

PATIENT REGISTRATION FORM

PATIENT NAME _____
(LAST) (FIRST) (MII) (SOC SEC #)

STREET OR BOX NO _____ CITY _____ ST _____ ZIP _____

HOME PHONE _____ CELL PHONE _____ EMAIL _____
 MARRIED DIVORCED WIDOWED F M BIRTHDATE _____

PATIENT EMPLOYER _____ OCCUPATION _____

EMPLOYER ADDRESS _____ WORK PHONE _____

RELATIVE/EMERGENCY CONTACT _____ PHONE _____

SPOUSE PARENT INFORMATION (* If parent information, fill both name sections out completely)

NAME _____ * NAME _____

ADDRESS _____ * ADDRESS _____

CITY _____ ST _____ ZIP _____ * CITY _____ ST _____ ZIP _____

HM PH _____ CELL _____ * HM PH _____ CELL _____

SOC. SEC # _____ BIRTH DATE _____ * SOC. SEC # _____ BIRTH DATE _____

EMPLOYER _____ * EMPLOYER _____

EMPL ADDRESS _____ PH _____ * EMPL ADDRESS _____ PH _____

PRIMARY INSURANCE
NAME OF INS _____
ADDRESS _____
CITY _____ ST _____ ZIP _____
PHONE _____ EFFECTIVE DATE _____
POLICY HOLDER NAME _____
POLICY HOLDER BIRTHDATE _____
POLICY ID/GRP # _____

SECONDARY INSURANCE
NAME OF INS _____
ADDRESS _____
CITY _____ ST _____ ZIP _____
PHONE _____ EFFECTIVE DATE _____
POLICY HOLDER NAME _____
POLICY HOLDER BIRTHDATE _____
POLICY IF/GRP # _____

PRIMARY CARE PHYSICIAN/REFERRING DOCTOR _____

ASSIGNMENT OF INSURANCE BENEFITS AND FINANCIAL RESPONSIBILITY AGREEMENT: I hereby authorize my signature on all insurance claim forms at the office of Midwest Ear, Nose, and Throat Surgery for payment directly to him/her for service rendered to me/patient. I authorize this office to make and send copies of medical records that may be needed to file my insurance claims. I understand that I/patient are responsible for changes incurred regardless of whether my insurance pays or not. I also understand I am responsible for any attorney fees and or court costs incurred in collecting any unpaid balances for services I/patient received. I authorize Midwest Ear, Nose, and Throat Surgery and any of its agents to contact me by telephone, at any of the numbers provided including any wireless number for me and/ or my spouse which could results in charges to me/us. Furthermore, I also authorize methods of contact may include using pre-recorded and/ or artificial voice messages and/ or automatic dialing devices, as applicable. **ALL CO-PAYMENTS, DEDUCTIBLES OR COINSURANCE ARE DUE AT TIME OF CHECK IN. THERE WILL BE A \$10 LATE FEE ADDED PER MONTH ON ALL BALANCES OVER 30 DAYS UNLESS PAYMENT ARRANGEMENTS HAVE BEEN APPROVED.**

SIGNATURE _____ DATE _____

Message to our Patients

We file your insurance as a courtesy to you; but you are expected to pay your co-insurance/co-payments/deductibles on the day of service. We accept cash, check, and credit cards.

All patients under the age of eighteen (18) will need a parent in attendance or legal guardian with written authority to treat patient at the appointment before medical care can be provided.

If your insurance company requires prior authorization for you to see a specialist, please contact your insurance company or referring doctor, whichever is applicable, before your appointment and bring your prior authorization form if required.

Medicare- We participate with Medicare using their guidelines. If you do not have a Medicare supplement the remaining 20% coinsurance will be collected at the time of visit.

Returned checks have a \$50 handling fee added to the account.

Forms – There is a fee for filling out forms. This includes FMLA forms.

It is the patient's responsibility to know what facilities and which physicians are providers of their insurance company network. You need to verify with your insurance company whether a referral or pre-certification is necessary. We will be happy to assist you as well to pre-certify a surgery; however it is your responsibility to know if it is actually a covered benefit with your member services.

We understand that information about you and your health is personal and we are committed to protecting the privacy of that information. Because of this commitment, we must obtain your special authorization before we may use or disclose your protected health information to communicate with you about the products and services available through our office. This form provides that authorization and helps us make sure that you are properly informed of how this information will be used or disclosed.

The information to be disclosed will relate to problems of the ears, nose, and throat and their treatment options. By signing below, I authorize Midwest Ear, Nose, and Throat Surgery to contact me via mail and/ or email regarding information as described above.

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Midwest Ear, Nose and Throat Surgery, PSC, for any services furnished to me. I authorize any holder of medical or other information about me, be released to the Health Care Financing Administration and its agents needed to determine these benefits or benefits for related services.

SIGNATURE

DATE

PRINTED NAME

DO YOU HAVE A COMMUNICABLE DISEASE TO REPORT TO THIS PHYSICIAN?

YES NO

Midwest Ear, Nose, & Throat Surgery, PSC

HIPPA RELEASE FORM

Patient Name: _____ Patient DOB: _____

By signing this authorization, I authorize Midwest Ear, Nose, & Throat Surgery, PSC to use and/or disclose certain medical and financial information to the people listed below. Privacy regulations require us to have a release signed by our patients so we may speak with family, friends, and other relations regarding your medical and patient financial information.

Please print each person's Name, Relationship to you, and a good contact phone number to reach them if we have any questions and are unable to reach you. And please check mark if you would like them to have medical or financial information access or that they are able to obtain both medical and financial information.

_____ Name	_____ Relationship	_____ Phone Number	<input type="checkbox"/> Medical	<input type="checkbox"/> Financial
_____ Name	_____ Relationship	_____ Phone Number	<input type="checkbox"/> Medical	<input type="checkbox"/> Financial
_____ Name	_____ Relationship	_____ Phone Number	<input type="checkbox"/> Medical	<input type="checkbox"/> Financial

Expiration of authorization—Provide a date or event that this authorization will expire (if unsure, put 30 days from today's date or "until disability resolved"): _____

** If there is anyone you would like to EXCLUDE from obtaining any or all of your medical or financial information please list them by name below.

Name

Name

This authorization gives **Midwest Ear, Nose & Throat Surgery, PSC** permission to use and/or disclose protected health information (PHI), including medical records and billing statements, (an authorization is not required for the purposes of treatment, payment or healthcare operations).

Right not to sign: You may refuse to sign this authorization. However, Midwest Ear, Nose & Throat Surgery, PSC cannot complete or release any forms without a signed authorization. Refusal to sign this authorization will not affect your ability to obtain treatment by Midwest Ear, Nose & Throat Surgery, PSC except in the case of care/evaluation that would be required for completing the requested forms to be disclosed to a third party (for example, a pre-employment physical, disability forms, etc.). In those instances, we may require a signed authorization prior to care/evaluation/consultation with a provider.

Right to revoke: You may revoke this authorization at any time except to the extent that we have relied on the authorization. To revoke this authorization, please submit a written revocation to the following address: Midwest Ear, Nose & Throat Surgery, PSC, Attn: Privacy Officer, 1020 Professional Blvd, Evansville IN 47714.

Re-disclosure: Health information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient, which we cannot be responsible.

Signature: _____

Date: _____

Midwest Ear Nose and Throat Surgery, PSC
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our office is dedicated to protect the privacy rights of our patients and the confidential information entrusted to us. The commitment of each employee to ensure that your protected health information (PHI) is never compromised is a primary concept of our practice as well as a federal requirement in the Health Insurance Portability and Accountability Act (HIPAA). We may amend our privacy policies and practices but will always inform you of any changes that might affect your rights. We reserve the right to call or contact you electronically to confirm or reschedule your appointment.

Protecting Your Personal Healthcare Information

We may use and disclose your PHI for:

- The care and treatment provided for health care services to you. We may use and disclose your PHI
- To pay your health care bills and to support the operations of your physician's practice such as coordinating your care.
- As require by law and will be limited to the relevant requirements of the law.
- To the public health authorities for public health activities purpose that are permitted by law such as preventing or controlling disease, injury, disability and exposure to a communicable disease or risk of contracting or spreading a disease or condition.

Disclosure of your Protected Health Information

- Agencies authorized by law for audits, investigations, and inspections such as government agencies who oversee health care system, government benefit programs and other civil rights laws.
- Public health authority authorized by law to receive reports of child abuse or neglect. In addition, we may disclose PHI if we believe that you have been a victim of abuse, neglect or domestic violence to the government entity or agency authorized to receive such information.
- Authorized person or company by the Food and Drug Administration for the purpose of quality, safety, or effectiveness of FDA-regulated products or activities such as tracking products, enable product recalls, or conduct post marketing surveillance as required by law.
- Any judicial or administrative proceeding in response to an order of a court or administrative tribunal, or conditions to a subpoena.
- Law enforcement for the purposes of locating a suspect, fugitive, material witness or missing person.
- A funeral director, coroner or medical examiner for identification purposes, determining cause of death or to perform duties authorized by law.
- Research regulated and approved by an institutional review board.
- Appropriate conditions such as: for individuals who are Armed Forces personnel, as deemed necessary by appropriate military command authorities; by the Department of Veterans Affairs; to foreign military authorities if you are a member of that foreign military service; for the purpose of conducting national security and intelligence activities including provisions of protective services to the President or others legally authorized.
- Comply with workers' compensation laws.
- Your provider of care if you are an inmate of a correctional facility.

Patient Rights

- Other use and disclosure of your PHI will be made only with your written authorization unless otherwise permitted or required by law.
- You may revoke this authorization in writing at any time. If you revoke your authorization, we will not use or disclose your PHI for the specifications of the written agreement.
- You have the right to inspect and copy your PHI for as long as we maintain the PHI. You may not inspect or copy psychotherapy notes, information compiled in anticipation of a civil or criminal proceeding, laboratory results that are subject to law the prohibits access, if you signed your authorization rights due to a trial program. As permitted by federal law, we may charge you're a reasonable copy fee for a copy of your records.
- You have the right to request a restriction of your PHI for the purpose of treatment, payment or health care operations when payment for the treatment has been made in full from out of pocket expense. You may also request PHI not be disclosed to family members or friends who may be involved in your care. Your physician is not required to agree to a restriction that you may request.
- You have the right to request to receive confidential communication by alternative means or locations.
- You have the right to have your physician amend your PHI, in certain cases we may deny your request for amendment.
- Your PHI cannot be used for marketing products and services without authorization from you.
- You have the right to receive an accounting of certain disclosures we have made, if any, on your PHI. This excludes disclosures we may have made for you if you authorized us to make the disclosure, for participating physicians who consult or assist with your care, for national security or other law enforcement disclosures.
- You have the right to complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer. We will not retaliate against your for filing a complaint.

This notice is effective as of March 31, 2013. If there are questions regarding this privacy policy or you believe your privacy rights have been violated or you wish to file a complaint about our privacy practices, you may contact: Julie Hanson at 812-473-2060 ext 219.

MIDWEST EAR, NOSE & THROAT SURGERY, PSC

**RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM.**

I, _____ have been made available a copy of

Midwest Ear, Nose & Throat Surgery, PSC's Notice of Privacy Practices.

Signature of Patient

Date