DeFatta
ENT & ALLERGY

Thank you for choosing our office! In order to serve you properly, we need the following information. Please Print

Patient's Legal Name _____Maiden/Previous Names: _____

Address_____City_____State_____Zip_____

SSN_____ Birthdate_____ ☐ Male ☐ Female

Home Phone#_____ Cell Phone#_____

Email Address:_____ Preferred Contact Method:_____

Please Check One: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Race: ☐ White ☐ Asian ☐ African American ☐ American Indian ☐ Hispanic ☐ decline to specify ☐ other:

Ethnicity: ☐ Not Hispanic/Latino ☐ Hispanic/Latino

Emergency Contact Name: _____ Phone Number _____

Relationship to patient_____ Who is your Primary Care Physician/Provider? _____

Name of referring physician_____ Is this the result of an auto accident? Yes No

Is this a work related injury? Yes No If yes, has a first report of injury been filed with your employer? Yes No

Patient's Employer_____ Work Phone _____

Employer Address _____City _____State_____Zip_____

How did you hear about DeFatta ENT & Facial Plastic Surgery?

_____

RESPONSIBLE PARTY

Name of person responsible for this account _____Relationship to Patient _____

Address (if different from above)_____ Phone _____

Birthdate_____Employer_____ Work Phone _____

INSURANCE INFORMATION *(Required, unless you are self-pay.)*

Primary Insurance _____ID #_____Group #_____

Policy Holder_____ Employer_____ Work Phone_____

Relationship to Patient _____Birthdate _____SSN_____

Secondary Insurance _____ID # _____ Group #_____

Policy Holder_____ Employer_____ Work Phone_____

Relationship to Patient _____ Birthdate _____ SSN_____

Assignment of Benefits: I hereby assign all medical and/or surgical benefits to which I am entitled and authorize the release of any information relating to all claims submitted on behalf of myself and/or dependents. I hereby authorize and direct my current and future insurance carrier(s), including Medicare, private insurance, and any health/medical plan, to issue payment directly to **DeFatta ENT & Facial Plastic Surgery** for services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance. This assignment will remain in effect until revoked by me in writing.

Signature _____ Date _____

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FINANCIAL POLICY

Insurance

Insurance is a contract between you and your insurance company. It is your responsibility to contact your insurance company before receiving any care from our office to make sure they cover the services we are providing. Managed care plans, Health Maintenance Organizations (HMO), or Preferred Provider Options (PPO) benefits vary from plan to plan. Insurance companies may deny payment or reduce benefits if medical care is obtained outside of the plan's covered benefits.

Please check with your insurance carrier or employer for clarification of coverage *before* your appointment.

Payment Policy

Payment for services provided to you is ultimately your responsibility. Charges not covered by your insurance company are payable in full within 30 days of receiving the bill. Co-payments and non-covered services are to be paid at the time of service.

Self-pay patients are required to pay a $100.00 deposit at the time of their visit. Prior to any additional services being rendered, self-pay patients are required to pay in full.

Sublingual allergy drops and non-covered services require payment in full at the time of service. We do not bill your insurance for the fees associated with sublingual immunotherapy (allergy drops).

Patients with delinquent accounts will be required to make a $100 payment towards their balance at the time of service. Patients with an outstanding balance of $1000 or greater will be asked to pay 10% of their balance. If you are unable to make mutually agreeable payment arrangements, we will be glad to reschedule your appointment.

Payment Methods

For your convenience, we accept cash, checks, credit cards, and debit cards.

Returned Checks

There is a fee of $25.00 for checks returned by the bank for non-sufficient funds.

No Show Policy

A "no-show" is someone who misses an appointment without cancelling within 24 hours. A failure to be present at the time of a scheduled appointment will be recorded in your medical record as a "no-show". We understand that urgent circumstances could arise that might prevent you from cancelling your appointment ahead of time. As a courtesy, we will not post a charge for a first missed appointment. For a second missed appointment, a $25.00 fee will be billed to your account. A third missed appointment will result in a discharge from our clinic.

Assistance Paying Your Bill

DeFatta ENT & Facial Plastic Surgery realizes that medical costs can be an unexpected expense. We will work with you to create reasonable payment plans if you are unable to pay your bill all at once. It is important that you let us know as soon as possible if you will have difficulty paying your bill.

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Patient Treatment Waiver

I understand that in the event that I do not have the proper referral from my Primary Care Physician to cover services that I am requesting from DeFatta ENT & Facial Plastic Surgery I agree that I shall be responsible for payment in full for any charges related to services provided to me or my dependent(s)******You do have the right to arrange for the required referral before receiving the services you seek in order to receive full benefits under the term of your insurance contract. If you have any questions about the referral process under your benefit contract, or if you are not sure whether a referral is required before receiving treatment you seek today, please contact your customer service representative at the telephone number listed on the back of your insurance identification card.***

Non-covered Services

I realize that if I have services rendered that are not covered under my contract I will be responsible for the payment of the service and all associated charges incurred by me or by my dependent(s).

Authorization to perform in-office ENDOSCOPY

To thoroughly examine the nasal cavity and/or throat your physician may decide that a scope procedure is necessary. This examination is essentially painless and can be accomplished quickly. A procedural fee will be submitted to your insurance carrier for this procedure. If we accept your insurance company's allowance for this procedure, you will be obligated to pay only any deductible and/or co-payments that are applied to this claim. (Please note: some insurance companies may list this diagnostic procedure as "surgery" on the insurance remittance advice you receive.) This procedure has very little risk and provides your physician with an excellent view of the entire nasal cavity/and or throat.

Medical Care Request and Authorization

I understand that I may have a condition that requires medical care. I am requesting and authorizing medical care by Defatta ENT & Facial Plastic Surgery, any of the physicians associated with DeFatta ENT & Facial Plastic Surgery or the facility at which the medical care is rendered whom DeFatta ENT & Facial Plastic Surgery considers reasonably necessary for my care. I agree to their participation in my care. I am aware that medicine is not an exact science and I acknowledge that no guarantee has been made to me concerning the results of my medical care.

I understand that unforeseen conditions may arise during the rendering of my medical care I hereby authorize DeFatta ENT & Facial Plastic Surgery and its designees to perform any other procedures they deem appropriate in the exercise of their professional judgment to address such conditions.

I recognize that I may, at any time, be a participant in and make decisions regarding my health care, including the right to accept or refuse medical or surgical treatment, the right to formulate advance directives, and to provide any such directive for my physicians and health care providers to be aware of and to rely on.

Disclosure of Health Information

In compliance with DeFatta ENT & Facial Plastic Surgery privacy practices, you may designate individual(s) to whom DeFatta ENT & Facial Plastic Surgery may disclose your protected health information. This may include individually identifiable information related to past, present, or future appointments, medical or financial information. This does not include information relating to mental health treatment or HIV test results as releasing that information requires separate written consent. *If you do not wish to designate individual(s) to receive your protected health information, indicate "none" below.* I understand that I have an option to revoke Disclose of Health and Information authorization at any time.

I grant the following person(s) permission to speak to my Doctor and/or Doctor's assistant regarding my medical records and treatment:

_____	_____	_____
Name	Relationship to Patient	Telephone number

I acknowledge by my initials/signature that I understand all of the above and agree to abide by the terms of this document

Please initial

_____ **FINANCIAL POLICY**
_____ **PATIENT TREATMENT WAIVER**
_____ **NON-COVERED SERVICES**
_____ **AUTHORIZATION TO PERFORM PROCEDURE**

Please sign

Accepted and agreed: _____ _____
Patient or Legal Guardian Signature — Date

Witnessed: _____ _____
Employee Signature — Date

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Acknowledgement of Receipt of Privacy Notice

(Please ask assistant if you'd like to have a copy of the privacy notice.)

Patient Name: _____ Today's Date: _____

By signing this form, you acknowledge that **DeFatta ENT and Facial Plastic Surgery** has given you a copy of its Privacy Notice, which explains how your health information will be handled in various situations. We must try to have you sign this form on your first date of service with us after April 14th, 2003. This includes the situation where your first date of service occurred electronically.

If your first date of service with us was due to an emergency, we must try to give you this notice and get your signature acknowledgement receipt of this notice as soon as we can after the emergency.

Check all that are true:

[ ] I have been offered DeFatta ENT and Facial Plastic Surgery's Privacy Notice.

[ ] DeFatta ENT and Facial Plastic Surgery has given me the opportunity to discuss my concerns and questions about the privacy of my health information.

_____ _____

Patient or Guardian Signature (relationship to patient) Date

****

FOR OFFICE USE ONLY

DeFatta ENT and Facial Plastic Surgery staff must complete if Acknowledgement Form is not signed:

1. Does patient have OR has the patient been offered a copy of the Privacy Notice? [ ] Yes [ ] No

2. If you answered "No" above, please explain why the patient did not sign an acknowledgement form and DeFatta ENT & Facial Plastic Surgery, S.C.'s efforts in trying to obtain the patient's signature (check all that apply):

[ ]	Patient Unable to Comprehend	[ ] Patient/Legal Representative left before Signature Obtained
[ ]	Patient Communication Barrier	[ ] Emergency Admission/Patient Not Present for Registration
[ ]	Legal Representative not Available	[ ] Patient bypassed Registration – Not Available

[ ] Other: _____

_____ _____

Employee Signature Date