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EAR NOSE & THROAT

Head & Neck Surgery Otorhinolaryngology

PATIENT DEMOGRAPHIC INFORMATION

Patient Name: _____
(Last) (First) (MI)

Birth date: _____ Age: _____ Sex: _____ Marital Status: _____

Race: _____ Ethnicity: _____ Preferred Language: _____
(Hispanic or Non-Hispanic)

Home Address: _____
(Street) (Apt. #)

City: _____ State: _____ Zip Code: _____ SS#: _____

Home Phone: _____ Work Phone: _____ Cell/Pager: _____

Email Address: _____

Emergency contact name: _____ Phone # _____

INSURANCE INFORMATION

PRIMARY	SECOND	THIRD
Name of Insurance Co:	Name of Insurance Co:	Name of Insurance Co:
Name of Insured:	Name of Insured:	Name of Insured:
Date of Birth:	Date of Birth:	Date of Birth:
Insured's SS#:	Insured's SS#:	Insured's SS#:
Insured's Employer:	Insured's Employer:	Insured's Employer:

Primary Care Physician name: **Phone #:**

I hereby authorize Dr. J. Roy Lowry D.O./Dr. Jeremy P. Watkins M.D./Dr. John B. McIntyre M.D. to release any medical information to my insurance company, family physician, or referring doctor. I understand that I am responsible for all charges and full payment is due at time of service, including my co-pay. If my insurance plan requires a referral authorization and no authorization is provided, I understand that I am responsible for the charges. I will notify the office of any changes that occur such as address, phone number, family doctor and insurance plan. I understand that when my insurance changes from one HMO to another that my previous referral is void. I must contact my family physician to get another referral under my new plan. I understand that if I fail to notify the office of changes, I will be held accountable for those charges. I authorize Dr. J. Roy Lowry D.O./Dr. Jeremy P. Watkins M.D./Dr. John B. McIntyre M.D./office to file my insurance on my behalf. In the event that my insurance company does not pay for any of the services provided, I understand that I am responsible for the charges.

_____ _____
(Signature) **(Date)**

Complete only if patient is a minor	
Mother /Guardian Name:	Father/Guardian Name:
Date of Birth	Date of Birth
Address	Address
Home Phone	Home Phone
Work Phone	Work Phone

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Authorization and Consent Forms

Our notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent. As provided in our notice, the terms of our Privacy Officer for Fort Worth ENT.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care options. We are required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. Your information will be disclosed to your insurance company and physician for billing purposes and to required federal and state reporting agencies. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your consent.

In the event a family member or caregiver attends my office visit and remains in the exam room at the time of my evaluation and/or treatment, I give Fort Worth ENT and its physician or employees my permission to discuss freely my condition, treatment, or diagnosis.

May we call you and/or leave a message on the numbers listed below?

Home Phone _____ May we leave a message Yes/No (please circle one)

Work Phone _____ May we leave a message Yes/No (please circle one)

Cell Phone _____ May we leave a message Yes/No (please circle one)

May we mail healthcare information to your home?

Any and all medical information can be released to the following:

1. _____ Relationship _____
2. _____ Relationship _____
3. _____ Relationship _____

Patient Name/DOB _____ Guardian Name _____

Patient or Guardian Signature _____ Date _____

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Otorhinolaryngology Head and Neck Surgery

Date: _____

PATIENT MEDICAL INFORMATION

Patients' Name: _____
Sex F / M Age _____ Birth Date _____ HT _____ WT _____ TEMP _____ VITALS _____

List any allergies to medications and/or food:

_____

Briefly describe your present problem and how long it has caused you problems:

_____

Prior Medical History:

___Heart Attack/Heart Disease
___Congestive Heart Failure
___Hypertension
___COPD/Lung Disease
___Stroke
___HIV/AIDS
___Seizures
___Diabetes
___Sleep Apnea
___Asthma
___Arthritis
___Glaucoma/Cataracts
___Tuberculosis
___Cancer (specify) _____
___Liver/Kidney Disease (specify) _____
___Spine Disorders (specify) _____
___Thyroid Disorders (specify) _____
___Bleeding/Clotting Disorder (specify) _____

Please check following current complaints:

Constitutional: ___Weight Loss ___Fever ___None
Eyes: ___Vision Change ___None
Respiratory: ___Wheezing ___Shortness of Breat___None
Cardiovascular: ___Chest Pain ___Palpitations ___None
Gastrointestinal: ___Heartburn ___ Nausea _____None
Genitourinary: ___Painful Urination ___Blood in Urine ___None
Musculoskeletal: ___Joint Pain ___None
Skin: ___Lesions on Skin ___None
Neurological: ___Numbness ___Weakness ___Seizures ___None
Psychiatric: ___Depression ___Anxiety ___Sleep Disorder ___None
Endocrine: ___Temperature Intolerance ___None
Hematologic/Lymph nodes: ___Blood Clotting Disorder ___None
Allergic/Immunologic: ___Sneezing ___Eye Irritation ___None

Problems not listed above? _____
Do you drink alcohol? _____ How much daily? _____
Caffeine drinks? _____ How many daily? _____
Do you smoke? _____ How much? _____ Quit? _____ When? _____

Current Medications _____

Preferred Pharmacy: _____ **Location and Number:** _____

List all prior surgeries with the year in which they were performed:

_____

Any anesthesia related problems? _____ If so, what type? _____

Family History: Cancer_____ Diabetes_____ High Blood Pressure_____ Heart Disease _____
Problems not listed? _____

Birth History: (for Patients under the age of 18 only)

Was the child born on time? _____ Problems during Mother's Pregnancy? _____

Breathing problems at birth? _____ Immunizations current? _____

History of: Asthma _____ Reflux _____ Seizures _____

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OFFICE POLICY

- All patients must complete new patient paperwork before seeing the doctor. Information must at least annually or as changes occur. Please let us know of changes in address, phone number, insurance or PCP.

- Completion of any medical /disability/FMLA forms will have a $25 charge.

- All prescription refills should be called into pharmacy at least five working days before the last pill is taken to allow us adequate time to obtain approval. All refills will be handled during normal office hours.

- Referrals – you are responsible for contacting your PCP for a referral if your plan requires one. Most PCP's require at least 48 hours notice for referral to be completed.

- We appreciate your patience in the waiting room. While we strive to maintain our clinic schedule we often have to work in emergencies. In these instances your wait may be longer than normal.

- Physical and /or verbal abuse towards the office staff of physicians will not be tolerated.

- **IF WE ARE NOT IN CONTRACT WITH YOUR INSURANCE WE ARE UNABLE TO TAKE YOU AS A PATIENT.**

Thank you for your understanding of our clinic policies. We are glad you have chosen our office for you healthcare needs

_____ _____

Patient's Signature **Date**

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PATIENT FINANCIAL POLICY

Thank you for choosing our practice! We are committed to providing you with quality and affordable health care. Some of our patients have had questions regarding patient and insurance responsibility for services rendered; we have developed this financial policy. Please read it, ask us any questions you may have, and sign in the space provided.

- **Insurance.** We participate in most insurance plans. We will bill your insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility.
- **Claims Submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; We are NOT a party to that contract.
- **Referrals**. If you have an HMO plan with which we are contracted, you need a referral authorization from your primary care physician. If we have not received an authorization prior to your arrival at the office, we have a telephone available for you to call your primary care physician to obtain it. **If you are unable to obtain the referral at that time, you will be rescheduled.** If you choose to keep the scheduled appointment without a referral, you will be responsible for full charges to be paid that day and to also sign a waiver.
- **Co-payments and Deductible**. All co-payments must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.
- **Non-covered Services.** Please be aware that some- and perhaps all- of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.
- **Proof of Insurance**. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.
- **Coverage Changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.
- **Methods of Payments.** We accept payment by cash, check, VISA, Mastercard, American Express and Discover.
- **Patient Statements.** Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid by the end of the month
- **Nonpayment.** If your account is past due, you will receive a letter from us stating you have 10 days to pay your account in full. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency, If this is to occur, you will not be able to be seen in the office until your balance is paid in full and all charges for future visits will be collected upfront. Until the balance is paid in full, our physicians will only be able to treat you on an emergency basis for a previously treated injury or problem.
- **Returned Checks.** There is a fee of $25 for any checks returned by the bank.
- **Divorce:** In case of divorce or separation, the party responsible for the account is the parent authorizing treatment for a child. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.
- **Missed Appointments**. Our policy is twenty four hours notice on an appointment change. We understand emergencies arise. If an emergency keeps you from keeping your appointment, please contact us as soon as you know you will not be able to keep the scheduled appointment. Please help us to serve you better by keeping your regularly scheduled appointments.
- **Surgery**. If your physician recommends surgery, you will be to his Surgery Coordinator. She will answer specific questions about the surgery scheduling process, discuss the paperwork and tests.

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Our Precert Coordinator will complete all pre-certification/authorization if your insurance company requires it. The Precert Coordinator may request a pre-surgical deposit, the amount of which depends on your coverage and deductible amount. The Precert Coordinator will explain a cost estimate, which shows your financial responsibility, based on the benefit levels and coverage of your insurance plan.

Our practice is committed to provide the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have questions or concerns

_____ _____

Signature of Patient/Guardian **Print Patient's Name**

_____

Date

Fort Worth Ear, Nose, & Throat
J. Roy Lowry, D.O., Jeremy P. Watkins M.D., John B. McIntyre M.D.
1250 8th Avenue Suite 135
Fort Worth, TX 76104
817-332-8848 Phone/ 817-335-2670 Fax

If You Have.....	You Are Responsible....	Our Staff will....
HMO & PPO Plans with which we have a contract	<u>If the services you receive are covered by the plan:</u> All applicable co-pays and deductibles are requested at the time of visit. <u>If the services you receive are not covered by the plan:</u> Payment in full is requested at the time of visit.	Call your insurance company ahead of time to determine copays/deductibles. File an insurance claim on you behalf.
Commercial Insurance	Payment of the patient responsibility for all office visits, procedures, injections, and other charges at the time of visit.	Call your insurance company ahead of time to determine copays/deductibles. File an insurance claim on your behalf.
Medicare/More Than One Insurance Coverage	Any services not covered by Medicare are requested at the time of visit <u>If you have Medicare as primary or secondary</u>: No payment is due upfront unless it is determined that your secondary will not pick-up copay/deductible in full.	File a claim on your behalf as well as any claims to your secondary insurance.
No Insurance	Payment in full at time of visit	Provide you a receipt so you can file the claim with your carrier.
Health Savings Account/ High Deductible Plans	Your insurance company will be billed if you have enough funds in your health savings account. If you do not have enough funds in your health savings account-Payment in full is requested at time of visit.	Call your insurance company ahead of time to determine deductible and verify health savings account funds Work with you to settle your balance. Please ask to speak with our staff if you need assistance.

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IMPORTANT PATIENT INFORMATION NOTICE

Physician Office Compliance with the Red Flag Rule

The Federal Trade Commission (FTC), in conjunction with other agencies, published the Red Flag Rules defining with a creditor and financial institution must do to implement an Identity theft program. The Red Flag Rule requires those covered, including medical practices, to identify at-risk accounts and to define, detect, and respond to Red Flags in order to prevent or mitigate identify theft. Medical identity theft happens when a person seeks health care using someone else's name or insurance information.

Fort Worth ENT is committed to protecting your identity and has developed a compliance policy that will help us protect your vital personal information. Beginning **February 1, 2010**, our staff will be asking patients and /or guardians to provide the following at each appointment:

- Photo ID (Drivers license, Passport, Employment picture ID)
- Current insurance card
- Verification of patient demographics, including phone numbers

Please note: no one, **including minors,** will be permitted to use a Medical Flex Card, major credit card, or make a payment by check if the patients name does not match the form payment used- **UNLESS** we have a written permission from payer.

We have a form available for the person named on the card or check to complete, sigh and return to our office.

Please remember that this is being instituted for your protection. Fort Worth ENT is committed to protecting our patients through the highest level quality of care and unparalleled services.

Thank you for your assistance in helping us to comply with our Identity Theft Program. If you would like a complete copy of the Red Flag Rule, please ask the receptionist and she will be happy to provide you with a copy