* required fields

Patient Information/Responsible Party:

*Social Security #: ___________________*Last Name: _________________ *First Name: ________________________

Other Name (nickname/name you go by): _________________________________ Middle Name: _____________

*Address: ____*City/State: ________________________*Zip: __________

*Home Phone: ___________________Work Phone: ___________________ Ext: ____Cell Phone: __________________

*Sex: *Race: _______ *Birthdate: __________________ Marital Status: S M W D

Employer name: _______________________ Work Address: ____

Insurance and Employer Information:

***Primary** Insurance Co. Name: ____*Policy #:_______________________

*Name of Subscriber: _______________________________*Birthdate: _________________ *SS#: _____________

Subscriber's Employer: _________________ Work Address: __________________________Phone #: _________

*Patient's relationship to subscriber: SELF SPOUSE CHILD OTHER ____________________________

Secondary Insurance Co. Name: ____Policy #: _______________________

Name of Subscriber: _________________________________Birthdate: _________________SS#: ________________

Subscriber's Employer: _________________ Work Address: __________________________Phone #: _________

Patient's relationship to subscriber: SELF SPOUSE CHILD OTHER ____________________________

***Referring Physician Information:**

Dr. _______________________referred me.

***Emergency Contact:**

Name __________________________________ Relationship to Patient: _______________ Phone: ____________

Medical Consent: I consent to the examination, treatment, and procedures which may be performed during the office visit, including emergency treatment considered necessary by the physician. If an invasive procedure is necessary, a specific consent form will be discussed with me at that time.

Financial Policy: . Payment for services as rendered is expected unless other arrangements are made in advance. As a courtesy, we file most primary insurance carriers and some secondary (we do not accept Medicaid as a secondary payer). However, the patient or responsible party is responsible for all fees regardless of insurance coverage I hereby authorize Carolina ENT, PA to furnish information to my insurance carrier concerning my illness and treatments. I hereby assign the physician all payments for medical services rendered to my dependents and myself. I understand that I am responsible for any amount not covered by insurance and am responsible for the payment of this account. If my self-pay balance becomes more than 90 days old I understand that my account could be turned over to a collection agency.

***SIGNATURE:** ____ **DATE:** _____________

***As an adult, the patient is the primary contact and responsible party on this account. If a person other than the patient is to be the primary contact on this account, please fill out the following:**

Name: ______________________________ **Address:** ____

Phone #: ________________________**Alternative Phone #:** ____________________ **Relationship to Patient:**________________________

Signature of alternative responsible party: ____

MEDICAL AND SURGICAL HISTORY

Name: ____ Age: _______ Date of Birth: _____________

Referring Physician (if any) ____

Today's Date: _____________Reason for today's visit? ______________________________________

How long have you had this problem? ____

Is your problem related to an accident? Yes☐ No☐ Date of accident _____/_____/______

What medications or tests (i.e. x-rays, labs, etc) have you received for this problem in the past year?

____

MEDICAL HISTORY:

List all medical problems: ____

____

____

List all surgeries: ____

____

Please list your daily medications: (with strengths and dosage) _________________________________

____

____

Please list all *medications* you are allergic to:____

____

Please list any food or environmental *allergies*: ____

____

SOCIAL HISTORY:

Do you currently smoke tobacco? _______ Packs/day? ______ Have you ever smoked tobacco? _______

Do you use smokeless tobacco? ________ Packs/day? ______

Do you drink alcohol or beer? ________ Amount per week? ______________

Occupation? _____________________________ If patient is a child, does child attend daycare? ________

Number of children in classroom? _____________________ Do any caregivers smoke? ______________

FAMILY HISTORY:

Please list any illnesses which run in your family. Include bleeding disorders, or bad reactions during surgery. ____

____

Other information you would like the doctor to know: ____

Patient's name ____________________________ **Today's date** __________________

Do you have OR have you had problems with the following?

GENERAL	YES	NO
1. Chills	☐	☐
2. Weight loss	☐	☐
3. Night sweats	☐	☐
4. Other _______________	☐	☐

EARS	YES	NO
1. Hearing loss-gradual	☐	☐
2. Hearing loss-sudden	☐	☐
3. Pain	☐	☐
4. Ringing	☐	☐
5. Dizziness or vertigo	☐	☐
6. Frequent infections	☐	☐
7. Other________________	☐	☐

NOSE	YES	NO
1. Nose bleeds	☐	☐
2. Injury	☐	☐
3. Congestion	☐	☐
4. Runny Nose	☐	☐
5. Mouth breather	☐	☐
6. Other________________	☐	☐

THROAT	YES	NO
1. Frequent sore throats	☐	☐
2. Difficulty swallowing	☐	☐
3. Hoarseness	☐	☐
4. Foreign body	☐	☐
5. Swollen tonsils	☐	☐
6. Thyroid problems	☐	☐
7. Other________________	☐	☐

EYES	YES	NO
1. Cataracts	☐	☐
2. Glaucoma	☐	☐
3. Distorted vision	☐	☐
4. Other________________	☐	☐

HEART	YES	NO
1. High blood pressure	☐	☐
2. Chest pain	☐	☐
3. Irregular heart beat	☐	☐
4. Previous heart attack	☐	☐
5. Other________________	☐	☐

LUNGS	YES	NO
1. Bronchitis	☐	☐
2. Asthma/wheezing	☐	☐
3. Congestion	☐	☐
4. Other________________	☐	☐

GASTROINTESTINAL	YES	NO
1. Indigestion	☐	☐
2. Ulcers	☐	☐
3. Diarrhea	☐	☐
4. Diverticulitis	☐	☐
5. Gall bladder trouble	☐	☐
6. Nausea & vomiting	☐	☐
7. IBS	☐	☐
8. Other _______________	☐	☐

URINARY TRACT	YES	NO
1. Kidney problems	☐	☐
2. Painful urination	☐	☐
3. Bloody urination	☐	☐
4. Prostate problems	☐	☐
5. Other________________	☐	☐

MUSCULOSKELTEL	YES	NO
1. Back Pain	☐	☐
2. Weakness of limbs	☐	☐
3. Arthritis	☐	☐
4. Other________________	☐	☐

NEUROLOGICAL	YES	NO
1. Numbness	☐	☐
2. Migraine Headaches	☐	☐
3. Seizures	☐	☐
4. Stroke	☐	☐
5. Convulsions	☐	☐
6. Other________________	☐	☐

ENDOCRINE	YES	NO
1. Thyroid problems	☐	☐
2. Diabetes	☐	☐
3. Menopause	☐	☐
4. Hormonal replacement	☐	☐
5. Pregnant in past	☐	☐
6. Pregnant currently	☐	☐
7. Other________________	☐	☐

BLOOD DISORDERS	YES	NO
1. Low blood counts	☐	☐
2. Free bleeding	☐	☐
3. Blood clots	☐	☐
4. Hepatitis	☐	☐
5. Other________________	☐	☐

ALLERGY/IMMUNE	YES	NO
1. Seasonal allergies	☐	☐
2. Itchy eyes	☐	☐
3. Allergy testing in past	☐	☐
4. HIV or AIDS	☐	☐
5. Other________________	☐	☐

PATIENT PAYMENT POLICY

OFFICE AND SURGICAL SERVICES

- Payment is expected at the time of service. **This includes co-pays, co-insurance, and deductibles**.
- It is our policy **not** to extend professional courtesy discounts.
- For our self-pay patients (patients who have no insurance coverage), we offer a **5%** discount for professional services paid in full at the time of service. This does not apply to co-pays, co-insurance, deductibles, non-covered services, and medical supplies. We also offer a **25%** discount for out-patient or in-patient surgical services paid in full prior to service. This does not apply to co-pays, co-insurance, deductibles, non-covered services, medical supplies or surgical services performed in the office.
- Any old balances on your account must be paid in full prior to receiving additional services.
- A parent or legal guardian must accompany patients who are minors. This accompanying adult is responsible for payment of the account. We reserve the right to reschedule if the minor child is not accompanied by a parent or legal guardian.

INSURANCE INFORMATION

- Not all insurance policies cover all services. **It is your responsibility to check with your insurance company to determine covered benefits**.
- If your insurance plan requires a referral or authorization number, it is your responsibility to make sure that referral is in place at the time services are rendered. **Any services performed without the referral in place becomes the patient's responsibility** in full and will not be billed to the insurance company.
- Hearing Aids: MEDICARE DOES **NOT** PAY FOR ANY SERVICES FOR THE SOLE PURPOSE OF HEARING AID SELECTION OR EVALUATION.
- We do **NOT** accept Medicaid as a secondary payor. You will be responsible for any co-pays, co-insurance, or deductibles applicable to your primary policy.

PRESCRIPTIONS & PRESCRIPTION REFILL REQUESTS:

Due to the high volume of calls, in addition to the extra workload our nurses have acquired, it has become necessary to charge for prescriptions and prescription refill requests not obtained during your appointment. There will be a **$10.00** charge for the first prescription and **$5.00** for each additional prescription per request. This fee will be collected when the prescription is picked up at the office. The prescription or the prescription refill will not be called in to the pharmacy. We will also charge **$15.00** due to loss or damage to reissue a prescription. These fees are the responsibility of the patient and cannot be filed with any insurance company. To avoid this fee, please bring all your medication prescription information to your scheduled appointment. There will be no charge for prescription or prescription refills written during your office visit.

DISABILITY FORMS:

We charge **$15.00** for completing the first three pages of disability forms and **$20** for forms four pages and up. Please allow five business days for completion. These must be picked up at our main office (Greenville Eastside) and the fee must be paid before they will be released.

NO SHOW FEES/CANCELLATIONS:

We charge a **$25.00** fee for all missed appointments not cancelled within 24 hours of the appointment. Due to the work required to schedule a surgery we charge a **$50.00** fee if the surgery is rescheduled without a medical reason.

BILLING FINANCE CHARGES:

Due to the rising cost of postage supplies, we reserve the right to assess a finance charge for each month any self pay balance remains unpaid. Please pay all balances as soon as you receive your statement to avoid these additional charges.

I have read, understand, and agree to the above financial policy. I understand that charges not covered by my insurance company, as well as applicable co-pays and deductibles are my responsibility.

_______________________________   _______________________________

Printed name, patient #   *Signature

____

Date

Carolina ENT, PA

Authorization to Use and Disclose Protected Health Information

Use and Disclosure of Your Protected Health Information

Your protected health information will be used by Carolina ENT, PA or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice. There is potential for re-disclosure. The person or organization to which health information is sent may repeatedly disclose health information that is identified by this authorization. The privacy of this information may not be protected under the federal privacy regulations.

Notice of Privacy Practices

Carolina ENT, PA is required to provide you with a notice that describes how information about you may be used and disclosed. Additionally, we must provide you information on how you may get access to this information. These policies and practices are defined in the "Notice of Privacy Policies and Practices" letter provided to you. **PLEASE REVIEW IT CAREFULLY.**

Requesting a Restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your protected health information. Carolina ENT, PA may or may not agree to restrict the use or disclosure of your protected health information.

If Carolina ENT, PA agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected health information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected. Contact Joan Moore, Office Manager/Privacy Official at 864-281-9440 to terminate this authorization.

Reservation of Right to Change Privacy Practices

Carolina ENT, PA reserves the right to modify the privacy practices outlined in the notice. I understand that Carolina ENT, PA will notify me of these changes via the method I have authorized or upon my next appointment.

Rights of the Individual

*You may inspect or copy the information used or disclosed under this authorization by contacting Joan Moore,864-281-9440.

*You may refuse to sign this authorization. If you refuse to sign, Carolina ENT, PA will not deny you treatment.

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1. Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis: **If you wish a spouse, step-parent, child, secretary, friend, etc. to have access to appointment times, health information, and/or billing information, please list them here.**

______________________________	**may have access to:**	**all info**	**appt info only**	**billing info only**	**diagnosis/medical info only**
______________________________	**may have access to:**	**all info**	**appt info only**	**billing info only**	**diagnosis/medical info only**
______________________________	**may have access to:**	**all info**	**appt info only**	**billing info only**	**diagnosis/medical info only**
______________________________	**may have access to:**	**all info**	**appt info only**	**billing info only**	**diagnosis/medical info only**
______________________________	**may have access to:**	**all info**	**appt info only**	**billing info only**	**diagnosis/medical info only**

2. Your billing statements and/or correspondence from our office will be sent to the address provided by you on your patient information sheet.

All clinical correspondence will be marked "CONFIDENTIAL" when mailed directly from our office.

3. The practice may use your information to remind you about upcoming appointments. Typically, appointment reminders are done by telephone and a brief, non-specific message may be left on your answering machine or voicemail. The home number you provided on your patient information sheet will be used to contact you.

We may also leave messages regarding treatment and/or other information pertinent to your healthcare and payment for your care provided at Carolina ENT, PA.

If you do not wish to be contacted in this manner, how else may we contact you?______________________________

Signature

I have **reviewed this consent form** and **received a copy of the notice entitled "Notice of Privacy Policies and Practices"**. I consent for Carolina ENT, PA to use and disclose my health information in accordance with this authorization and the notice of privacy provided to me.

______________________________ ______________________________ ______________

Name of Patient (Print/Type) *Signature of Patient **OR** Signature of Patient Representative Date

____

Relationship of Patient Representative to Patient

Auth0804