DeFatta
ENT & ALLERGY

Thank you for choosing our office! In order to serve you properly, we request the following information. Please print. By providing your contact information, you are consenting to receive future emails, text messages, and/or calls from DeFatta Health.

Patient's Legal Name: _____ Birthdate: _____

SSN: _____ Gender: ☐ Male ☐ Female ☐ _____

Parent/Guardian Name(s): _____

Address: _____ City: _____ State: _____ Zip: _____

Primary Phone Number: _____ Phone Type (*circle one*): Cell Home Work

Secondary Phone Number: _____ Phone Type (*circle one*): Cell Home Work

Email Address: _____ Preferred Contact Method: _____

Emergency Contact Name: _____ Phone Number: _____

Relationship to Patient: _____ How did you hear about DeFatta Health? _____

Responsible Party (*If different from patient*)

Name of person responsible for this account: _____

Address (*If different from patient*): _____

Relationship to Patient: _____Phone number: _____Birthdate: _____

Disclosure of Health Information: I hereby authorize DeFatta Health to verbally disclose protected health information to the following person/individual. I agree that this authorization includes the release of all medical records on file unless I check the applicable box below.

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	Phone Number

☐ I decline DeFatta Health verbally sharing my treatment information with others, excluding emergency situations as indicated above.

Acknowledgement of Receipt of Privacy Notice

By signing this form, you acknowledge that DeFatta Health has offered you a copy of its Privacy Notice.

_____	_____
Patient or Legal Guardian Signature	Date

Authorization to perform in-office SCOPE, EAR CLEANING, BLOOD DRAW, AND/OR BIOPSY: A separate procedural fee will be submitted to your insurance carrier for these procedures. You will be obligated to pay any deductible and/or co-payments that are applied to this claim.

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 Health, any of the physicians and/or nurse practitioners associated with DeFatta

Health or the facility at which the medical care is rendered whom DeFatta Health considers reasonably necessary for my care. I recognize that I may, at any time, by 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.

Insurance: Insurance is a contract between you and your insurance company. It is your responsibility to understand your benefits and coverage before receiving any care from our office. It is also your responsibility to pay any deductible, co-insurance, or any other balance not paid by your insurance. 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 or need for referral 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. Waiver of co-pays may constitute fraud under State and Federal law. 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 can assist you in rescheduling your appointment. All returned checks from the bank for non-sufficient funds will be charged a $25.00 fee. DeFatta Health 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.

Self-pay: Patients without insurance coverage, patients covered by insurance plans in which the clinic does not participate or patients without an insurance card on file with us. Deposits of $200 for New Patients and $100 for Established Patients are due at the time of check-in. Two options are available for payment of the balance: 1) A 15% discount is available if you pay in full at the time of service; or 2) We can send you a statement. Prior to any additional services being rendered, self-pay patients are required to pay in full. It is never our intention to cause financial hardship on our patients, only to provide them with the best care possible with the least amount of stress. We are willing to work with you on a payment arrangement for the balance of our account if necessary.

Non-covered services: I understand that in the event that I do not have the proper referral from my Primary Care Physician to cover the services that I am requesting from DeFatta Health, I agree that I shall be responsible for the payment in full for any charges related to services provided to me or my dependent(s).

No Show Policy: Please cancel your appointment with at least a 24 hours' notice to allow us to give another patient your appointment time. After the first "No-Show" appointment, you will receive a phone reminder about our "No-Show" policy. If you have 2 "No-Show" appointments within one-year, you will receive a letter advising you of your $25 fee. If you have 3 "No-Show" appointments within one-year, you will receive a second $25 fee, and dismissal from the practice will be considered.

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 Health 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