Patient Registration Form

Carolina Ear, Nose & Throat

Last Name: _____ First: _____ M.I. _____

Address: _____City/State/Zip: _____

Sex: _____ Date of Birth: _____

Phone: (C) _____ (H): _____

Email: _____

Select how you would like to be contacted by our office and if personal information regarding your care may be left:

Cell/text: Y/N Home: Y/N Email: Y/N

Emergency Contact: Name and relationship to patient: _____
Phone: _____

Primary Care Physician: _____ Referring Physician: _____

Pharmacy Name, Address & Phone: _____

How did you hear about our office?

** Doctor referral _____ Website: _____ Patient: _____ Other: _____ **

Privacy Policy

I acknowledge that the Notice of Privacy Practices has been provided to me regarding how ***Carolina Ear, Nose and Throat*** will protect my health information. I acknowledge that I have been given the opportunity to ask any questions that I may have regarding this policy. I understand that Carolina Ear, Nose and Throat may use or disclose my personal health information relating to me for purposes of treatment, payment, and health operations as disclosed in the notice.

_____ _____

Patient Name Signature of Patient, Parent or Legal Guardian

Patient refused to sign: _____

Employee signature/Date

Authorization to Release Information

I hereby give ***Carolina Ear, Nose and Throat*** permission to release my (Medical/Financial) information to Name: _____Relationship:_____.

This authorization will remain in effect until otherwise revoked. I understand that this authorization may be revoked at any time by contacting our office, in writing. Revoking authorization will not apply to anything up to that date.

_____ _____

Signed Dated

Insurance/Payment Policy

Carolina Ear, Nose & Throat will file insurance with contracted companies as a courtesy. It is however, your responsibility to be sure that any balances on your account are settled in a timely manner. We expect payment at the time of service. If your insurance policy requires a referral from your primary care physician, it is ***your responsibility*** to request that referral from them ***prior*** to your appointment. If you do not have the referral in place ***prior*** to your appointment, you will be asked to reschedule or ***pay in full***. Delinquent accounts may be reported to the Credit Bureau.

I agree to be responsible for all my medical expenses, therefore, I authorize my insurance company, attorney or other parties to pay directly to ***Carolina Ear, Nose and Throat*** and/or provide any information regarding payment of my bill, including appeals if necessary. I accept responsibility for any balance not paid for by my insurance company. I authorize the physician involved in my medical care to release any medical information necessary as related to treatment or payment including but not limited to diagnostic imagining and lab reports.

I have read and understand my financial obligation. _____

Sign Date

Diagnostic Procedures: Your physician may determine that they need to perform a diagnostic endoscopy to see inside your nose/throat to fully evaluate your symptoms.

This type of in-office procedure is a separate charge that is not included with your office visit. Your insurance company will view this procedure as “surgery” and will be listed as such on your EOB. All insurance plans are different so we have no way to determine how your insurance company will process and pay this claim according to your plan.

Although you have the right to refuse this procedure, we cannot be held responsible for any treatment we did not administer or recommend due to your refusal.

I have read and understand this diagnostic endoscopy policy. _____

Sign Date