

Patient Profile

Doctor: _____

Copy of Card Scanned: YES NO

PATIENT INFORMATION

Name: _____

Patient ID# _____ Sex: M F

Address: _____

Date of Birth: _____ Age: _____

Social Security: _____

City, State _____ Zip: _____

Marital Status: Married Single Divorced Other

Phone: _____ Home Work Cell

Referring Physician: _____

Phone: _____ Home Work Cell

Ref MD Phone: _____

Phone: _____ Home Work Cell

Ref MD Fax: _____

PATIENT EMPLOYMENT

Employment Retired Unemployed Student

Primary Physician: _____

Employer: _____

Prim MD Phone: _____

RESPONSIBLE PARTY

Same as Patient

Prim MD Fax: _____

Name: _____

RESPONSIBLE PARTY EMPLOYMENT

Address: _____

Employer: _____

Social Security: _____

City, State _____ Zip: _____

Date of Birth: _____

PRIMARY INSURANCE

Same as Patient Same as Responsible Party

Relationship to Patient: Self Spouse Parent

Insured Name: _____

Social Security #: _____

Insurance Name: _____

Policy ID#: _____

Office Co-pay Amount: _____

Policy Group #: _____

Date of Birth: _____

SECONDARY INSURANCE

Same as Patient Same as Responsible Party

Relationship to Patient: Self Spouse Parent

Insured Name: _____

Social Security #: _____

Insurance Name: _____

Policy ID#: _____

Office Co-pay Amount: _____

Policy Group #: _____

Date of Birth: _____



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.

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

DATE

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

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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)