



Patient Information/Responsible Party:

Social Security #: _____ Last Name: _____ First Name: _____

Other Name (nickname/name you go by): _____ Middle Name: _____

Address: _____ City/State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cell Phone: _____

Sex: M F Race: _____ Birthdate: _____ Marital Status: S M W D

Employer name: _____ Work Address: _____

Insurance and Employer Information:

Primary Insurance Co. Name: _____ Policy #: _____

Name of Subscriber: _____ Birthdate: _____ SS#: _____

Subscriber's Employer: _____ Work Address: _____ Phone #: _____

Patient's relationship to subscriber: SELF SPOUSE CHILD OTHER _____

Secondary Insurance Co. Name: _____ Policy #: _____

Name of Subscriber: _____ Birthdate: _____ SS#: _____

Subscriber's Employer: _____ Work Address: _____ Phone #: _____

Patient's relationship to subscriber: SELF SPOUSE CHILD OTHER _____

If Medicare is secondary payor, please indicate reason _____

Is this visit related to Workers Compensation or Motor Vehicle Accident? _____

If yes, please note we do not file 3rd party liability claims (MVA/WC) therefore; payment is due when services are rendered. We will provide you with a receipt that you can use to seek reimbursement directly.

Referring Physician Information:

Dr. _____ referred me. Pharmacy: _____ Phone #: _____

Emergency Contact: *(The phone number needs to be different from the home phone number.)*

Name _____ Relationship to Patient: _____ Phone: _____

Medical Consent: I consent to the examination, treatment, and procedures which may be performed during the office visit, including emergency treatment considered necessary by the physician.

Financial Policy: Payment for services as rendered is expected unless other arrangements are made in advance. As a courtesy, we file most primary insurance carriers and some secondary (we do not accept Medicaid as a secondary payer). However, the patient or responsible party is responsible for all fees regardless of insurance coverage. I hereby authorize Carolina ENT to furnish information to my insurance carrier concerning my illness and treatments. I hereby assign the physician all payments for medical services rendered to my dependents and myself. I understand that I am responsible for any amount not covered by insurance and am responsible for the payment of this account. If my self-pay balance becomes more than 90 days old I understand that my account could be turned over to a collection agency.

SIGNATURE: _____ **DATE:** _____

As an adult, the patient is the primary contact and responsible party on this account. If a person other than the patient is to be the primary contact on this account, please fill out the following:

Name: _____ **Address:** _____

Phone #: _____ **Alternative Phone #:** _____ **Relationship to Patient:** _____

Signature of alternative responsible party: _____



MEDICAL AND SURGICAL HISTORY

Name: _____ Age: _____ Date of Birth: _____

Referring Physician (if any) _____

Today's Date: _____ Reason for today's visit? _____

How long have you had this problem? _____

Is your problem related to an accident? Yes No Date of accident ____/____/____

What medications or tests (i.e. x-rays, labs, etc) have you received for this problem in the past year?

MEDICAL HISTORY:

List all medical problems: _____

List all surgeries: _____

Please list your daily medications: (with strengths and dosage) _____

Please list all *medications* you are allergic to and your reaction(s) to each: _____

Please list any food or environmental *allergies* and your reaction(s) to each: _____

SOCIAL HISTORY:

Do you currently smoke tobacco? _____ Packs/day? _____ Have you ever smoked tobacco? _____

Do you use smokeless tobacco? _____ Packs/day? _____

Do you drink alcohol or beer? _____ Amount per week? _____

Occupation? _____ If patient is a child, does child attend daycare? _____

Number of children in classroom? _____ Do any caregivers smoke? _____

FAMILY HISTORY:

Please list any illnesses which run in your family. Include bleeding disorders, or bad reactions during surgery. _____

Other information you would like the doctor to know: _____

Patient's name _____ Today's date _____

Do you have OR have you had problems with the following?

GENERAL **YES** **NO**

- 1. Chills
- 2. Weight loss
- 3. Night sweats
- 4. Other _____

EARS **YES** **NO**

- 1. Hearing loss-gradual
- 2. Hearing loss-sudden
- 3. Pain
- 4. Ringing
- 5. Dizziness or vertigo
- 6. Frequent infections
- 7. Other _____

NOSE **YES** **NO**

- 1. Nose bleeds
- 2. Injury
- 3. Congestion
- 4. Runny Nose
- 5. Mouth breather
- 6. Other _____

THROAT **YES** **NO**

- 1. Frequent sore throats
- 2. Difficulty swallowing
- 3. Hoarseness
- 4. Foreign body
- 5. Swollen tonsils
- 6. Thyroid problems
- 7. Other _____

EYES **YES** **NO**

- 1. Cataracts
- 2. Glaucoma
- 3. Distorted vision
- 4. Other _____

HEART **YES** **NO**

- 1. High blood pressure
- 2. Chest pain
- 3. Irregular heart beat
- 4. Previous heart attack
- 5. Other _____

LUNGS **YES** **NO**

- 1. Bronchitis
- 2. Asthma/wheezing
- 3. Congestion
- 4. Other _____

GASTROINTESTINAL **YES** **NO**

- 1. Indigestion
- 2. Ulcers
- 3. Diarrhea
- 4. Diverticulitis
- 5. Gall bladder trouble
- 6. Nausea & vomiting
- 7. IBS
- 8. Other _____

URINARY TRACT **YES** **NO**

- 1. Kidney problems
- 2. Painful urination
- 3. Bloody urination
- 4. Prostate problems
- 5. Other _____

MUSCULOSKELTEL **YES** **NO**

- 1. Back Pain
- 2. Weakness of limbs
- 3. Arthritis
- 4. Other _____

NEUROLOGICAL **YES** **NO**

- 1. Numbness
- 2. Migraine Headaches
- 3. Seizures
- 4. Stroke
- 5. Convulsions
- 6. Other _____

ENDOCRINE **YES** **NO**

- 1. Thyroid problems
- 2. Diabetes
- 3. Menopause
- 4. Hormonal replacement
- 5. Pregnant in past
- 6. Pregnant currently
- 7. Other _____

BLOOD DISORDERS **YES** **NO**

- 1. Low blood counts
- 2. Free bleeding
- 3. Blood clots
- 4. Hepatitis
- 5. Other _____

ALLERGY/IMMUNE **YES** **NO**

- 1. Seasonal allergies
- 2. Itchy eyes
- 3. Allergy testing in past
- 4. HIV or AIDS
- 5. Other _____

CAROLINA ENT FINANCIAL POLICY

OFFICE AND SURGICAL SERVICES

- Payment is expected at the time of service. **This includes co-pays, co-insurance, and deductibles.**
- For our self-pay patients (patients who have no insurance coverage), we offer a discount for professional services paid in full at the time of service.
- A parent or legal guardian must accompany patients who are minors. This accompanying adult is responsible for payment of the account. We reserve the right to reschedule if the minor child is not accompanied by a parent or legal guardian.

INSURANCE INFORMATION

- Not all insurance policies cover all services. **It is your responsibility to check with your insurance company to determine covered benefits.**
- If your insurance plan requires a referral or authorization number, it is your responsibility to make sure that referral is in place at the time services are rendered. If you choose to obtain services without the referral on file, you will be considered self-pay, and payment in full is expected at time of service.
- We do **NOT** accept Medicaid as a secondary payor. You will be responsible for any co-pays, co-insurance, or deductibles applicable to your primary policy.
- It is the patient/guarantor's responsibility to provide our office with a copy of the current insurance card. If unable to provide the card, Carolina ENT will make an attempt to obtain verification/benefits with the carrier. However, if we are unable to obtain verification /benefits, you will be considered self-pay with full payment being due at the time of service. It is also the patient/guarantor's responsibility to notify our office of any changes to your insurance coverage.

AUDIOLOGY SERVICES

Medicare requires a written referral for certain audiology tests in order for diagnostic tests to be covered. It is the patient's responsibility to ensure the referral is on file at the time of the visit. Should you choose to receive these tests without a referral, you will be asked to sign a Medicare waiver whereby you are acknowledging responsibility for non-covered charges and payment will be due at time of service.

PRESCRIPTIONS

Carolina ENT will charge **\$15.00** for prescriptions picked up at the office or called into a pharmacy. This charge must be paid prior to prescription being called in or at time of pick up. These fees are the responsibility of the patient and cannot be filed with any insurance company.

FORM COMPLETION FEES

Carolina ENT will charge a **\$25.00** processing fee for all forms plus a **\$5.00** per page form completion fee which must be paid at the time the request is made. Please allow five business days for completion. All completed forms will need to be picked up at the Greenville office.

NO SHOW FEES/CANCELLATIONS

Carolina ENT will charge a **\$25.00** fee for all missed follow up appointments and **\$50.00** for all missed New Patient appointments not cancelled within 24 hours of the appointment. We also reserve the right to charge a **\$50.00** cancellation fee if a surgery is rescheduled without a medical reason.

PAST DUE ACCOUNT BALANCES

If you accrue a balance after your insurance has paid or considered your claim, we will send you 3 statements for payment. If your account becomes 90 days old, your balance will automatically be sent to collections. You will be charged a 20% fee in addition to your collection balance. You will also be subject to a review by the physician for dismissal from the practice.

I have read and understand Carolina ENT's financial policy and I agree to be bound by the terms. I also understand and agree that such terms may be amended by the practice from time to time.

Printed name, patient #

Signature

Date

Carolina ENT
Authorization to Use and Disclose Protected Health Information

Use and Disclosure of Your Protected Health Information

Your protected health information will be used by Carolina ENT or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice. There is potential for re-disclosure. The person or organization to which health information is sent may repeatedly disclose health information that is identified by this authorization. The privacy of this information may not be protected under the federal privacy regulations.

Notice of Privacy Practices

Carolina ENT is required to provide you with a notice that describes how information about you may be used and disclosed. Additionally, we must provide you information on how you may get access to this information. These policies and practices are defined in the "Notice of Privacy Policies and Practices" letter provided to you. **PLEASE REVIEW IT CAREFULLY.**

Requesting a Restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your protected health information. Carolina ENT may or may not agree to restrict the use or disclosure of your protected health information.

If Carolina ENT agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected health information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected. Contact our Office Manager/Privacy Official at 864-281-9440 to terminate this authorization.

Reservation of Right to Change Privacy Practices

Carolina ENT reserves the right to modify the privacy practices outlined in the notice. I understand that Carolina ENT, PA will notify me of these changes via the method I have authorized or upon my next appointment.

Rights of the Individual

*You may inspect or copy the information used or disclosed under this authorization by contacting our office, 864-281-9440.

*You may refuse to sign this authorization. If you refuse to sign, Carolina ENT will not deny you treatment.

1. Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis: **If you wish a spouse, step-parent, child, secretary, friend, etc. to have access to appointment times, health information, and/or billing information, please list them here.**

_____	may have access to:	all info	appt info	billing info	diagnosis/medical info
			only	only	only
_____	may have access to:	all info	appt info	billing info	diagnosis/medical info
			only	only	only
_____	may have access to:	all info	appt info	billing info	diagnosis/medical info
			only	only	only
_____	may have access to:	all info	appt info	billing info	diagnosis/medical info
			only	only	only
_____	may have access to:	all info	appt info	billing info	diagnosis/medical info
			only	only	only

1. Your billing statements and/or correspondence from our office will be sent to the address provided by you on your patient information sheet.

All clinical correspondence will be marked "CONFIDENTIAL" when mailed directly from our office.

2. The practice may use your information to remind you about upcoming appointments. Typically, appointment reminders are done by telephone and a brief, non-specific message may be left on your answering machine or voicemail. The home number you provided on your patient information sheet will be used to contact you.

We may also leave messages regarding treatment and/or other information pertinent to your healthcare and payment for your care provided at Carolina ENT.

If you do not wish to be contacted in this manner, how else may we contact you? _____

Signature

I have reviewed this consent form and received a copy of the notice entitled "Notice of Privacy Policies and Practices". I consent for Carolina ENT to use and disclose my health information in accordance with this authorization and the notice of privacy provided to me.

Name of Patient (Print/Type)

Signature of Patient **OR** Signature of Patient Representative

Date

Relationship of Patient Representative to Patient