Alaska Ear Nose & Throat

3841 Piper Street | Suite T311 | Anchorage, Alaska 99508 | Telephone 907-563-3096| fax 907-563-3094

Patient Registration Form

PATIENT: *Please print all information clearly.*

Name: ____ DOB: __________ First M.I Last

Nickname: ________________________ SS# _________/_________/_________ Sex: □ Male □ Female

Mailing Address: ____ City State Zip

Home Phone: __________________ Work Phone: ____________________ Cell: __________________ Race: □American Indian/Alaska Native □ Asian □African American □Hawaiian/Pacific □ OK to call, leaving detailed message if no answer Islander □ Caucasian □ other □ OK to call, but leave no message

Ethnicity: □Hispanic or Latino □Not Hispanic or Latino

Were you referred to us by another doctor? If so, by whom? ____

Employer Name & Address: ____

Preferred Language: __________________ E-Mail:____ May we discuss your condition with a member of your household or friend? □ YES □ NO

If so, whom? ____________________________ Relationship to patient: __________________________ **EMERGENCY CONTACT**: ________________________Phone#:___________________Relationship:_________________

INSURANCE:

(Please present insurance card(s) and a photo ID to the receptionist for scanning.)

Primary Insurance Name: ________________________ Policy Holders Name: ______________________

Policy # _______________________________ Group #: ________________________________ Policy Holders DOB: ________________________ Relationship to Patient: ________________________ **Secondary Insurance Name**: ________________________Policy Holders Name: ____________________ Policy # _______________________________ Group #: ________________________________ Policy Holders DOB: ________________________ Relationship to Patient: ________________________

Please complete the following ***if the patient is a minor or is disabled.***
(The person accompanying the patient today will be considered the "responsible party.")

Responsible Party Name: __________________________ DOB: _____/_____/_____ SS# _____/_____/_____

Mailing Address: ____
City State Zip

Assignment and Release
I authorize the release of any information to my referring physician. I hereby authorize Alaska Ear Nose & Throat to furnish my information to insurance carriers upon their written request and hereby assign to Alaska Ear Nose & Throat all payments for medical services rendered to the above patient.

Patient Signature (or responsible party) ,Date

Alaska Ear Nose & Throat

3841 Piper Street | Suite T311 | Anchorage, Alaska 99508 | telephone 907-563-3096| fax 907-563-3094

PAYMENT FOR SERVICES

Please read, initial where indicated, and sign below.

PATIENT RESPONSIBILITY

- Insurance coverage is not a guarantee of payment. (________*initial*)
- We will bill your insurance if you present your insurance card(s) at the time of your appointment. It is important for you to know that **we are not contracted with your insurance carrier.** This means that you are responsible for monitoring the processes of your insurance company to make certain your claim is processed in a timely manner, for contacting them if you have questions as to how your claim was processed, and that you are ultimately responsible for the payment of services rendered. (_________*initial.*)
- Any co-payments or "patient responsibility" percentages must be paid at the time of service. (________*initial*)
- **If we do not receive a response from your insurance company within forty-five days from the date we bill them, the balance will become your responsibility.** (________*initial*)
- You will receive a statement for any remaining balance after all applicable insurances have been applied. That balance is due in full at that time. (________*initial*)
- If we do not receive your payment in full within 90 days from the date of the first statement, your account may be turned over to a third-party collection agency. (________*initial*)
- Complexity or additional procedures might dictate extra charges in your visit or surgery (________*initial*)
- After 2 No-show appointments you will be required to pay in full before your appointment. These charges will be your responsibility and billed directly to you. (________*initial*)

*****PLEASE NOTE: WE DO REQUIRE 24 HOUR NOTICE FOR CANCELLATIONS. WE CHARGE A $25 FEE FOR NO-SHOWS OR LATE CANCELLATION.***

We also recommend that you research your insurance benefits prior to your office visit, if possible, as there could be reasons why your insurance may not pay for your visit. These reasons might include the following:

- Your deductible has not been met. Many policies have separate, higher deductibles for surgical procedures. All of the procedures performed in this office, including certain types of injections, are considered to be surgical procedures.
- You have not received the proper referral or preauthorization for the visit or procedure. If your insurance company requires preauthorization, it is your responsibility to obtain it before the procedure is performed. Remember, preauthorization is not a guarantee of payment.
- The services or procedures are not covered by your insurance. We will inform you when we know a treatment/procedure will not be covered, but many times it is not possible for us to know with certainty, as this varies greatly among insurance companies, and because they will not make a final determination until they have received the claim. If there is any uncertainty about coverage, we will be happy to provide you with an estimate of your fees before treatment is given. You are responsible to pay for the non-covered services at the time of the visit.

We accept cash, checks, and Visa or MasterCard. If a payment in check is returned because of insufficient funds, you will be charged a $25.00 fee. Payment **IN FUL**L at the time of service is required in the following circumstances:

- You do not have insurance coverage.
- You have not brought your insurance card(s) with you.
- You have not met your deductible.
- A contract is required by your policy and we are not contracted with your insurance carrier.
- A referral or preauthorization is required by your policy and you have not obtained one.
- Any procedure or treatments we believe are not covered by insurance.

LABORATORY AND PATHOLOGY SERVICES

We use a laboratory of our choice for laboratory services unless you request otherwise. The lab will bill separately for these services. We will share your insurance information with the lab so that they may file a claim with your carrier. The lab will then bill you for any remaining balance. You will need to contact them directly for any questions regarding their bill.

By my signature below, I acknowledge that I have read and that I understand the above statements and am willing to accept responsibility to pay for services rendered if my insurance does not cover them. I also understand that I am responsible for laboratory and pathology charges as well. This authorization is not limited in time. **Patient Signature (or responsible party) Date**

Patient Financial Responsibility Waiver

Practice Alaska Ear Nose and Throat
Address: 3841 Piper Street St, St T311 Anchorage Alaska 99517
Date of Service: / /

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. Before you make any decision about your options, you should:

- Read this entire notice carefully
- Ask us to explain, if you don't understand why insurance probably won't pay
- Ask us how much these items or services will cost you in case you have to pay for them yourself or through other insurance

Please choose one option and initial your choice

Option 1
( ) Yes, I want to receive these items or services.
I understand that insurance will not decide whether to pay unless I receive these items or services. Please submit my claim to the insurance. I understand that you may bill me for items or services and that I may have to pay the bill while my insurance is making a decision. If insurance does pay, you will refund me any payments I made to you that are due to me. If insurance denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand I can appeal my insurance's decision.

Option 2
( ) Yes, I want to receive these items or services.
Please do not bill or submit any claims to my insurance. I agree to be personally and fully responsible for payment. I will not bill the insurance. That is, I will pay out of pocket as a self-pay Patient. I understand that the amount collected may be subject to change after being reviewed by the billing office and entered into our software.
<u>Payments received today does NOT guarantee the account is paid in full and if there is a remaining balance you will receive a statement.</u>

Option 3
( ) No, I have decided not to receive these items or services.
I will not receive these items or services. I understand that you will not be able to submit a claim to insurance and that I will not be able to appeal your opinion that insurance won't pay.

Signature: ________________________________ **Date:** _______________

Note: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our office. If a claim is submitted to insurance, your health information on this form may be shared with insurance. Your health information, which insurance sees, will be kept confidential by your insurance.

Alaska Ear Nose & Throat

3841 Piper Street | Suite T311| Anchorage, Alaska 99508 | telephone 907-563-3096| fax 907-563-3094

HIPAA

In order to comply with federal regulation, we are required to have a document available to you that explains our privacy information policy. There is a copy of this policy at the reception desk. Please advise the front office administrative assistant if you would like a copy.

Read the following carefully. Initial the line below to acknowledge that you have been informed, then sign and date at the bottom.

_______ I have the option to accept or decline that advice and treatment offered by Dr. Jerome List or allied health professionals associated with Alaska Ear Nose and Throat, for myself, or my minor child. Should I decide not to follow a suggested treatment plan, I will accept responsibility for the outcome; this will apply to advice offered in the clinic setting, hospital or by telephone.

CONSENT TO USE OR DISCLOSE HEALTH INFORMATION FOR TREATMENT, PAYMENT OR COORDINATION OF CARE WITH OTHER PROVIDERS.

I hereby consent to the use or disclosure of my individually identifiable health information by Alaska Ear Nose & Throat, in order to carry out treatment, payment or coordination of care with other providers.

At the time, I retain the right to revoke this consent. Such revocation must be submitted to Alaska Ear Nose & throat in writing. The revocation shall be effective except in those instances that occur prior to the revocations.

I have read and understood the information. I am the patient, or the individual authorized to act on behalf of the patient. *If you're signing this form for the patient, please explain your relationship and authority to perform this act.*

Patient Signature (or responsible party) Date

Alaska Ear Nose & Throat

3841 Piper Street | Suite T311 | Anchorage, Alaska 99508 | telephone 907-563-3096| fax 907-563-3094

NAME: ____ DOB: _________________ AGE: ________

Do you have any **allergies** to medications? □ YES □ NO

If so, please list the medication allergy and reaction to medication:

Please list all medications you are currently taking: (prescription and non-prescription)

Please list ALL surgeries you have had in your LIFETIME:

Have you had any hospitalizations in the last 5 years?................................□ YES □ NO Are you pregnant and/or currently nursing?..□ YES □ NO Have you been exposed to tuberculosis?..□ YES □ NO Have you ever had hepatitis?...□ YES □ NO Do you or any family members have bleeding tendencies?..□ YES □ NO Have you ever sustained a head injury?...□ YES □ NO Do you use tobacco products?..□ YES □ NO Do you drink alcoholic beverages?.. □ YES □ NO

FAMILY HISTORY	Age	State of Health	If Deceased, Age & Cause of Death
Mother			
Father			
Siblings			
Brother/Sister			
Brother/Sister			
Children			
Son/ Daughter			
Son/ Daughter			
Son/ Daughter			

Please provide the name of your pharmacy: ____

Please provide any additional comments about your health that will assist with your care: ___________________________________

Patient Signature (or responsible party) Date