Advanced
Ear, Nose, & Throat Associates, PC
Atlanta, Georgia

PATIENT REGISTRATION
PLEASE FULLY COMPLETE FORM

Patient Name _____ **Today's Date** _____

Date of Birth _____ **Social Security Number** _____ - _____ - _____

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced **Gender** ☐ Male ☐ Female

Home Address _____

Phone Numbers: Home _____ **Cell** _____ **Work** _____

Primary Phone Number ☐ Home ☐ Cell ☐ Work **Email** _____

Preferred Language ☐ English ☐ Spanish ☐ French ☐ German ☐ Italian ☐ Portuguese ☐ Russian ☐ Chinese ☐ Japanese ☐ Other _____

Race/Ethnicity ☐ White ☐ Black/African American ☐ Asian ☐ Hispanic/Latino ☐ American Indian/Alaskan Native ☐ Pacific Islander ☐ Native Hawaiian/Other ☐ Other _____

EMPLOYMENT Employer _____ Dept./Title _____

Employer's Address _____

PREFERRED PHARMACY INFORMATION Pharmacy Name _____ Phone _____

Pharmacy Address _____

INSURANCE INFORMATION

Primary Insurance Co._____ Subscriber's Name _____

Relationship to Patient _____ Date of Birth _____ ID# _____

Secondary Insurance Company _____ Subscriber's Name _____

Relationship to Patient _____ Date of Birth _____ ID# _____

Referring Physician _____ **Primary Care Physician** _____

Whom may we thank for referring you? _____

List below any persons/family members whom you authorize to access your medical records and/or authorize us to leave a detailed message regarding all aspects of your medical chart, health condition, medications, and financial history.

Name _____ **Relationship to Patient** _____

Name _____ **Relationship to Patient** _____

May we leave a detailed message on voice mail/ answering machine? ☐ Yes ☐ No

All Patients: I consent to medical treatment for myself, my child or the above named minor, for which I am legally responsible. I authorize the release of any medical information to any insurance for the purpose of filling my medical/surgical claim. I authorize payment on behalf of myself, and/or my dependents to be made directly to Advanced Ear, Nose, & Throat Associates, P.C. I further understand that I am financially responsible for any services deemed Non-Covered by my insurance company, and deductibles, co-pays and co-insurance is due at that time of service. I also understand that I will be financially responsible for any and all costs and fees relating to the collection of my debt.

Medicare Patients: I authorize the physicians of Advanced Ear, Nose, & Throat Associates, P.C. to release to the Social Security Administration or its intermediary carriers, any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physicians(s) services. I understand that I am responsible for my health insurance deductibles, co-insurance and for any services deemed Non-Covered by Medicare.

Signature: _____ **Date**: _____

Patient and/or Legal Guardian in Patient is a Minor

Advanced
EAR NOSE & THROAT ASSOCIATES

FINANCIAL POLICY AGREEMENT AND CONSENTS

Thank you for choosing Advanced Ear, Nose, and Throat Associates for your medical care. We are honored to help you, but before we can do so, you must complete this form.

Please read and initial the following statements, then sign at the bottom:

_____ Each patient is responsible for his or her own bill. Payment of all insurance co-payments, co-insurances, deductibles, and outstanding balances must be paid in full at the time of your visit and prior to any surgery. We accept cash, checks, and major credit cards.

_____As a courtesy, we will file insurance claims. You must provide accurate insurance information and report any changes immediately. If your insurance information is incorrect, you will be responsible for the charges. We cannot provide you with information on what your insurance company will cover and what they will not, and your insurance may have their own "Usual, Customary, and Reasonable (UCR)" fee schedule. This is your insurance company's fee schedule, and we are not obligated to adjust our fees to match their UCR schedule. We encourage you to contact your insurance provider directly for answers to these questions. Please bring your health insurance card and a photo identification to each visit to facilitate this process.

_____**AUTHORIZATION OF INSURANCE FILING AND PAYMENT:** I authorize my insurance company to pay benefits on my behalf to Advanced Ear, Nose, and Throat Associates for professional services or goods, and I authorize the practice to release any medical records necessary to secure payment. I understand that I am financially responsible for any charges not covered by insurance.

_____Some insurance companies require authorization for care provided by a specialist. It is your responsibility to know if your insurance requires, and provide a referral authorization in advance of your visit. If this is not done prior to the date of your appointment, you will be asked to reschedule or pay the full cost of the visit. If a claim is filed and rejected because a valid referral authorization was not in place, you are responsible for the full cost of your visit.

_____"Self-pay" patients and those with limited health insurance are required to pay 100% of services rendered at each visit. A minimum of $250 is due on the initial visit. For extended treatments or surgery, payment arrangements can be made with the billing office.

_____Worker's compensation claims require your assistance in obtaining authorization from your case manager or adjuster for all office visits. We will bill your employer or worker's compensation insurance plan, but you are responsible for payment if your claim is denied.

_____In the case of minors, custody and maintenance issues are not our responsibility to define or enforce. Payment is expected from the parent/guardian accompanying the minor to the office at the time of service.

_____A $30 fee will be charged on any returned check.

_____A $25 fee will be assessed for any no-show appointment or an appointment cancelled within 24 hours of the appointment time. Insurance does not cover this charge.

_____A $25 fee will be assessed for completion of various forms such as disability paperwork. This charge is not covered by insurance, and is due prior to the completed forms being returned to you. Please allow 7-14 business days for completion of these forms.

_____Charges will be assessed for reproduction of medical records based on guidelines from the state of Georgia and the Federal Government. Insurance does not cover the cost of document reproduction.

_____Outstanding balances past 60 days will be turned over to a third-party collection agency. Additional fees may apply and will result in your dismissal from the practice.

_____ I have been provided with a copy of the practice's Notice of Privacy Practices.

_____**ENDOSCOPY CONSENT**: The nature of our expertise often involves use of endoscopy of the nasal passages or throat in the office for a magnified evaluation of these anatomic locations. If this procedure is performed, an additional charge will apply. The "allowable" or contracted insurance rate for these procedures generally ranges from $125 to $225. The amount covered by insurance depends on your plan and if your annual deductible has been met. We encourage you to call your insurance carrier to inquire about "allowable" amounts for CPT codes 31575 (throat endoscopy), 31231 (nasal endoscopy), and 31237 (nasal or sinus debridement). I understand that I may refuse these procedures, but that the accuracy of diagnosis or surveillance of my condition may be compromised by my refusal. By initialing above, I understand that I am responsible for the charges associated with these procedures when they are performed.

CONSENT FOR TREATMENT:

I, _____, hereby voluntarily consent to care at Advanced Ear, Nose, & Throat Associates, P.C., including, but not limited to examination and medical treatment, routine diagnostic procedures, examination and laboratory work, imaging including computed tomography (CT) scan, and administration of medications prescribed by the physician.

I further consent to the performance of those diagnostic procedures, examinations and rendering of medical treatment by the physicians and their assistants, including physician assistants, audiologists, medical assistants, or their designees as is necessary in the physician's judgment.

By signing below, I acknowledge this policy and the responsibilities defined above.

X_____ Date:_____
Signature of patient or responsible party

MEDICARE CONSENT (MEDICARE BENEFICIARIES ONLY):

I certify that the information given by me in applying for payment under Title SVIII and/or Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release any information needed for a Medicare claim to the Social Security Administration or its intermediary. I request that payment of authorized benefits be made on my behalf, and I assign the benefits payable for physician services. I understand that I am responsible for my health insurance deductibles and coinsurance.

X_____ Date:_____
Signature of patient or responsible party

Golde | Mickelson | Rogers | Bomeli
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AdvancedENTpc.com

NEW PATIENT HEALTH HISTORY

Name: _____DOB:_____

What doctor recommended an ENT visit? _____

How did you choose us? ☐*Referring Dr* ☐*Family/Friend* ☐*Internet* ☐*Other*

Reason for Visit: _____

Pharmacy Info: _____

PAST MAJOR MEDICAL HISTORY: *please circle*

☐ Allergies	☐ Cholesterol problem	☐ Acid Reflux
☐ Anxiety	☐ Chronic back pain	☐ Heart Disease
☐ Arthritis	☐ Chronic lung disease	☐ High Blood Pressure
☐ Asthma	☐ Depression	☐ Hypothyroidism
☐ Bleeding disorder	☐ Diabetes	☐ Vascular Disease
☐ Major cancer	☐ Fibromyalgia	

OTHER SERIOUS ONGOING MEDICAL PROBLEMS: _____

PAST SURGERY: *please circle*

☐ Ear surgery	☐ Brain surgery	☐ Kidney surgery
☐ Ear tubes	☐ Breast surgery	☐ Liver/Spleen surgery
☐ Nasal/Sinus surgery	☐ Cardiac Stent	☐ Orthopedic surgery
☐ Neck surgery	☐ Chest/Lung Surgery	☐ Prostate surgery
☐ Parathyroid surgery	☐ Colon surgery	☐ Skin cancer surgery
☐ Sleep apnea surgery	☐ Cosmetic surgery	☐ Spine/Back surgery
☐ Thyroid surgery	☐ GYN surgery	☐ Spine/Neck surgery
☐ Tonsillectomy	☐ Heart surgery	☐ Stomach/Intestine
☐ Bladder/Urinary	☐ Hernia surgery	

OTHER MAJOR SURGERY: _____

SIGNIFICANT FAMILY MEDICAL HISTORY: *please circle*

☐ Cancer at young age
☐ Cardiac death at young age
☐ Multiple ear infections
☐ Thyroid cancer

OTHER SIGNIFICANT FAMILY HISTORY: _____

HEALTH HABITS: *please circle*

☐ Daily alcohol use
☐ Illicit drug use
☐ Smoker: current ☐ | former ☐
☐ Other tobacco

MEDICAL SYSTEMS REVIEW: *circle any that apply*

☐ fever ☐ chills ☐ weight loss ☐ night sweats ☐ loss of apetite
☐ double vision ☐ new change in vision
☐ chest pain ☐ palpitations ☐ syncope ☐ leg edema ☐ heart murmur ☐ chest pain
☐ shortness of breath ☐ wheezing ☐ cough ☐ coughing blood
☐ abdominal pain ☐ heartburn ☐ blood in stools
☐ urinary frequency ☐ urinary pain ☐ blood in urine
☐ skin rash ☐ skin itching ☐ skin redness
☐ nerve weakness ☐ tingling ☐ numbness ☐ incoordination ☐ headaches
☐ unexplained hair loss ☐ excessive thirst ☐ frequently too hot ☐ frequent urination
☐ bleeding gums ☐ easy bleeding ☐ easy bruising ☐ anemia

MEDICATIONS: *List prescribed medications and dosages:*

☐ Also taking non-prescription dietary supplements, vitamins, or minerals

MEDICATION ALLERGIES: