initial)

Authorization for Release of Information: The Provider (through its employees or other contracted agents) may disclose the patient's medical record account to:

1. Any person or corporation which is or may be liable for all or any portion of the patient's charges; including but not limited to insurance companies, health care service plans, and worker's compensation carriers to the extent necessary to determine insurance benefits, liability for payment and to obtain reimbursement.
2. Any referring physician to ensure continuity of medical care.

Financial Agreement: (Please initial as applicable)
We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care. The following is a statement of our Financial Policy in order to reduce confusion and misunderstanding between our patients and practice, which we require you to read and sign prior to any treatment. If you have any questions regarding these policies, please discuss them with our office manager.

- Unless other arrangements have been made in advance by either you or your health insurance carrier, full payment is due at the time of service. For your convenience we accept VISA, MasterCard, and Discover.
- We have made prior arrangements with many insurers and health plans to accept an assignment of benefits. This means that we will bill those plans for which we have an agreement and will only require you to pay the authorized co-payment, deductibles and/or coinsurance at the time of service. It is our policy to collect this co-payment when you arrive for your appointment.
- In the event that your health plan determines a service to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office. If you disagree with your insurance company's determination, you must contact your insurance company.
- HMO's and some other insurances require an official referral/authorization number or form. If the patient presents without this authorization form and we have not received it in our office, you will be required to sign a Waiver of Responsibility Form and payment at the time of service will be expected.
- In the event of default on the patient balance owed, for any reason, the patient (or guardian) will be responsible for any and all collection agency fees, attorney fees, and court costs.
- For all services rendered to minor patients, we will look to the adult accompanying the minor for payment.
- **Your provider might need to perform a procedure (i.e. Nasal Endoscopy) that your insurance may consider a "surgery". In some cases the cost of procedure may be applied to your deductible and may consequently become an out-of-pocket expense for you**._____ (Initial)

Assignment of Insurance Benefits:
I request my insurance carrier to pay to Ear Nose & Throat Specialists of Nashville all benefits due related to my pending claim for medical and surgical services. **I agree to pay all applicable deductible and coinsurance amounts** due and other fees for services rendered for which my insurance plan/HMO is not liable for payment to the Provider, and agree to pay the costs of collection including reasonable attorney's fees in the event of legal action to collect such amounts. Note that ENTSON policy is that all patients must provide a copy of their current insurance card and photo ID at the time of service. _____ (Initial)

Self-Paying Patients:
I am requesting medical services as a fee-for-service, self-paying patient. I agree that I am responsible for all charges incurred as a result of this visit, including but not limited to all medical/surgical professional services, laboratory, radiological, and any other ancillary services. I agree to pay the costs of collection
including reasonable attorney's fees in the event of legal action to collect this account. _____ (Initial Self Pay Only)

Missed Appointments:
Any cancellation, reschedule or no show made less than **24 hours before the scheduled appointment or arrival over 15 minutes later than scheduled appointment** without prior contact with our office is considered a missed appointment. Failure to confirm appointment 24 hours before appointment will result in a cancellation of the appointment and will be subject to a **$25 fee**. _____ (Initial)

Ear, Nose & Throat Specialists of Nashville

Notice of Privacy Practices Acknowledgement

I understand that under the Health Insurance Portability & Accountability Act of 19936 ("HIPAA"), I have certain rights to privacy regarding my protected health insurance information (PHI). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operation such as quality assessments and physician certifications

I received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my PHI. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

☐ I would like a copy of my Patients Right and Responsibility

☐ I would not like a copy of my Patients Right and Responsibility

Patient Name or Legal Guardian: _____ Signature: _____

Date: _____

Office Use Only

I attempted to obtain the patients signature in acknowledgement of the Notice of Privacy Practices Acknowledgement but was unable to do so as documented below:

Date	Initials	Reason

CONSENT TO TREAT MINOR CHILDREN

Please print all information

I, _____, parent or legal guardian of _____, born _____, does hereby consent to any medical care and the administration of anesthesia determined by a physician to be necessary for the welfare of my child while said child is under the care of _____ and I am not reasonably available by telephone to give consent. This authorization is effective from _____ to _____.

Signature of Parent or Legal Guardian

_____ _____

Witness Signature Witness Name (please print)

Patient Portal Registration Form

We know you're busy. That's why Ear, Nose & Throat Specialists of Nashville would like to offer our patients a way for them to manage their healthcare online.

Ear, Nose & Throat Specialists of Nashville's Patient Portal is a convenient and easy-to-use online system that allows you to:

- ✓ View past and future medical visits
- ✓ View lab and other test results
- ✓ Request or directly schedule appointments with providers
- ✓ Request medication refills
- ✓ View current and past medications
- ✓ View immunization records
- ✓ View and update allergies
- ✓ Send and receive secure messages with provider's office
- ✓ Receive text alerts concerning appointment changes and other updates
- ✓ Download copies of their own medical records

Ear, Nose & Throat Specialists of Nashville Patient Portal is encrypted and password-protected, so health data remains secure. Sign up and make managing your healthcare a little easier. To get started, please fill out the information below and return this card to the receptionist at the front desk.

Print Patient's Name_____ Email Address: _____