Ear Nose & Throat Specialists PLLC
Patient Registration Form

Patient Information				
Today's Date	Home Phone	Cell Phone	**Alt. Phone**	**Email Address**
Reason for Visit				

Last	First Middle	☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms.	**Marital Status**	
Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	(Former Name)	Birth Date	Age	**Sex** ☐ **Male** ☐ **Female**
Street Address Apt #	City	State Zip	**Social Security #**	
Emergency Contact	**Relationship**	**Phone Number**		
Pharmacy Used for Medicines	**Location of Pharmacy**	**Phone #: (if known)**		
Primary Care Physician:	**Address:**	**Phone#:(if known)**		

Race – Circle Below		Ethnicity – Please Circle One Below		
American-Indian		African-American	American	Arabian
Asian		Asian-Indian	Australian	Austrian
Refuse to answer		Bavarian	British	Chinese
White/Caucasian		Eastern – European	European	Filipino
Hispanic		French	German	Hispanic
Pacific Islander		Irish	Italian	Japanese
Not Provided		Korean	Mexican	Polish
Other –Please List:		Puerto Rican	Russian	Scotch-Irish
		Scottish	Spanish	Other –Please List:

Billing Information		
Health Insurance Provider	ID #	Group #
Cardholder's Name (Subscriber)		**Cardholder's (Subscriber) Date of Birth**

Assignment and Release of Benefits

The above information is true to the best of my knowledge. I, the undersigned, certify that I (or my dependent) have insurance with ____________________ and assign directly to ENT Specialists PLLC all insurance benefits, if any, payable for services rendered. I understand that I am financially responsible for all charges whether paid by insurance. I authorize, ENT Specialists PLLC to release all necessary information to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature	**Relationship**	**Date**

Patient Billing Information		
Employer	Occupation	Employer Phone No.
Employer Address:		
Person Responsible for Acct (other than self)	**Relationship**	Address (if different)
Responsible Person's Phone #:	Date of Birth:	SS #:

Privacy Consent for Use or Disclosure of Patient Information for the Purposes of Treatment, Payment, and Healthcare Operation

I hereby consent to Ear, Nose and Throat Specialists, PLLC using or disclosing my protected health information for the purpose of providing treatment to me, obtaining payment for healthcare services rendered to me or to carry out the Practice's healthcare operations. I also consent Ear, Nose and Throat Specialists, PLLC using or disclosing my protected health information for treatment activities provided by another healthcare provider; as well as the payment activities conducted by another healthcare provider or entity. I further consent to the disclosure of my protected health information for another provider or healthcare entity to conduct healthcare operations including quality assessment and reviewing the competence of healthcare professionals.

Specific Records Expressly Included:

I expressly authorize release of the following information for the purposes of treatment, payment, and healthcare operations, if it is part of my protected health information: (CHECK ANY OR ALL YOU AGREE TO AUTHORIZE FOR RELEASE)

- o Chemical Dependency/Substance Abuse
- o Drugs
- o Alcohol
- o Sexually Transmitted Diseases

I further acknowledge Ear, Nose and Throat Specialist, PLLC has provided me a copy of its "Notice of Privacy Practices," which provides a detailed description of the uses and disclosures allowed by this consent; as well as other rights I have regarding my protected health information. I have also been given a copy of the office policies:

____

Signature of Patient or Personal Representative

____

Printed Name of Patient or Personal Representative

____
Description of Personal Representative's Authority

____
Date

Ear, Nose and Throat Specialists

Patient Name: Last____________________ First____________________ Middle______________________

Gender (Please Circle): Male Female Other

Date of Birth (Month/Day/Year): _________________________

Height: ___________ Weights: _______________ Blood Pressure: ______________

Name of Primary Care Physician:_______________ Name of Referring Provider:____________________

Preferred Pharmacy and Location: __________________________________

Reason for Today's Visit:__________________________________

Do you have any medication allergies (Please Circle)? Yes No

If you answered yes, please list them below:

Name of Medication	Type of Reaction (i.e., rash)

Please list any medications currently taking:

Name of Medication	Dosage	Condition Being Treated

Please list approximate dates/locations of any of the following studies done prior to today's visit:

X-rays:_________________ MRI/CT:_______________ Labs:_____________________

Labs:_________________ Sleep Studies:___________________________

Ear, Nose and Throat Specialists

Ultrasounds:______________________________

Please list approximate date/locations of any surgeries performed prior to today's visit:

Addendum to Billing Policy

Assignment of Benefits:

You hereby assign all medical/surgical benefits to include major medical benefits to which you are entitled. This includes Medicare, private insurance, and other health plans. Ear, Nose and Throat Specialists has a photocopy of this assignment and this is to be considered valid as the original. You understand that you are financially responsible for all charges whether paid by said insurance. You herby authorize the release of all your medical records from the physicians and institutions in order that you may be given the appropriate care.

Authorization of Release of Information:

You authorize any holder of medical or other information about me to release the social security administration and the Center for Medicare and Medicaid Services or its intermediaries or carriers any information needed for this or related claims. You permit a copy of this authorization to be used in place of the original signed assignment. You understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding information). We will file all claims as courtesy to you and your insurance company(s) and all necessary documentation for the claim processing.

Patient Financial Responsibility:

If your insurance company has not paid your claim after 90 days, the full amount of your bill is your responsibility and payment is due immediately. Furthermore, you understand that if for any reason the account is turned over to a collection agency, you will be responsible for a collection fee of 35% and should non-payment of account result in litigation, the collection fee shall increase to 50%, and you will also be responsible for court cost and service of summons cost. If at any time you provide a wireless telephone number at which to be contacted, you consent to receive calls, including but not restricted to communications regarding billing and payment for items/services, unless you notify Ear, Nose and Throat Specialists in writing.

________________________________ ________________________________

Signature of patient/responsible party Print Name

________________________________ ________________________________

Date Patient Name (If Different)

COVID 19 Waiver

Patient Name: ____

DOB: _________________________________

1) Have you traveled outside of the United States with the past 14 days?

   YES NO

2) Have you had contact with anyone associated with COVID-19?

   YES NO

3) Have you had a fever and/or any respiratory systems such as cough or shortness of breath within the past 14 days?

   YES NO

4) Have you tested positive for COVID-19 within the past 21 days and/or do you have a pending test result?

   YES NO

Date: ___________________________

Printed Name: ______________________________________

Signature: ____