Ear Nose &Throat Associates of Manatee, P.A.

Patient Information

PLEASE PRINT in all fields.

Today's Date _____

Last Name:_____ **First**:_____ **Middle**: _____ **Suffix**: ____

Nickname: _____ Marital Status: ◯Single ◯Married ◯Widowed ◯Divorced ◯Partner ◯Other

Social Security Number: _____ Birth Date: _____/_____/_____

Gender: ◯Female ◯Male ◯Other _____ Preferred Language: _____

Ethnicity: ◯Hispanic/Latino ◯Not Hispanic/Latino ◯Refused ◯Other _____

Race: ◯Asian ◯Black/African American ◯Caucasian ◯American Indian ◯Refused ◯Other _____

Emergency Contact: Name: _____ Relationship: _____

Phone: _____

PATIENT CONTACT INFORMATION Preferred phone # for patient contact: ◯Home ◯Work ◯Mobile

Home phone: (_____) _____ Work phone: (_____) _____ ext: _____

Mobile phone: (_____) _____ Is it OK to leave a detailed message? ◯Yes ◯No

Personal Email Address: _____

Florida Mailing Address: _____ Apt/Lot/Unit # _____

City: _____ State: _____ ZIP Code: _____

Seasonal Resident Start Date: _____ End Date: _____ ◯Permanent Florida Resident

Out-of-State Address: _____ Apt/Lot/Unit # _____

City: _____ State: _____ ZIP Code: _____

Employer's Name: _____ Occupation: _____

City: _____ State: _____ Retired: ◯Yes ◯No

Responsible Party (if patient is a minor): _____ SSN: _____

Relationship to Patient: ◯Parent ◯Other _____ Birth Date: _____/_____/_____

Address (if different from patient): _____ Apt/Lot/Unit # _____

City: _____ State: _____ ZIP Code: _____

◯Contact phone same as patient Phone: _____ Work #: _____

Patient Information...continued **PLEASE PRINT in all fields.**

Patient: _____ **Please provide your insurance cards and photo ID to scan into our records.**

Referring Physician Name: _____ Phone: _____

City: _____ State: _____

Primary Care Physician Name: _____ Phone: _____

City: _____ State: _____

Primary Insurance Name: _____ ○ Policy Holder is Patient

ID # _____ Group # _____

Other Policy Holder Name: _____ Birth Date: _____/_____/_____

Relationship: _____ SSN _____ Phone: _____

○ Address same as patient Address if different: _____

Secondary Insurance Name: _____ ○ Policy Holder is Patient

ID # _____ Group # _____

Other Policy Holder Name: _____ Birth Date: _____/_____/_____

Relationship: _____ SSN _____ Phone: _____

○ Address same as patient Address if different: _____

PLEASE NOTE: We file secondary insurances as a courtesy for our patients. **Tertiary insurance is submitted by the patient.**

Insurance Authorization, Assignment and Patient Billing

I understand that Commercial HMOs and Medicare Advantage HMOs may need a Primary Care Physician (PCP) referral through my insurance payer. HMO or PPO services that are not authorized will be rescheduled. If I have questions about referrals or authorizations, I will contact my insurance payer's Member Services Department or, if applicable, my Primary Care Physician. Depending on the services I need, I may be required to make a deposit or sign a payment agreement for estimated charges prior to treatment.

I understand that I am responsible for amounts not covered or authorized by my insurance payer for all office or surgical charges. If I fail to provide my current medical insurance card(s) at the time of my visit, or when my insurance coverage has changed, I agree to be fully responsible for payment of all charges if denied by my insurance payer. I understand I have the right to ask about additional costs for any services. I understand that procedures are separately billed in addition to the office visit and my insurance payer may apply deductible, co-insurance or copays to any service. I understand and agree that I am responsible for timely payment of co-insurance, copays and deductibles as determined by my insurance payer and billed to me by Ear, Nose & Throat Associates of Manatee.

I hereby authorize Ear, Nose & Throat Associates of Manatee, PA, to furnish information to insurance payers concerning my illness and treatment, and I hereby assign to the physician(s) all payments for medical services furnished to myself or dependents. **To the best of my knowledge the information I have provided is complete and accurate.**

Sign: _____ **Date: _____**

Ear
Nose
&Throat
Associates
of Manatee, P.A.

Authorization to Disclose Protected Health Information

Is it ok to release your medical information to anyone other than yourself? ◯ Yes ◯ No

Please list who we may speak with regarding your medical care; we cannot speak with anyone that is not listed below.

Name: _____

Contact Number: _____

Relationship to Patient: ◯ Spouse ◯ Parent ◯ Child ◯ Friend ◯ Other

Name: _____

Contact Number: _____

Relationship to Patient: ◯ Spouse ◯ Parent ◯ Child ◯ Friend ◯ Other

Name: _____

Contact Number: _____

Relationship to Patient: ◯ Spouse ◯ Parent ◯ Child ◯ Friend ◯ Other

HIPAA DISCLOSURE: By signing below, I understand that Ear, Nose, and Throat Associates of Manatee, PA shall not publish or otherwise make generally available any protected individually identifiable health information or data that identifies a patient for purposes other than treatment, payment or other health care operations without his/her express written consent. I understand that this does not restrict the internal use of such information or data that is required in the performance of the scope of work that this office has been engaged to perform for patients. I understand that this office maintains physical, electronic, and procedural safeguards to protect individually identifiable health information. As a patient of Ear, Nose, and Throat Associates of Manatee, PA, I understand that I have the right to request special privacy protections. I have the right to request restrictions on certain uses and disclosure of my health information, by written request specifying what information I want to limit and what limitations on use or disclosure of that information I wish to have imposed. I hereby acknowledge that this medical practice's "*Protecting the Confidentiality of Our Patients' Personal Medical Information"* brochure has been made available to me.

I agree for my images to be used for medical records purposes ◯ Yes ◯ No

_____

Patient Name (Please Print) Date of Birth

_____

Patient Signature or Legal Representative Today's Date

Ear Nose &Throat Associates of Manatee, P.A.

Medical History Information

DATE OF VISIT: _____

NAME: _____ DATE OF BIRTH: _____

Pharmacy: _____ Pharmacy Location or Phone # _____

Referring Dr.: _____ Primary Dr.: _____

List ALL Medical Conditions (Add any additional information on the reverse side):

_____ _____ _____ _____

_____ _____ _____ _____

List ALL Surgeries (Add additional surgeries on the reverse side):

_____ _____ _____ _____

_____ _____ _____ _____

List ANY Medications you are currently taking (Add additional medication on the reverse side):

Name: _____ Dose: _____ Name: _____ Dose: _____

Name: _____ Dose: _____ Name: _____ Dose: _____

List ALL Medications you are allergic to (Add additional information on the reverse side):

Name of Medication: _____ Reaction: _____

Name of Medication: _____ Reaction: _____

Name of Medication: _____ Reaction: _____

Do you currently use tobacco? ◯ Yes ◯ No Did you previously smoke? ◯ Yes ◯ No

Do you drink? ◯ Yes ◯ No If so, how many per day? _____

Occupation: _____ Retired? ◯ Yes ◯ No

Family History (Add additional information on the reverse side):

Family member: _____ Disease: _____

Family member: _____ Disease: _____

Family member: _____ Disease: _____

Did you have the flu vaccine this season?	◯ Yes	◯ No
Have you had a mammogram within the past 2 years?	◯ Yes	◯ No
Have you ever had the pneumonia vaccine?	◯ Yes	◯ No
Have you had a pap test within the past 2 years?	◯ Yes	◯ No
Have you had a colonoscopy within the last 10 years?	◯ Yes	◯ No
Have you had a bone density scan?	◯ Yes	◯ No

Check any of the symptoms below that you are having TODAY!

◯ Night sweats ◯ Chest pain ◯ Painful Urination ◯ Severe Tremors ◯ Double Vision

◯ Coughing up blood ◯ Bleeding Skin ◯ Hallucinations ◯ Pale Skin ◯ Vomiting Blood

Reason for today's visit: _____

Ear
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&Throat
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of Manatee, P.A.

OFFICE POLICIES

Welcome to Ear, Nose & Throat Associates of Manatee. We are thankful that you have chosen us. We are committed to providing the highest quality care to our patients.

Identification

All patients are required to produce a government issued photo identification card along with their insurance cards. A photo of the patient will be taken and stored in their electronic medical record.

Scheduled Appointments

Every effort is made to keep patient waiting time to a minimum. We ask all patients to arrive well ahead of their appointment time as to facilitate any additional paperwork. To expedite the process, information can be updated through the patient portal. Please bring a list of all prescribed and over the counter (OTC) medications you are presently taking to each office visit. *If any testing has been done since your last visit, bring both the films and all reports for your doctor to review.* Patients who arrive 15 minutes or more after the appointment time maybe asked to reschedule for the next available opening.

Same Day Appointments

If you believe a "same day" appointment is required, please call the office as early as possible beginning at 8:00am. If your doctor does not have an available appointment but another has an opening, we may offer an appointment with another doctor within our group.

Cancellation/No Show Policy

If you are unable to keep a scheduled appointment, we ask that you call at least 24 hours in advance so that we may be able to accommodate another patient that may need immediate attention. There will be a $25 charge per NO SHOW which will have to be paid before your next scheduled visit.

Communication with Your Doctor

We encourage all our patients to contact our office and access specific portions of their medical record via their patient portal. Instructions for registering, accessing, and recovering your portal account are available. Your communication goes directly to your healthcare team and in most cases, your doctor will be the one to answer your email message. This is the fastest and most reliable means of communicating with your doctor.

Prescription Refills

Refills will not be handled outside office hours and request can take as long as three (3) business days to complete. *Call your pharmacy regarding refills well in advance to allow sufficient time for the pharmacy, and your doctor, to receive and respond to your request before you run out of your medication.* If you are out of refills, you may need to schedule a follow-up appointment with your doctor.

After Hours

If you have a life-threatening emergency, call 911, or go to the nearest emergency room. Otherwise, please call the office on the next business day or send a message via the patient portal.

Referrals

Incoming and outgoing referrals can take time to obtain the necessary authorizations from your primary care doctor and/or your insurance company. We will make every effort to keep you informed of our progress with all those requiring authorizations.

Medical Records

We assure the privacy and confidentiality of your medical records. No information will be released by our office to any parties other than your doctors without your consent. Please request a records release form if you are aware of any medical record transmission requirements.

Forms (FMLA, Disability, etc.)

Some forms are extensive; we access a fee of $25 at the time of request for completion. There are some forms that may require an appointment prior to completion. Completed forms will not be returned until payment is received. Due to the complexity of many forms, please allow up to (2) weeks.

Financial Policy

Our group participates with most major insurance carriers. It is your responsibility to check with your insurance to find an in-network doctor. *It is imperative that the office has your correct insurance information on file at all times.* ***It is ultimately your responsibility to know the benefits provided under your insurance plan.*** As a courtesy to our patients, we file insurance claims for those insurances with which we participate. Accounts with outstanding balances over 120 days may be sent to collections.

Payment

Payment will be required at the time the services are rendered. Please note that your insurance company may process the claim with a higher patient responsibility. You may receive a statement for any outstanding balance.

Non-Covered Services

Your insurance company may deem some services are non-covered by your policy. It is your responsibility to know what services are non-covered by your plan. You will be fully responsible for these services per your insurance company. Your insurance plan may determine that some services are not medically necessary, and you may be billed for those services as well. Please check with your insurance carrier with additional questions.

Self-Pay Uninsured Policy

We will gladly offer a self-pay **UNINSURED** discount rate. However, payment is due when services are rendered. By accepting this discounted rate, you are stating you have no insurance and agree to the cash price as **PAID IN FULL** and will not seek reimbursement from any outside entity.

Standards of Behavior

We have a strict Standards of Behavior policy. We would appreciate every effort on the part of you, your family and friends to help the atmosphere within our facility remain calm and respectful. Anyone who is disruptive, disrespectful, use abusive or profane language, etc., will be asked to leave and immediately dismissed from the practice.

We appreciate your selection of our office to provide you care, and we will work hard to serve your needs. After your visit, a Patient Satisfaction Survey is sent to the email you provide. Your satisfaction and experience in our practice is important to us. We would appreciate your feedback.

Patient Signature:_____ Date: _____

Patient Printed Name:_____ DOB:_____