PATIENT INFORMATION SHEET

Patient Name_____ PCP_____

Must Have for Medicare

Address_____ Referred by

City, State_____ □ Physician Name_____

Zip Code_____ □ Friend □ Yellow Pages □ Internet

Home Phone #_____ □ Other_____

Social Security #_____ Patient Employer_____

Patient Sex M □ F □ Marital Status_____ Address_____

Birth Date_____ Age_____ Work Phone # _____

Student Yes □ No □ Part Time □ Full Time □ E-mail address_____

Spouse's Name_____ Spouse's Social Security #_____

Spouse's Employer_____ Address_____

Work Phone #_____

IN CASE OF EMERGENCY CONTACT_____

Home Phone #_____ Work Phone #_____

Relationship to patient_____

Reason for Today's Visit

GUARANTOR INFORMATION (for signature listed below)

Guarantor Name_____ Employer_____

Address_____ Address_____

City, State_____Zip_____ City, State_____Zip_____

Phone #_____ Phone #_____

Birth Date_____Sex M □ F □ Social Security #_____

INSURANCE INFORMATION

Referral Required Yes □ No □ Policy holder's date of birth_____

Name of Insurance Company_____

Address_____ Phone #_____

Name of policy holder_____ Relationship to patient_____

Address_____ Phone #_____

Employer of policy holder_____

Policy #_____Group #_____Effective Date_____

Our office will file insurance claims for you; however, office visit co pays and deductibles are payable on the day you are seen. Please remember you are responsible for all fees, regardless of insurance coverage. All HMO's, IPA's and EPI's require authorization. This is your responsibility. If we do not receive the authorization, payment is due at the time of service. I authorize the release of medical information necessary to process this claim and to Health Care Professionals requesting consultation and third party payers responsible for all or part of the physician's fees. I authorize payment of the medical and surgical benefits to Northside Ear, Nose and Throat Associates, P.C.

Signature of Patient or Legal Guardian_____Date_____

MEDICAL HISTORY INFORMATION

PLEASE MARK EACH ITEM THAT APPLIES. ADD ANY ITEMS THAT ARE NOT LISTED

	Yes	No
CHILDHOOD ILLNESSES		
Measles		
Mumps		
Whooping Cough		
Other		
MEDICAL ILLNESSES		
Hearing Loss		
Ringing in ears		
Dizziness		
Noise exposure		
Diabetes		
TB		
Hepatitis		
Pneumonia		
Other Chest Problems		
Hypertension (BP)		
Heart Disease		
Cancer		
Disorder of Digestion		
Ulcers		
Heartburn		
HIV		
Diarrhea Frequent		
Constipation - Chronic		
Urinary Tract Problems		
Seizures		
Stroke		
Depression		
Anxiety		
Difficulty with Clotting		
TRAUMA (Injuries)		
Fractures		
Severe Lacerations		
Auto Accidents		
Injuries on the Job		
ALLERGIES		
Hayfever		
Asthma		
Frequent Injections		
Other Alergies		

SURGERY (List all Surgery)

OTHER HOSPITALIZATIONS:

CURRENT MEDICATIONS: (List)

Are you allergic to any medications: (List)

Tobacco History Use:

HEIGHT: WEIGHT:

ANESTHESIA COMPLICATIONS: _____

_____

LIST OTHER ILLNESSES:_____

_____

PATIENT NAME:_____ DATE:_____

NORTHSIDE HEARING CENTER
FINANCIAL POLICY

Patient Name _____ Chart/Account #_____

We are committed to meeting your healthcare needs. Our goal is to keep your insurance or other financial arrangements as simple as possible. In order to accomplish this in a cost effective manner, we ask that you adhere to the following guidelines.

1. You are ultimately responsible for payment of charges for services you receive from our office. Any check payment dishonored by your bank will result in a **$35.00 return check charge** being added to your account.
2. It is your responsibility to provide us with your current address and telephone number(s).
3. All medical records requests must be in writing and received in our office 72 hours prior to the date needed. Records over 10 pages will only be mailed not faxed, and all medical records requests will have a fee based on the number of pages. The range of fees for this service is from $10.00-$50.00.
4. Our office collects an optional **Administrative Services Fee (ASF) of $10.00 per year** at your first visit of the year. These administrative fees are intended to cover the cost of certain administrative services we provide that are not covered by your insurance. You are not required to pay the ASF; however, if you choose not to pay the optional ASF, you will be charged for all non-covered administrative services, as needed. Completion of all forms, to include but not to be limited to, that you will pay for on an "as requested" basis are: FMLA, disability forms, school forms, patient requested generated reports, such as claims, statements, payment histories. These "as requested" forms will be charged at $50.00 per form.
5. Attention Medicare Part A or Part B patients: hearing aids or examinations for the purpose of prescribing, fitting, or changing hearing aids are excluded from coverage. Therefore, examinations in our office for audiology testing that are found to not be medically necessary are expected to be paid in full at the time of service.
6. **Full payment of hearing aids purchased through Northside Hearing Center are the responsibility of the patient. If the patient has hearing aid benefits with their insurance company it is the responsibility of the patient to file their own insurance, and accept what their insurance reimburses them**.
7. In the event the balance of your account becomes 60 days delinquent, your account may be sent to our collection agency. You would be responsible for the collection fees incurred.

**By signing below the patient understands the financial agreement above:

Patient Signature _____ Date_____

NORTHSIDE ENT, PC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

We are required to provide you with a copy of our Notice of Privacy Practices, which stated how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of the office's Notice of Privacy Practices.

_____

Please print your name here

_____

Signature

_____

Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy from this patient but it could not be obtained because:

A. The patient refused to sign
B. Due to emergency situation it was not possible to obtain an acknowledgement.
C. We were not able to communicate with the patient.
D. Other. Please provide specific details

_____
_____
_____
_____
_____
_____

HIPAA Acknowledgement of Receipt of the Notice of Privacy Practices
This form does not constitute legal advice and covers only federal, not state law.