THIS FORM MUST BE FILLED OUT BY A PARENT OR LEGAL GUARDIAN – IF GUARDIAN, LEGAL DOCUMENTS MAY BE REQUIRED. IF YOU ARE NEITHER THE PATIENT'S PARENT NOR A COURT APPOINTED GUARDIAN, PLEASE INFORM THE RECEPTIONIST IMMEDIATELY.

Patient Information:

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

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

Address: _____ City/State: _____ Zip: _____

Home Phone: _____ Sex: _____ Race: _____ Birthdate: _____

Responsible Party: Person responsible for payment

Name of Accompanying Adult (Last, First, MI)

_____

Birthdate: _____ SS#: _____ Employer of responsible party:

_____

Patient's relationship to responsible party: CHILD OTHER _____

Address of responsible party: SAME AS ABOVE or Other: _____ City/State: _____ Zip:

____

Home Phone: _____Work Phone: _____ Ext: _____Cell Phone:

_____

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 _____

Referring Physician Information:

Dr. _____referred me.

Pharmacy: _____ Phone#: _____

Emergency Contact: Please fill in any spaces that apply: ***(The phone number needs to be different from the home phone number.)***

Mother's Name: _____ Phone:_____ Father's Name: _____ Phone:_____

Legal Guardian/Custodial Parent's name(s) _____ Phone: _____

Other Emergency Contact 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: Professional services rendered are the responsibility of the adult accompanying any minor. We file most primary insurance carriers and some secondary. We do not accept Medicaid as a secondary payer. However, the patient or responsible party will be responsible for all fees regardless of insurance coverage. Payment for services rendered is expected unless other arrangements are made in advance. 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 my dependents and myself. By signing this form 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 of responsible adult: _____ DATE: _____ RELATIONSHIP TO PATIENT:_____

Rev. 1/11

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.

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