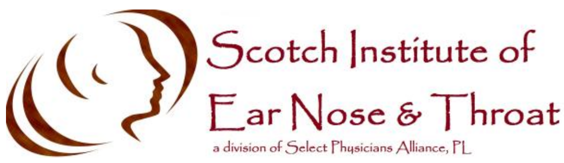


PATIENT REGISTRATION

Patient Name: ______________________ DOB: _____________

Date:_______________________

Please present insurance card & photo ID

Patient Last Name: ___________________________ First Name: _____________________ MI: _____

Preferred Name: _____________________________ Gender: ☐ male ☐ female

Date of Birth: _______ /_______ /________ Social Security #: __________________________

Local Address: _________________________________ City: ____________________ State: _____ Zip:__________

Permanent Address: ________________________________ City: _________________ State: ______ Zip: _________

Phones: Home (_____) ______________ Work (_____) ________________ Cell (_____) __________________

Contact Preference (circle one): Home / Work / Cell **Email:** ____

Preferred Language: English / Other: ____________ Race: _________________ Ethnicity: Not-Hispanic / Hispanic

Marital Status: ☐ Married ☐ Single ☐ Divorce ☐ Widow | ☐ Student ☐ Retired ☐ Employed (please complete next line)

Employer Name: _______________________________ Occupation: _______________________________________

Who referred you to our practice? Doctor (name) __________________________________

Insurance Plan ____________________________ Friend/Family (name) __________________________________

Internet (website name) __________________________ Yellow Pages ______________________________________

Advertisement (paper) ___________________________ Other (please specify) _________________________________

(If Patient Minor) Mother's Name: _______________ Father's Name: ________________ or Guardian: _____________

Emergency Contact Name: _______________________________ Relation to patient: ___________________________

Emergency Contact Home Phone: (_____) _________________ Emergency Contact Cell: (_____) __________________

<u>**Responsible Party** Information</u>

Patient's relationship to the Guarantor/Responsible Party: ____

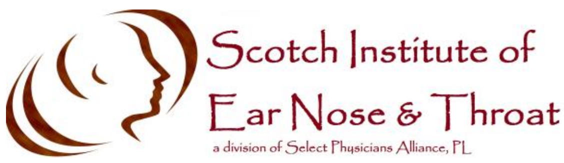
Guarantor Last Name: ______________________________ First Name: _______________________ MI: ________

Guarantor Date of Birth: ______ /_____ /________ Is guarantor's address the same at the patient? Yes / No

Guarantor Address: __________________________________ City: __________________ State: _____ Zip: __________

Guarantor Social Security #: ________-______-_________ Guarantor Phone: (_____) _________________________

Guarantor Email: ________________________________ Guarantor Employer Name: _________________________



PATIENT REGISTRATION

Patient Name: ________________________ DOB: ______________

Please list other **family member names** (and note relationships) that are existing patients:

____

____

Primary Insurance: ____ HRA Plan?___________

ID #___________________________________ Group #____________________ Phone #: _____________________

Policy Holder Last Name: ____________________________ First Name: ______________________ MI: ________

Social Security #: ______-_____-________ Date of Birth: ____ /____ /______ Gender: ☐ male ☐ female

Primary Care Physician: ____

Secondary Insurance: ____

ID #___________________________________ Group #____________________ Phone #: _________________

Policy Holder Last Name: ____________________________ First Name: ______________________ MI: ________

Tertiary Insurance: ____

ID #___________________________________ Group #____________________ Phone #: _________________

Policy Holder Last Name: ____________________________ First Name: ______________________ MI: ________

Preferred Pharmacy: ___________________________________ Pharmacy Location: ______________________________

Pharmacy Phone # if known: __________________________ (shopping plaza or cross streets if address not known)

Is the reason for your visit the result of an accident? ☐ YES ☐ NO

If YES, please complete this section:

Please check which type of accident: ☐ Workers Compensation ☐ Auto ☐ Other

Date of Accident: ____________________ What happened? ____

Claim # ______________________ Claim Representative/Adjuster: ____

FINANCIAL RESPONSIBILITY

Assignment of Insurance Benefits

I hereby assign Insurance / Medicare benefits to be paid directly to Scotch Institute of Ear Nose & Throat, a division of Select Physicians Alliance, PL. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned has personally signed the particular claim. I understand that I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by and paid to Scotch Institute of Ear Nose & Throat, will be credited to my account in accordance with the above said assignment.

Prompt Payment:

We require that our patients promptly pay all charges that we present to them. In some cases, our fees may be adjusted based on whether we participate in or accept insurance or government payments, allowances, or limitations. If you are reimbursed directly by a program for the cost of your care, you must still pay our charges promptly, whether or not you have received that reimbursement. If you do not agree with the patient responsibility amounts or reimbursement amounts set by your insurance or government program, this is a matter between you and that program. We are happy to provide you with factual information about your care and billing to help you discuss this with them, but we still require you to promptly pay the entire charge we present to you, even if your issue with the program is not resolved.

Payment for our services is due at the time that those services are provided to you. This includes co-pay amounts, coinsurance, deductibles, prior balances, and charges we believe are not covered by your insurance. We or our agents may send you statements and reminders of charges made and amounts that we believe must be paid, or may call you about the same. By accepting our services you are consenting to receive these communications.

I agree and understand that if payment is more than 60 days late, without having made any payments or payment arrangements, my account may be sent to **collections**, and Scotch Institute of Ear Nose & Throat may be entitled to interest, collection, and/or attorney fees as allowed by Florida law.

Patient information/authorizations/referrals:

I understand that insurance companies sometimes deny claims because of lack of information on the patient's part and will not pay these claims until the patient gives this information to them. If my insurance company has denied the claim because I have not given the information that they need to pay the claim, Scotch Institute of Ear Nose & Throat may transfer the balance to my responsibility.

I understand that if my insurance plan requires a referral or **prior authorization** for care and I do not obtain that authorization, Scotch Institute of Ear Nose & Throat may transfer the balance to my responsibility. It is my responsibility to know if my insurance plan requires a referral or authorization to see a specialist.

Scotch Institute of Ear Nose & Throat
a division of Select Physicians Alliance, PL

PATIENT REGISTRATION

Patient Name: ______________________ DOB: _____________

No Show Fees:

We require that you give our office **at least 24 business hours notice** if you need to cancel or reschedule an office or diagnostic testing appointment. We require at least **7 days notice** to cancel a scheduled surgery. Business hours are Monday through Friday from 8:30 AM to 5:00 PM.

The following no show/cancellation fees will apply:

No show / late cancellation appointment with Physician, Nurse, or Audiologist: **$35**
No show / late cancellation appointment for Allergy Testing with physician follow up: **$100**
No show/ cancellation of surgery less than 7 days prior: **$75**

INFORMATION ABOUT PROCEDURAL FEES FOR PATIENTS WITH HEALTH INSURANCE PLANS

With a copay plan, many insurance policies will cover only an office visit with the doctor which includes a comprehensive history and physical examination, diagnosis and treatment plan.

However, a patient presenting to our specialist office with sinus, allergy, throat or ear complaints requires a thorough examination of that specific area. In some cases, this can only be accomplished through the use of **additional specialized diagnostic equipment and procedures**. These medically necessary procedures allow your doctor to better evaluate and / or treat your condition. Some of the more common examples of these procedures that may need to be performed in conjunction with your office visit may include **nasal or laryngeal endoscopy** (a fiber optic telescope inserted through the nose to visualize the intranasal or laryngeal structures), use of **ear microscopy** (to visualize the external and / or middle ear anatomy or pathology), ear wax removal, minor surgical procedures, and others.

Therefore, **you may incur additional charges** should procedures be performed. Please note, we do not set the prices for the procedure fees, these are determined by your insurance company. Our office has no control over the prices set by the insurance company which you have contracted with.

A procedural fee will be submitted to your insurance carrier for any additional procedures that are performed during your office visit. We will accept your insurance company's allowance for this procedure. According to your policy, you will be obligated to pay any deductible, co-insurance, or co-payments that are applied to this procedure on the claim. Many insurance companies may list these diagnostic procedures as **"surgery"** on the insurance remittance advice you receive.

It is your responsibility to understand your particular insurance plan and benefits. If you have a high deductible plan or a co-insurance plan, you may receive a bill for these procedures.

We suggest you visit **http://www.fairhealthconsumer.org** for further information to help you understand your insurance policy and to estimate your costs for health care.

You have the right to refuse any medical care you wish, however you must understand this may impede the physician's ability to obtain the necessary diagnostic information to treat your individual condition.

Scotch Institute of Ear Nose & Throat
a division of Select Physicians Alliance, PL

PATIENT REGISTRATION

Patient Name: ______________________ DOB: _____________

AUTHORIZATION FOR THE USE OR DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT OR PAYMENT

As part of your healthcare, this practice originates and maintains paper and/or electronic records describing your health history, symptoms, examinations, test results, diagnoses, treatment, any plans for future care or treatment and payment for the services or treatment we provided. We use this information to:

- Plan your care and treatment
- Communicate with other health professionals or entities who contribute to your healthcare
- Submit your diagnosis and treatment information for payment for the services or treatment provided to you

"ONLY AS PERMITTED OR REQUIRED BY FEDERAL OR STATE LAW", WE MAY USE YOUR PROTECTED HEALTHCARE INFORMATION TO DO THE FOLLOWING:

- To disclose, as may be necessary, your health information (including HIV+/AIDS status, drug/alcohol abuse notes and qualified mental health notes) to other healthcare providers and healthcare entities (such as: referrals to or consultation with, other healthcare professionals, laboratories, hospitals, etc.) or to others as may be required by law or court order concerning your treatment, payment and/or healthcare.

- To request from other healthcare entities and/or healthcare providers (i.e. doctors, dentists, hospitals, labs, imaging centers, etc.) specific healthcare information we may need for planning your care and treatment.

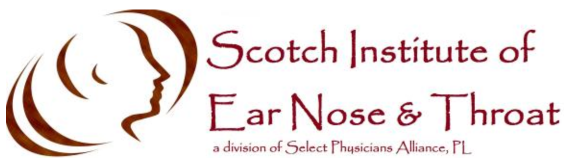
- To submit the necessary information to your insurance company(s) for coverage verification as well as the diagnosis and treatment information to your insurance company(s), other agencies and/or individual(s) for payment of our services or treatment we provided to you.

- To leave appointment reminders or other minimum necessary information related to your healthcare or healthcare payments on your answering machine, your mobile voice mail or with a household family member.
  [ ] **Please check here if you do not want us to leave messages on your answering machine or with a household family member.**
  [ ] **Please check here if you do not want us to leave a message on your mobile voice mail.**

- To discuss your health or payment information (only the minimum necessary in our judgment) with family members or other persons who are or may be involved with your healthcare treatment or payments.

- If you choose, please list by name and relationship the persons with whom we may share your healthcare or payment information____
  ____

- You have read or have had the right to read the "*Notice of Patient Privacy Practices*" prior to signing this authorization.



PATIENT REGISTRATION

Patient Name: ________________________ DOB: ______________

CONSENT TO TREAT

I hereby give my consent to all physicians and healthcare providers of Scotch Institute of Ear Nose & Throat, a division of Select Physicians Alliance, PL to provide medical treatment as deemed necessary.

CONSENT TO OBTAIN EXTERNAL PRESCRIPTION HISTORY

I authorize Scotch Institute of Ear Nose & Throat, a division of Select Physicians Alliance, to view my external prescription history via the RxHub service. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by the staff of Scotch Institute of Ear Nose & Throat, and it may include historical prescriptions for several years.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

By law, we are required to make available to you a copy of our Notice of Privacy Practices (“Notice”). By signing below you acknowledge that you received, or been offered and declined, a copy the Notice.

A current copy of the Notice is also posted in the office, or is available to you upon request. If the Notice is revised, you may review and obtain the new version at any time.

I have received, or declined, a copy of the Notice of Privacy Practices.

SIGNATURE SECTION

The undersigned has read and agrees to the information stated above for the:

- Assignment of Insurance Benefits
- Financial Responsibility of Patient, including prompt payment and referrals/authorizations, no show fees
- Authorization for the use or Disclosure of Health Information for Treatment or Payment
- Consent for Treatment
- Authorization of Release Confidential Prescription Information
- Notice of Privacy Practices for Protected Health Information

I fully understand and agree to this authorization and acknowledge the above rights and disclosures.

Patient Name (Print): _________________________ Legal Representative* (Print): ________________________________

Signature of Patient or Legal Representative*: ______________________________________Date: ____________________

*If other than patient is signing, are you the parent, legal guardian, legal custodian or have Power of Attorney for treatment and/or payment for this patient. Yes [ ] No [ ] RELATIONSHIP_____________________________________