

Orlando Ear, Nose & Throat Associates, PA

Patient Information

Name _____ Soc. Sec. # _____

Address _____

City _____ State _____ Zip Code _____

Sex M ___ F ___ Age _____ Birth date _____ Single ___ Married ___ Widowed ___ Separated ___ Divorced ___

Home Phone _____ Cell Phone _____ email _____

Employment

Patient Employer _____ Occupation _____

Business Address _____ Bus. Phone _____

Primary Care Physician _____ Phone _____

Emergency Contact _____ relation _____ Phone _____

Primary Insurance Information

Person Responsible for Account _____ Soc. Sec. # _____

Relation to Patient _____ Birthdate _____

Address (if different) _____

City _____ State _____ Zip Code _____

Responsible's Employer _____ Occupation _____

Business Address _____ Business Ph _____

Insurance Company _____

Contract # _____ Group # _____ Subscriber # _____

Additional Insurance

Subscriber Name _____ Relation to Patient _____ Birthdate _____

Address (if different) _____ Phone # _____

City _____ State _____ Zip Code _____

Insurance Company _____ Social Security # _____

Contract # _____ Group # _____ Subscriber # _____

Signature _____

Orlando Ear, Nose & Throat Associates, PA

Authorization to Release or Use Information for Treatment, Payment, or Health Care Operations

Assignment & Release

I, the undersigned, hereby authorize the release of any information relating to all claims for benefits submitted on behalf of myself and/or my dependents. Further, I expressly agree and acknowledge that my signature on this document authorizes the physician or practice to submit claims for benefits, for services rendered, and for services to be rendered, without obtaining my signature on each and every claim to be submitted. For myself and/or my dependents, I acknowledge that I will be bound by this signature as though the undersigned had personally signed each particular claim.

I, _____ hereby authorize my insurance company _____ to pay and hereby assign directly to Orlando Ear, Nose and Throat Associates, PA all benefits payable to me for services as described on the following forms. I understand I am financially responsible for all charges incurred, regardless of insurance. I further acknowledge that any insurance benefits, when received by and paid to Orlando Ear, Nose and Throat Associates, PA will be credited to my account, in accordance with the above assignment.

Signature of Insured/Guardian

Non-Medical Charges

I authorize Orlando Ear, Nose and Throat Associates, PA, to bill to my account any required nonmedical or clerical charges and/or fees, inclusive of, but not limited to: medical records copying, medical records transferring, Family Medical Leave Act (FMLA) form completion, short term disability form completion/submission, long term disability form completion/submission, and postage for such items. Charges for returned checks, rates for paperwork completion, copying and submission will be in accordance with Federal and State laws regarding such fees, to the maximum allowed.

Signature of Insured/Guardian

Orlando Ear, Nose & Throat Associates, PA

Authorization to Release or Use Information for Treatment, Payment, or Health Care Operations

Information Release

I hereby authorize the release or use of my individually identifiable health information (“protected health information”) and medical record information by Orlando Ear Nose & Throat, PA (“the practice”) in order to carry out treatment, payment, or health care operations. A complete description of the potential release and use of such information is in the Practice’s Notice of Privacy Practices. You may request to review these notices prior to signing these consent forms.

The practice reserves the right to change the terms of its Notice of Privacy Practices at any time. If this occurs, you may request a copy of the revised notice.

You retain the right to further restrict how your protected health information is released or used to carry out treatment, payment or operations. Our practice is not required to agree to such requested restrictions; if we do agree to your requested restrictions, such restrictions are then binding to the Practice.

I acknowledge and agree that the Practice may disclose my protected health information and medical record information to the following entities, not inclusive of family members, legal representatives, guardians, health care surrogates, or powers of attorney, on my behalf:

I agree that the Practice may also disclose the following type of specific information contained in my medical record by initialing next the following:

_____ HIV/AIDS Information

_____ Mental Health Information

_____ Substance Abuse Information

_____ Sexually Transmitted Disease Information.

_____ Pregnancy Information (if patient is under the age 18)

Signature of Insured/Guardian

www.orlandoent.com

Orlando Ear, Nose & Throat Associates, PA

Authorization to Release or Use Information for Treatment, Payment, or Health Care Operations

Contact Preferences

I agree and consent to the Practice releasing information to me or to any designate in the following manners:

Please initial:

_____ Email _____ @ _____

_____ Regular Mail, marked "personal and confidential"

_____ Telephone, provided identity can be confirmed

_____ Fax, to preferred fax # _____

_____ SMS/Text, to wireless # _____

A change to the above information is the responsibility of patient/guardian. Regular mail and SMS to your wireless phone may incur additional charges. You may revoke this consent at any time, but must be submitted in writing. The revocation shall be effective except to the extent that the Practice has already taken action based on the prior consent.

The practice may refuse to treat you if you (or an authorized representative) do not/does not sign this Consent Form. If this Consent Form is signed and then revoked, the Practice reserves the right to refuse to provide further treatment to you as of the time of the revocation (except as required by law).

I have read and understand the information in this Consent. I may receive a copy of this consent at my request. I am either the patient or the party authorized to act on behalf of the patient to sign this document verifying consent to the above terms.

DATE _____ TIME _____ am/pm

Signature

Printed Name

www.orlandoent.com