

# Patient Profile

Doctor: \_\_\_\_\_

## PATIENT INFORMATION

Name: \_\_\_\_\_  
Preferred: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
City,State: \_\_\_\_\_  
Alt Address: \_\_\_\_\_  
\_\_\_\_\_  
Alt City,State: \_\_\_\_\_  
Phone: \_\_\_\_\_ [ ]Home [ ]Work [ ]Other  
Phone: \_\_\_\_\_ [ ]Home [ ]Work [ ]Other  
Phone: \_\_\_\_\_ [ ]Home [ ]Work [ ]Other

## PATIENT EMPLOYMENT

[ ]Employed [ ]Retired [ ]Unemployed [X]Other  
Phone: \_\_\_\_\_  
Employer: \_\_\_\_\_

## GUARANTOR

[X]Same as Patient  
Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
City,State: \_\_\_\_\_

## PRIMARY INSURANCE

[ ]Same as Patient [ ]Same as Guarantor [ ]Other  
Insured Party: \_\_\_\_\_  
Company: \_\_\_\_\_  
Policy Group: \_\_\_\_\_

## SECONDARY INSURANCE

[ ]Same as Patient [ ]Same as Guarantor [ ]Other  
Insured Party: \_\_\_\_\_  
Company: \_\_\_\_\_  
Policy Group: \_\_\_\_\_

Patient ID #: \_\_\_\_\_ Sex: [ ]M [ ]F  
Age: \_\_\_\_\_ yrs  
Date of Birth: \_\_\_\_\_  
Social Security #: \_\_\_\_\_  
Marital Status: [ ]Married [ ]Single [ ]Divorced  
Referring Physician: \_\_\_\_\_  
Primary Physician: \_\_\_\_\_  
Preferred Language: \_\_\_\_\_  
Email Address: \_\_\_\_\_  
Contact By: \_\_\_\_\_

## CONTACTS

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## GUARANTOR EMPLOYMENT

Employer: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Alt Phone: \_\_\_\_\_  
Social Security #: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_

Relationship to Primary Insured/Guarantor: \_\_\_\_\_  
Social Security #: \_\_\_\_\_  
Insured ID: \_\_\_\_\_  
Insured Date of Birth: \_\_\_\_\_

Relationship to Primary Insured/Guarantor: \_\_\_\_\_  
Social Security #: \_\_\_\_\_  
Insured ID: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_

**Release of Benefits and Information:** I consent for medical treatment and I have verified the insurance listed on this slip and authorize my insurance benefits be paid directly to the doctor. I am financially responsible for any balance due. I authorize the doctor or the insurance company to release any information required for this claim. I have read and understand the office insurance/payment policy stated above.

Signed: \_\_\_\_\_

Date: \_\_\_\_\_



## **VALLEY ENT, PC BILLING & FINANCIAL POLICY INFORMATION**

Due to increased insurance company demands, the following policy has been established for this office. There are no exceptions to this policy. Please read this policy carefully.

We make every attempt to ensure that all services are compatible with your special insurance requirements. However, all policies have different benefits, depending on the requests and desires of the employer or applicant. Benefits are not always available to all employees, even if they have the same insurance company. Your insurance company informs all participants that it is ultimately your responsibility to know and understand your policy with the insurance company. We do not have the capability to know each individual policy, as it varies per patient. We cannot guarantee all services will be covered. It is your responsibility to verify all benefits and coverage information prior to having any services rendered.

Insurance companies require that we submit all claims within a specified time limit. We do our best to follow all guidelines set forth by your insurance company. However, if your insurance changes and you fail to inform us, we may be unable to bill the appropriate company within these time limits. If you do not provide new information, a denial from the previous carrier is our only way of knowing your insurance has changed. Denials are generally not returned to us until after the filing deadline. Therefore, if you do not notify us of any changes, you may be responsible for payment of services. For your benefit, please notify us of any changes as soon as possible.

You will be responsible for payment of all services if any of the following circumstances apply:

- If you do not have insurance;
- If you do not have a referral when required and have elected to be seen;
- If you are with an insurance company we are not contracted with; or,
- If your insurance company denies your claim for any reason that is not resolvable.

We have stringent rules that apply to payment plans. If your balance is not paid in full within 90 days of receiving a statement, we reserve the right to turn your account to a collection agency. The responsible party or guarantor of the account will be responsible for all collection fees and legal expenses in the event this becomes necessary. A \$25.00 fee will be applied to all returned checks.

A fee will be charged to patients requesting medical records for personal use, family medical leave (FMLA) forms and physician-dictated letters for personal reasons.

By signing this form, you agree to all the information listed above, authorize the release of any medical information necessary to process your claims and authorize payment of medical benefits to Valley ENT, PC , or supplier for services rendered.

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SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

DATE

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Print Name

## **NOTICE OF PRIVACY POLICY FOR PROTECTED HEALTH INFORMATION (PHI)**

The office of Valley Ear, Nose and Throat is dedicated to protect your "nonpublic personal health information". This notice is to tell you how and why we collect that information, and who has access to that information.

### **HOW WE COLLECT YOUR INFORMATION:**

Your personal demographic information such as name, address, birth date, social security number and medical insurance information is obtained from you. This is why we ask you to fill out the patient information sheet and why we ask for a copy of your insurance card. This ensures that the information we collect is correct.

If you came to our practice through a hospital encounter, we may obtain that information from the hospital. However, on your first visit to this office, we will ask you to fill out our information sheet to ensure that the information we received from the hospital was correct. We may also ask a doctor or other health care provider who referred you to this practice to give us health information that will enable us to better treat your medical condition. This benefits you in that we will have test results that have already been obtained by the referring entity.

### **WHY WE COLLECT THIS INFORMATION:**

We collect this information so that we can treat your medical condition and obtain payment from you or your health insurance.

### **MAINTAINING ACCURATE AND TIMELY INFORMATION:**

To ensure that the information we maintain is accurate, each time you visit this office you will be asked if any of your information needs to be updated.

### **WHO HAS ACCESS TO THIS INFORMATION:**

Any person or persons you designate in writing, people directly involved in your medical care, people creating and maintaining your medical record, and those entities that need your information to process health care claims and obtain payment for our services have access to your Protected Health Information. Entities such as Governmental Oversight agencies, Judicial and Administrative Proceedings, Law Enforcement Agencies, Coroners and Medical Examiners, and Organ Procurement Organizations may

obtain copies of your Protected Health Information. Law mandates these entities and this practice has no jurisdiction over such entities.

### **HOW WE PROTECT YOUR INFORMATION:**

We release your information only to those people who need your information. We maintain physical, electronic, and procedural safeguards so that no one but persons involved in your healthcare or entities that need this information for claims processing have access to your Protected Healthcare Information.

### **YOUR RIGHTS:**

You have the right to inspect your Protected Healthcare Information. You also have the right to amend any errors you may find in your record. (The physician or other healthcare provider is not required to make such amendments). You may file a statement of disagreement if your amendment is denied, and require that the request for amendment and any denial be attached in all future disclosures of your Protected Healthcare Information.

If you leave this practice, your Protected Healthcare Information will continue to receive the protection outlined in this notice.

### **COMPLAINTS/COMMENTS:**

If you feel your privacy rights have been violated you may file a written complaint at our office or you may contact the Chief Executive Officer of this practice at (480) 614-5406. You may also file a complaint by mailing it to the Secretary of the Department of Health and Human Services at 200 Independence Avenue, S.W. Room 509F, HHH Building, Washington D.C. 20201.



Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Account: \_\_\_\_\_

### HIPAA Acknowledgement

I have received a copy of the Privacy Rules from *Valley ENT, P.C.*, and authorize the following list of people who may receive my Protected Health Information. I understand that I may revoke this authorization at any time by giving written notification to this office.

These people may receive my Protected Health Information:

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Relationship to Patient:  Spouse  Child  Parent  Significant Other

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Relationship to Patient:  Spouse  Child  Parent  Significant Other

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Relationship to Patient:  Spouse  Child  Parent  Significant Other

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Relationship to Patient:  Spouse  Child  Parent  Significant Other

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Relationship to Patient:  Spouse  Child  Parent  Significant Other

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Relationship to Patient:  Spouse  Child  Parent  Significant Other

May we leave messages regarding office and testing appointments on your answering machine?  YES  NO

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
*(Patient or parent/legal guardian if patient is minor)*



Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Account: \_\_\_\_\_

### RELEASE OF INFORMATION

I consent for medical treatment and I have verified the information provided on the *Patient Profile and Patient Medical History*. I further authorize the doctor to release any medical or any other information to:

- 1) Any third party responsible for paying for my care;
- 2) Any outside peer review or an auditing agency engaged by a third party payer to review my medical records;
- 3) Any third party health care service or health care provider responsible for my personal care including but not limited to hospitals and other involved physicians;
- 4) Those individuals listed on my *HIPAA Acknowledgement* form.

The original authorization will be kept on file by *Valley ENT, P.C.* A photocopy of this release is to be considered as valid as an original.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
*(Patient or parent/legal guardian if patient is minor)*

### ASSIGNMENT OF INSURANCE BENEFITS

I hereby direct remittance of payment of all insurance benefits, including Medicare if I am a Medicare recipient, to *Valley ENT, PC.*, for all covered medical services and supplies provided to me during all courses of treatment and care provided by the physicians and staff of *Valley ENT, PC.* I understand and agree this Assignment of Benefits will have continuing effect for so long as I am being treated or cared for by *Valley ENT, PC.*, and constitute a continuing authorization, maintained on file by *Valley ENT*, throughout the course of my treatment. I understand that I am financially responsible for all charges whether or not these services are paid by my insurance.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
*(Patient or parent/legal guardian if patient is minor)*



## Patient Communication Disclosure

**Please initial by each form of communication by which we can contact the patient.**

\_\_\_\_\_ The practice may call my home at the following number and leave the appointment date and time on my telephone answering machine, voicemail, or with whomever answers my phone if I am not available. I understand that other individuals may have access to the information left by this method. I understand that no other information will be provided in granting permission to leave the date and time.

**Telephone Number on which messages can be left:** \_\_\_\_\_

\_\_\_\_\_ The practice may email my home or other email address any information that will assist the practice and physician with the treatment, payment, and health care operations for the patient. This can include appointment reminders, statements, insurance information, and any information concerning my clinical care.

**Email Address to which information can be sent:** \_\_\_\_\_

\_\_\_\_\_ The practice may send a text message to my cellular phone regarding appointment reminders, cancellations, or time changes. This form of communication will be for the use of the Appointment Desk and not private or clinical information.

**Cell Phone to which information may be texted:** \_\_\_\_\_

**I understand that I have the right to a written request to restrict how the practice may use or disclose my protected health information to complete treatment, payment, and health care operations. The practice is not required to agree to my requested restrictions, but if my request is granted it is bound by that agreement. I further understand that I may revoke this authorization at any time in writing to the practice. At any time I can change the way in which I am contacted. I have read, agree and give my consent to the practice to communicate with me in the above method(s).**

\_\_\_\_\_  
Patient / Legal Guardian Signature

\_\_\_\_\_  
Date



**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**TO OUR PATIENTS:**

We are currently working on converting our paper records to an electronic medical record system, a task we hope to complete by late 2009 at all of our locations. One feature of this new system is the ability to directly forward any prescriptions to pharmacy of your choosing. In order to utilize this feature, we must capture this information for your files in our computer system. Please indicate the pharmacies that you must commonly use:

**1<sup>st</sup> Choice:**

\_\_\_\_\_ *Pharmacy Name*

\_\_\_\_\_ *Address (or street it is located on)*

\_\_\_\_\_ *City*

\_\_\_\_\_ *State*

\_\_\_\_\_ *Phone*

**2nd Choice:**

\_\_\_\_\_ *Pharmacy Name*

\_\_\_\_\_ *Address (or street it is located on)*

\_\_\_\_\_ *City*

\_\_\_\_\_ *State*

\_\_\_\_\_ *Phone*

**3rd Choice:**

\_\_\_\_\_ *Pharmacy Name*

\_\_\_\_\_ *Address (or street it is located on)*

\_\_\_\_\_ *City*

\_\_\_\_\_ *State*

\_\_\_\_\_ *Phone*

*Instructions to Staff:*

*Record this information under the patient's name by using the REGISTRATION button and then navigating to the CONTACTS tab.*