ENT south | Ear, Nose and Throat Specialist

DATE: _____

PATIENT INFORMATION

Patient's last name:	First:	Middle initial:	Marital status:		
Is this your legal name?	Race/ Ethnicity:	Preferred name:	Birth date:	Age:	Sex:

By suppling this email address, I give ENT South permission to email me.

**Email Address:

Social Security no.:	Home phone no.:	Cell phone no.:
Address:	Employer:	Employer phone no.:

Referred by Doctor: _____

PHARMACY: : **LOCATION:**

RESPONSIBLE PARTY (IF APPLICABLE)

Person responsible for bill:	Birth date:	Address (if different):	Phone no.:
Occupation:	Employer:	Employer address:	Employer phone no.:

POLICY HOLDER'S INFORMATION

Subscriber's name:	Birth date:	Policy name:	Policy no.:
Patient's relationship to subscriber:			
Name of secondary insurance (if applicable):	Subscriber's name:	Birth date:	Policy no.:
Patient's relationship to subscriber:			

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home phone no.:	Cell phone no.:

Insurance filing and collection information: Due to the constant changes in insurance, it is not possible for ENT South to interpret each patient's individual policy. **It is the responsibility of each patient to know their coverage**. We will be glad to offer assistance with determining benefits but the final responsibility belongs to the patient.

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that if my account becomes delinquent that it will be placed with Prim and Mendheim LLC. Further, I agree to the following terms regarding any outstanding balance that I owe: (1) I will incur interest at the rate of 1.5 percent per month (18% PER ANNUM); (2) I agree and hereby consent that I will be responsible for reasonable collection costs and attorney's fees and costs of court incurred by this office in the collection of same, whether such outstanding balance is satisfied prior to, after initiation of a lawsuit, or after a judgment has been issued in a lawsuit; and (3) I agree and hereby consent that any lawsuit and/or legal proceeding surrounding the outstanding balance and debt, and fees and costs thereon, shall be initiated and litigated in the court of appropriate jurisdiction of Houston County, Alabama, and I hereby waive any and all defenses and/or objections to said jurisdiction and waive all rights to claim exemption. By signing below, I consent to the terms contained herein and affirmatively acknowledge that I have read the same before signing. Furthermore, I agree that if a cell phone number has been provided I can be contacted regarding my balance on said cell phone. Additionally, if I reside in Florida I agree to waive my rights to any exemption that would prohibit a wage garnishment should it become necessary to secure payment of any outstanding balance. I also agree that at any time if my balance has not been paid according to policy I understand my credit history will be investigated and thoroughly reviewed. I also authorize ENT SOUTH or my insurance company to release any information required to process my claims.

I understand there will be a $30.00 fee assessed to my account for appointments not canceled within 24 hours of scheduled time.

Patient/Guardian signature: _____ Date: _____

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MORE ON BACK----------→

HIPAA PRIVACY RIGHTS REQUEST FORM

REQUEST FOR CONFIDENTIAL COMMUNICATIONS REGARDING MEDICAL INFORMATION

PATIENT NAME: _____ DATE OF BIRTH: _____

You have the right to request that we communicate with you privately about your medical care by alternative means or alternative locations than the contact information of the person who pays for your health insurance. Please provide us with your private contact information that you would like us to use. ENT South, PC will then take reasonable steps to accommodate this request.

I request that ENT South, PC communicate with me **confidentially** about my medical care in the following manner (check the box of your preferred contact information):

□ **Address where you can contact me confidentially:**

Street Address: _____

City: _____State: _____Zip Code: _____

□ **Daytime phone number:** _____□ **Evening phone number:** _____

Can we leave a voice mail: □ **YES** □ **NO**

The following people are authorized to receive medical and billing information concerning my treatment with this facility.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Due to the constant changes in insurance, it is not possible for ENT South to interpret each patient's individual policy. It is your responsibility to know your coverage. We will be glad to assist you with determining benefits but the final responsibility belongs to the patient. I authorize ENT South, PC to release to my insurance company and its agent any information requested to determine benefits or benefits payable.

I have been offered a copy of the Privacy Notice for ENT South and understand that a copy is available upon request.

I, the undersigned, on behalf of the patient whose name appears above, consent to, and authorize all diagnostic and therapeutic treatments deemed necessary by the attending physician, or his staff, in accordance with today's medical standards and consent for future treatment may be revoked in writing and will not be revoked by implication.

_____ _____

Patient Printed Name Date

_____ _____

Patient/Guardian Printed Name Patient/Guardian signature