Patient Registration

Referred to our office by: _____ Patient Account #: _____
(Office use only)

Patient Name: _____
(Last Name) (First Name) (Middle Initial)

Patient Soc Sec #: _____ Patient Date of Birth: _____ Age: _____

Patient Gender: M / F Patient Marital Status: __S __M __D __W Patient Preferred language: _____

Patient Race: _____ Patient Ethnicity: _____

Patient Home Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone #: _____ Alternate #: _____ Cell___ Work __

Email address: _____

Insurance Information

(Please provide information for the insured/person who provides the coverage **Please have cards ready to scan)

Name of **Primary** Insurance: _____ Policy / ID #: _____

Group # (if any): _____ **Policyholder's Employer**: _____

Name of Policyholder: _____ Policyholder's DOB: _____

Policyholder's SS #: _____ Relationship to patient: _____

Name of **Secondary** Insurance: _____ Policy / ID #: _____

Group # (if any): _____ Policyholder's Employer: _____

Name of Policyholder: _____ Policyholder's DOB: _____

Policyholder's SS#: _____ Relationship to patient: _____

Emergency Contact

Name: _____ Phone #: _____ Relationship: _____

Insurance Assignment / Billing policy of the office

I hereby authorize payment directly to the physician for medical and/or surgical benefits. I acknowledge that if this office is non-participating with my insurance, that I am responsible for payment on the date of service. I understand that I am responsible for any amount not covered by insurance including co-pays, deductible or co-insurance set forth by my insurance company. I understand co-pays are due on the date of service. I authorize the physicians of this office to release any information in the course of treatment to ONLY my insurance company upon their request. I understand this office will not engage in matters involving third party personal billing resulting in custody, court order or personal circumstances (if patient is a minor). I understand that if my insurance is an HMO, that I must obtain a referral from my primary care physician prior to services being rendered. I fully understand the insurance assignment and billing policies of this office. I certify that all information provided is accurate and correct.

_____ _____
Patient Signature or Legal Guardian if patient is a minor Date of signature

Patient Name: _____ DOB: ____/____/____

Primary Care Doctor: _____ PCP phone #: _____

Medications that you are CURRENTLY taking: _____

_____

_____

Medication Allergies (list all and reactions): _____ ( ) None Known

_____

Patient Height: _____ Weight: _____ Pharmacy name & phone#: _____

Past medical history (check all that apply)

___ Hypertension
___Gastroesophageal reflux disease (GERD)
___Asthma
___Diabetes (type I___ type II___)
___Hepatitis (A or B or C)
___Liver disease
___Coronary artery disease
___Atrial Fibrillation
___Sleep apnea
___Thyroid disease
___Emphysema
___Psychiatric condition
___Seizure
___Migraine headaches
___Stroke
___Kidney disease/failure
___Malignant hyperthermia
___Cancer (site _____)

Please note any other medical conditions: _____

_____

Review of systems (check all that apply)

___fevers
___constipation
___Incoordination
___nipple discharge
___chills
___diarrhea
___lightheadedness
___vaginal discharge
___itchy skin
___nausea or vomiting
___spinning sensation
___runny nose
___frequent colds
___difficulty hearing
___shortness of breath
___nose bleeds
___swollen glands
___light sensitivity
___chronic cough
___nasal obstruction
___headaches
___change in vision
___coughing up blood
___sinus infections
___heartburn
___blood in urine
___easy bleeding/bruising
___neck stiffness
___difficulty swallowing
___blood in stool
___enlarged lymph nodes
___neck pain
___change in voice
___limb weakness
___change in sleep pattern
___CPAP use

Past surgical history and approximate date(s): _____

_____

Are there illnesses that run in your family? (yes / no) What? _____

Are you on a blood thinner? (yes / no) Name: _____

Do you use tobacco products? (yes / no) Have you ever used tobacco products in the past? (yes / no)

What product, how much, low long ago, and (if applicable) how long have your quit? _____

Do you drink alcohol? (yes / no) Do you use recreational drugs? (yes / no) If so, what? _____

Have you had a flu shot this year? (yes / no) If so, approximate date? _____

Have you seen another physician for the condition you're being seen for today? _____

Are there any imaging studies (xr-ays/CT/MRI) performed for this condition? (yes / no) If so, where? _____

_____ _____ Physician Reviewed _____

Signature of patient or legal guardian Date Date_____

Oakland ENT PLC

Office Billing Policy:

(This form requires a signature)

Insurance copays will be collected on the date of service. If you are not able to pay your copayment today, please reschedule your appointment. For your convenience, our office accept checks, Visa, Mastercard, Discover, American Express and cash.

There will be a $5.00 per month statement fee that will be charged to your account each month if our office has to mail a statement to collect for an office copay. Initials_____

It's our office policy to verify eligibility for ALL insurances on the date of service. If we determine your policy is in the "grace period," you will be informed and have the option to reschedule your appointment. Our office reserves the right to collect IN FULL for services rendered on the date of service and thereafter, if there's a lapse in coverage and/or termination of the plan.

We reserve the right to collect ANY and ALL balances IN FULL on the date of service, prior to being seen.

Private pay (no-insurance) must pay IN FULL on the date of service, prior to being seen.

Our returned check fee is $35.00. In addition, there will be a $5.00 statement fee.

There is a $50.00 charge for ALL scheduled appointments that you DO NOT show for. Initials_____

We require 24 hour notice for cancelled and/or rescheduled appointments. The office reserves the right to refuse rescheduling future appointments after several cancelled and/or rescheduled appointments.

If after 90 days, we have not received payment from your insurance company, our office reserves the right to send the entire bill to the patient for payment. It will be your responsibility at that point to contact your insurance company with any questions or concerns regarding your bill.

Due to many changes to insurance policies, it is no longer an easy task to interpret each individual policy. Although we try to stay on top of these changes, it is not always possible. **It is your responsibility to know the special terms, deductibles and/or copays of your insurance coverage.** Failure to notify us will result in non-covered expenses which will be your responsibility.

Please remember your insurance policy is between you and your insurance company and not with the insurance company and your doctor.

The intention of this notice is to clarify our office policies and procedures and promote good communication between our patients and our office.

I understand the billing procedures associated with this office and completely understand additional charges will be incurred if I fail to comply. I agree to pay ANY balance IN FULL as set forth by my insurance company and/or charges set forth by this office.

_____ _____

Print patient name Signature of patient and/or guardian if under 18 yrs old

_____ _____

Relationship to patient Date of signature

HIPAA OMNIBUS RULE

Patient Acknowledgement of Receipt of Notice of Privacy Practices And Consent / Limited Authorization & Release Form

You may refuse to sign the acknowledgement & authorization. In refusing, we will not be allowed to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for the healthcare providers of this office. A copy of this signed, dated document shall be as effective as the original. **My signature will ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTORS AND/OR FACILITY IN THE FUTURE.**

_____ _____

Please PRINT patient name Signature of Patient and/or Legal Guardian

_____

Signature of Witness / Office Representative

Comments (if any) regarding Acknowledgment of Consent: _____

_____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION: (This includes Parent(s), Step-parent(s), Grandparent(s), Sibling(s) and any other Caregiver(s) who can have access to patient's protected health information):

Spouse: _____ ___Yes ___No

Parent: _____ ___Yes ___No

Other: _____ ___Yes ___No Relationship: _____

Other: _____ ___Yes ___No Relationship: _____

I authorize contact from this office to CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFO via:
___ Cell phone ___Home phone ___Work phone ___ Email ___ Facsimile ___ **ALL INCLUDED**

I authorize INFORMATION ABOUT MY HEALTH be conveyed via:
___Cell phone ___Home phone ___ Work phone ___Email ___ Facsimile ___**ALL INCLUDED**

In signing this HIPAA Patient Acknowledgment Form, you have acknowledged and authorized, that this office may recommend products or services to promote your improved health. We understand current HIPAA Omnibus Rule and provide you this information with your knowledge and consent.

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Office Use Only: I attempted to obtain written authorization of receipt of Notice of Privacy Practices, but acknowledgement could not be obtained because: ___ Individual refused to sign ___ Communication barrier ___ Emergency situation occurred with patient ___ Other (explain): _____

_____ (Signature of Privacy Official)