Austin ENT ASSOCIATES

WELCOME TO OUR PRACTICE
New Patient Form
Adults 18 and older

Today's date: _____ MR#: _____

PATIENT INFORMATION

Last name _____ First Name _____ MI _____ Sex: ❑ M ❑ F

Age _____ Birth Date _____ Social Security # _____ Driver's Lic # _____

Home Address _____

City _____ State _____ Zip _____

Primary Phone _____ Secondary Phone _____ Work Phone _____

E-mail address to reach you: _____

May we share your e-mail address with the hospital or surgery center if you schedule surgery with one of our physicians? ❑ Yes ❑ No

Are you employed? Yes _____ No _____ Retired _____ Student _____

If yes, name of Employer _____

Occupation _____

Employer Address _____ Phone _____

Are you married? ❑ Yes ❑ No Name of spouse/partner _____ Phone _____

Spouse/Partner Employer's name & address _____

The Pharmacy you normally use _____ Phone _____

Name of nearest relative not living with you _____ Relationship _____

Address _____ Phone _____

Who do you authorize us to speak to regarding your medical care? Please list their name and relationship. _____

_____

PRIMARY INSURANCE INFORMATION

❑ Medicare ❑ Medicaid ❑ PPO ❑ HMO ❑ POS ❑ Private Pay

Insurance Company name & address _____

Policy holder's name _____ Birth date _____

Relationship to patient _____ Social Security # _____

Phone # _____ Identification # _____ Group # _____

SECONDARY INSURANCE INFORMATION

Insurance Company name & address _____

Policy holder's name _____ Birth date _____

Relationship to patient _____ Social Security # _____

Phone # _____ Identification # _____ Group # _____

REFERRED BY: ❑ Primary Care Physician ❑ Dentist ❑ Other Physician ❑ Friend ❑ Internet ❑ Other

Have you or any of your family members been seen as patients in this Practice? ❑ Yes ❑ No

If yes, name of patient _____ When? _____

Primary Care Physician _____ Phone _____

Dentist _____ Phone _____

Physician who referred you to our Practice? _____ Phone _____

***Please be sure to include first and last name of your physicians**

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Patient: _____ DOB: _____ Date: _____

Your current medication(s), medication allergies, and past health problems are an important part of your diagnosis and treatment plan. Please try to answer all questions fully.

What problem are you being seen for today? _____

_____

_____

What medications are you currently taking? Include any blood thinning over the counter agents such as aspirin, Motrin, Orudis, Aleve, Relafen, Lodine, ibuprofen, or naproxen. If you have a list, please let us make a copy of your list.

_____ _____

_____ _____

_____ _____

_____ _____

What medication allergies do you have? Please include the type of reaction you experienced:

_____

_____

Please list medical problems that are currently being treated by another physician (i.e. Hypertension, Heart Attack, Emphysema, etc.):

_____ _____

_____ _____

_____ _____

Do you have a history of cancer? If so, what type? _____

Please list any surgeries you have had in the past and the approximate dates:

_____ _____

_____ _____

Have you or any family member had any adverse reactions to general anesthesia? If yes, please explain: _____

_____

Have you received radiation in the past? Yes _____ No _____ Why? _____ When? _____

Do you or have you ever smoked? Yes _____ No _____ If so, for how long? _____ How much? _____ Currently Smoking? _____

Have you ever chewed tobacco? Yes _____ No _____ If yes, for how long? _____ Currently chewing? _____

Do you drink alcohol on a regular basis? Yes _____ No _____ If yes, how many drinks per day? _____ OR per week _____

Do you use any other "recreational drugs"? Yes _____ No _____

Please list any other information you think your physician should know about your health:

_____

_____

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Patient _____ DOB _____ Date _____

The following list reviews a number of health problems. Please place a check mark if you or your family has experienced any of these health problems.

	Problem	Patient	Family	Please explain
General	Fever/chills Fatigue Weight change			
Eye	Change in vision Glasses Cataracts or glaucoma			
Ear, Nose, & Throat	Nosebleeds Sore throat or tonsillitis Hoarseness Swallowing problems Hearing problems Dizziness or Vertigo Sinus or nose problems Tinnitus (ears ringing)			
Allergy	Seasonal Hayfever Food reactions Allergy shots Latex reactions			
Lung	Asthma Chronic cough Bronchitis or pneumonia			
Heart	Chest pain or palpitations Congestive heart failure Heart disease or surgery High blood pressure Coronary artery disease High cholesterol/triglycerides			
GI	Acid reflux / heartburn Abdominal pain Peptic ulcer disease Hepatitis / jaundice			
GU	Prostate problems GYN problems			
MS	Arthritis problems Back or neck problems Muscle weakness Gout			
Skin	Hives or rashes Eczema Breast disease			
Neurologic	Stroke Seizures Headaches or Migraines Neurologic problems			
Endocrine	Diabetes Thyroid problems Pituitary or adrenal problems Perimenopausal symptoms			
Psyche	Depression Anxiety			
Immune	Bleeding disorders Anemia problems Enlarged lymph nodes HIV / AIDS			

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AUSTIN ENT CONSENT PAGE

CONSENT FOR TREATMENT. I hereby authorize evaluation and treatment by the physician(s) at Austin ENT Associates.

_____ Date_____

SIGNATURE OF PATIENT/RESPONSIBLE PARTY

RELEASE OF INFORMATION. I hereby authorize Austin ENT Associates to furnish medical information for my current illness or injury, including hepatitis and HIV information, to my family physician(s), referring physician(s), and my insurance companies. I further authorize my family physician, referring physician, and other healthcare providers to furnish all medical information regarding my present illness or injury to Austin ENT Associates.

_____ Date_____

SIGNATURE OF PATIENT/RESPONSIBLE PARTY

ASSIGNMENT OF BENEFITS. I request payment of the medical and/or surgical benefits, otherwise payable to me, directly to Austin ENT Associates for services provided to me by them. I understand that I am financially responsible to Austin ENT for charges not covered by this assignment of benefits.

_____ Date_____

SIGNATURE OF PATIENT/RESPONSIBLE PARTY

RECORDINGS, VIDEOS, PHOTOS. At Austin ENT we have complete respect for your privacy. We would never make an audio, photographic or video recording of you without your specific permission. We ask that you likewise agree that neither you nor anyone with you will make any audio, photographic or video recording of anyone in this clinic without their express and specific permission. Please indicate your agreement by signing below:

_____ Date_____

SIGNATURE OF PATIENT/RESPONSIBLE PARTY

PATIENT APPOINTMENT REMINDERS. I authorize Austin ENT to send appointment reminders as indicated below- **PLEASE CHOOSE ONLY ONE**

____Send text to cell phone (_____) _____-_____

____Voicemail to cell phone (_____) _____-_____

____Voicemail to home phone (landline) (_____) _____-_____

_____Date _____

SIGNATURE OF PATIENT/RESPONSIBLE PARTY

***IF SIGNING AS RESPONSIBLE PARTY ABOVE, RELATIONSHIP TO PATIENT:**

_____

Austin ENT ASSOCIATES

AUSTIN ENT PAYMENT POLICIES

INSURANCE. There have been many changes in recent years in the way health insurance pays for your services at healthcare facilities. As a result, insurance has shifted more and more financial responsibility to patients. It is your responsibility to understand your insurance benefits. Please contact your insurance company with any questions you may have regarding your coverage, We will assist as best we can, but we do not have the staff time available nor is it our responsibility to educate patients on their individual plans as plans vary so much. Please understand that if you have a deductible plan, you basically have no insurance until that deductible has been met annually.

If your insurance card has a copay listed on it, we will collect the specialist copay and file your claim for services rendered. Deductible may apply if you are out of network. If you have any procedures with your office visit and your insurance applies those services to your deductible, you will receive a statement for the balance due. **Payment will be due upon receipt, or prior to any follow-up appointments, whichever comes first.**

If the insurance card does not show a copay, then that indicates it is a deductible plan. You will be charged the insurance allowable for any services rendered at the time of the visit. We will promptly file your claim and issue a refund if any overpayment has occurred. **If you owe an additional balance, a statement will be sent to you payable upon receipt, or prior to any follow-up appointments, whichever comes first.**

If you are private pay, the charge for the first consultation with the physician is $175 and will be collected at check-in prior to seeing the physician. Any additional procedures such as scopes, biopsies, hearing tests, etc. will be in addition to that and will be collected at check-out.

If you are private pay and you are an established patient, the charge for the office visit is $135 and will be collected at check-in prior to seeing your physician. Any additional procedures will be in addition to that and will be collected at check-out.

If you are scheduled for surgery, our office will verify your insurance benefits and eligibility for those services. ***An estimate of your financial responsibility will be given to you prior to your procedure***. You will be expected to pay your estimated amount. A refund will be issued to you promptly once the claim processes should any overpayment occur. **If you owe an additional balance, a statement will be sent to you payable upon receipt, or prior to any follow-up appointments, whichever comes first.**

Proof of Insurance. We must obtain a copy of your current insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information, you will be responsible for the balance of the claim. We also require a photo ID be presented at check-in. You will be asked for these items each time you see the physician. If you cannot provide your insurance card, you will be considered private pay.

Referrals and authorizations. Patients are responsible for obtaining necessary referrals and authorizations prior to your visit. You will be asked to reschedule your appointment or sign a waiver stating you will be responsible for the balance if the referral or authorization is not received by our office in a timely manner. It is the patient's responsibility to track the expiration date and number of referrals remaining.

Third party Insurance. We do not file third-party insurance under any circumstances, including motor vehicle accidents or other liability claims. You will be considered private pay and payment is expected at the time services are rendered.

Tertiary Insurance. We will assist in filing secondary claims, but we will no longer file tertiary insurance claims.

Nonpayment. Our office makes multiple efforts to inform patients of balances due. If your account is delinquent and you have not responded to statements and phone calls regarding your balance, you account will be forwarded to an outside collection agency. Once your account is referred to an outside agency, we cannot accept payment from you, you will have to deal with them directly.

I have read and understand the payment policy of Austin ENT Associates. I agree to abide by their guidelines above.

Signature of patient or responsible party_____Date_____

Relationship of responsible party_____

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