EAR, NOSE, & THROAT CLINIC
OF COFFEE COUNTY

312 Westside Drive, Douglas, GA 31533
(912) 384-2200 phone (912) 383-7992 fax

2016 Pineview Avenue, Tifton, GA 31794
(229) 391-3440 phone (229) 386-2082 fax

Jeffrey L. Silveira, MD
David Martini, MD
Todd Sumler, FNP-C
Annsley Mathews, PA-C
Victoria Suttles, PA-C

Preferred Method for Appointment Reminders
Telephone Call_____ Text Message_____

Cell Phone: _____

Email: _____ Pharmacy: _____

Patient Information

Last Name: _____ First Name: _____MI: ___ SSN#:_____

Address: _____ City: _____ State: ___ Zip Code: _____ Home #: _____

Sex: M ___ F ___ Age: ____ Birthday: _____ Single: ___ Married: ___ Widowed: ___ Separated: ___ Divorced: ___

Employer: _____ Occupation: _____ Business Phone#: _____

Whom may we thank for referring you? _____

Personal Primary Care Physicians (s): _____

Primary Insurance

Insurance Company: _____ Address: _____

Insurer's Name: _____ Relation to Pt: _____ Insurer's Sex: _____

Insurer's DOB: _____ SSN/ID Number: _____ Group Number: _____

Policy Holder Address: _____ Phone #: _____ Employer: _____

Secondary Insurance

Insurance Company: _____ Address: _____

Insurer's Name: _____ Relation to Pt: _____ Insurer's Sex: _____

Insurer's DOB: _____ SSN/ID Number: _____Group Number: _____

Emergency Information

Emergency Contact: _____ Relationship: _____Phone#: _____

Assignment of Benefits and Billing Terms

I hereby authorize direct payment of surgical/medical benefits to Jeffrey L. Silveira, MD, for services rendered by him or under his supervision. I realize I am responsible for any deductibles or co-insurance as set forth in the financial agreement. I hereby authorize Jeffrey L. Silveira, MD, to release any medical or incidental information that may be necessary for either medical care or in processing applications for insurance benefits.

Signature of Pt (or Responsible Party): _____Date: _____

Financial Agreement

We are going to do our very best to provide you the finest health care available. We will do this with little emphasis on payment; but without payment we would be unable to continue to provide health care. It is important to both of us that you have a clear understanding of our financial policy.

By signing below, I understand that the Ear, Nose, and Throat Clinic of Coffee County, PC will file a claim with my insurance carrier (if applicable) on my behalf. I will provide documentation of correct proof of insurance. If insurance benefits are not paid within 60 days of rendered services, I understand that my account is immediately due and payable to me. I agree to pay those unpaid amounts in a timely fashion.

I understand that should my account become delinquent and require the services of a collections agency or attorney, I agree to pay all reasonable collections fees and/or court costs for said collection. A finance charge of 1 ½ % per month (18% annum) on all past due accounts on the unpaid amount will be assessed. The Ear, Nose, and Throat Clinic of Coffee County, PC will not be involved in disputes regarding deductible, co-payments, secondary insurance, etc.

Signature of Patient (or Responsible Party) _____

Relationship: _____ Date: _____

For Medicare Supplement Policy Holders Only- Medigap Assignment Authorization

I request that payment of authorized Medigap benefits to be made on my behalf to Jeffrey L. Silveira, MD and/or Ear, Nose & Throat Clinic of Coffee County, PC. I authorize any holder of medical information to release to _____ (Name of Medigap/Medicare SupplementInsurer) any information needed to determine these benefits. This authorization is in effect until I choose to revoke it.

Signature of Patient (or Responsible Party) _____

Relationship: _____ Date: _____

Beneficiary Agreement for Non-Covered Services

We are required to inform you of services that are non-covered services. These include:

Hearing Aids

Ear Plugs

I have been notified by Jeffrey L. Silveira, MD. and staff that the above listed services are non-covered services. I agree to be responsible for payment.

Signature of Patient (or Responsible Party) _____

Relationship: _____ Date: _____

EAR, NOSE, & THROAT CLINIC
OF COFFEE COUNTY

FINANCIAL POLICY

Patient Name: _____ Date: _____

Responsible Party: _____ Relationship: _____

ENT CLINIC OF COFFEE COUNTY is committed to meeting your health care needs. Our goal is to keep your insurance or other financial arrangements as simple as possible. In order to accomplish this we ask that you adhere to the following guidelines. We submit all personal checks electronically.

__PLEASE INITIAL ON EACH LINE__

_____All co-payments are due at check-in, before your appointment. We accept check, (we submit all personal checks electronically), cash, debit cards, health flex spending cards, and all major credit cards. We also offer Care Credit, (a patient payment plan). Please inquire at check-in. There will be a $30 returned check charge.

_____ It is your responsibility to provide us with your current address, telephone number and insurance information at each visit. If you do not have proof of your current insurance at your visit you will be considered a self-pay patient for that visit and payment will be due in full that day.

_____It is your responsibility to contact your insurance carrier to confirm that our physician participates with your plan and you understand your insurance benefits and requirements.

_____If we do not contract with your insurance provider you will be responsible for the entire bill at the time of service. We can submit a claim to your insurance as a courtesy just so that they will have it on file.

_____If you have a procedure, we bill only for our physician services. You should receive a separate bill from the facility, and/or other providers (Ex: Anesthesia, Pathology, etc...)

_____ Ear, Nose, and Throat Clinic will not become involved with any disputes in regards to co-insurance, deductibles, Primary/Secondary coverage conflict with Insurance Coverage. This is the responsibility of the insured. Ear, Nose, and Throat Clinic will not become involved in responsible guarantor party disputes.

Patient Signature: _____ Date: _____
(Guarantor/Responsible party if patient is a minor)

Ear, Nose, and Throat Clinic of Coffee County, PC

Policy 2.1

Consent for Use of Disclosure of Protected
Health Information for Payment, Treatment
and Health Care Options

By signing below, you hereby consent for this Practice to use or disclose information about yourself (or another person for whom you have the authority to sign) that is protected under federal law, for the sole purposes of treatment, payment, and health care operations. You may refuse to sign this consent form.

You should read the Notice of Privacy Practices for PHI attached to this form before signing the Consent. The terms of the Notice may change from time to time, and you may always get a revised copy by asking the Privacy Officer of the Practice. (I have read the Notice of Privacy Practices.) Please Initial: _____

You have the right to request that the Practice restrict how PHI is used or disclosed to carry out treatment, payment, or health care operations. The Practice is not required to agree to requested restrictions; however, if the Practice agrees to your requested restrictions, the restriction is binding on it.

Information about you is protected under federal law, and you have the right to revoke this Consent, unless we have taken action in reliance on your authorization (as determined by our Privacy Officer). By signing below you recognize that the protected health information used or disclosed pursuant to this Consent may be subject to redisclosure by the recipient and may no longer be protected under federal law.

You may communicate with the following individuals regarding my condition or course of treatment:

Name:	**Relationship to Patient:**
_____	_____
_____	_____
_____	_____

Please list all acceptable methods of communication, and the appropriate information for each:

Phone number(s): _____

Email: _____

Fax: _____

Other: _____

Signature of Patient or Responsible Party: _____ Date _____

As a personal representative, I have authority to act for the individual because I am the individual's

_____

ATTENTION: We can only release any information to persons listed above. If any information is requested by anyone not listed it will not be released. This also means any person that will bring a patient to an appointment

EAR, NOSE, & THROAT CLINIC
OF COFFEE COUNTY

Authorization for Disclosure of Protected Health Information

Patient Name: _____ Medical Record No. _____

Date of Birth: _____ Social Security No. _____

1. I authorize the use or disclosure of the above named individual's health information as described below.
2. The following individual or organization is authorized to make the disclosure:

   _____
3. The type and amount of information to be used or disclosed is as follows:
   - ☐most recent history and physical from (date) _____ to (date) _____
   - ☐most recent discharge summary from (date) _____ to (date) _____
   - ☐laboratory results from (date) _____ to (date) _____
   - ☐x-ray and imaging services from (date) _____ to (date) _____
   - ☐consulting reports from (date) _____ to (date) _____
   - ☐entire reports from (date) _____ to (date) _____
   - ☐other: _____ from (date) _____ to (date)_____
4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
5. This information may be disclosed to and used by the following individual or organization:

   Ear, Nose & Throat Clinic of Coffee County
   Dr. Jeffrey L Silveira, MD
   312 Westside Drive
   Douglas, GA 31533
6. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to the information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event, or condition this authorization will expire in six months.
7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assume treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of health information carries with it the potential for an unauthorized re-disclosure and the information may not be protected and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact Kristin Patterson at (912) 384-2200 Ext. 224.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Relationship to Patient Signature of Witness

ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS

AS WELL AS AN

APPOINTMENT AND/OR DESIGNATION AS MY PERSONAL REPRESENTATIVE AND AN ERISA/PPACA REPRESENTATIVE AND BENEFICIARY

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay Jeffrey Silveira, MD, Ear, Nose & Throat Clinic of Coffee County and/or Westside Surgery Center, as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided.

I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Jeffrey Silveira, MD, Ear, Nose & Throat Clinic of Coffee County and/or Westside Surgery Center for any and all medical/healthcare services, supplies, tests, treatments, and/or medications that **have been or will be** rendered or provided; as well as designating and appointing Jeffrey Silveira, MD, Ear, Nose & Throat Clinic of Coffee County and/or Westside Surgery Center as my beneficiary under all health insurance or medical plans which I may have benefits under.

I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same.

I hereby assign directly to Jeffrey Silveira, MD, Ear, Nose & Throat Clinic of Coffee County and/or Westside Surgery Center all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Jeffrey Silveira, MD, Ear, Nose & Throat Clinic of Coffee County and/or Westside Surgery Center can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Jeffrey Silveira, MD, Ear, Nose & Throat Clinic of Coffee County and/or Westside Surgery Center, myself, and/or my family members as a result of services rendered by Jeffrey Silveira, MD, Ear, Nose & Throat Clinic of Coffee County and/or Westside Surgery Center, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Jeffrey Silveira, MD, Ear, Nose & Throat Clinic of Coffee County and/or Westside Surgery Center is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Jeffrey Silveira, MD, Ear, Nose & Throat Clinic of Coffee County and/or Westside Surgery Center can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan.

This assignment, appointment, and designation will remain in effect unless revoked by me in writing. It is my intent that the effective date of this document shall relate back to include all services, supplies, test, treatments, or medications that have been previously provided by Jeffrey Silveira, MD, Ear, Nose & Throat Clinic of Coffee County and/or Westside Surgery Center. A photocopy or scan or this document is to be considered as valid and as enforceable as the original.

Signed this _____ day of _____, 20 ____.

X_____

(Patient or Guardian Signature)

_____

(Please Print Patient or Guardian Name)

Notice of Privacy Practices
(Medical)

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!!

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. The "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your insurance company for payment.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest of you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer.

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosure to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with the respect to protected health information.

This notice is effective as of April 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice of the policies and procedures of our office. We will not retaliate again you for filing a complaint.

Please contact us for more information:
For more information about HIPAA
Or to file a complaint:
The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775