ALLERGY & ENT ASSOCIATES OF MIDDLE TENNESSEE, P.C.

Patient Legal Name: _____ Social Security #: _____-_____-_____

Drivers' License #: _____ Marital Status: Single Married Divorced Widow / Widower

Date of Birth: _____/_____/_____ Age_____ Sex: (Please Circle One) Male Female

Race: _____ Religion: _____ Primary Language Spoken: _____

Parent Name: (If patient is a minor) _____

Legal Guardian of Patient: (Please specify relationship) _____

Residence Address: _____ City: _____ State: ____ Zip: _____

Mailing Address: _____ City: _____ State: ____ Zip: _____

** How did you hear about us?: _____

CONTACT NUMBERS

* Please check the box beside the number(s) that are best to reach you Monday through Friday from 8am to 5pm.

☐ Home Telephone: (_____)_____-_____ Employer's Name:_____

☐ Work Telephone: (_____)_____-_____ Occupation: _____

☐ Mobile Telephone:(_____)_____-_____ Referring Physician: _____

E-Mail Address: _____ Primary Care Physician: _____

Individual to contact in case of an emergency: Physician Telephone: (_____)_____-_____

Name: _____DOB:_____ **Pharmacy**: _____

Relationship to Patient: _____ Pharmacy Address: _____

Contact Telephone #1: (_____)_____-_____ City: _____ State: ____ Zip: _____

Contact Telephone #2: (_____)_____-_____ Pharmacy Telephone: (_____)_____-_____

BILLING INFORMATION

Person responsible for paying bill: (Please circle one) Patient Parent Spouse Other_____

Name _____DOB:_____ Mobile Telephone: (_____)_____-_____

Home Telephone:(_____)_____-_____ Work Telephone: (_____)_____-_____

Residence Address: _____ City: _____ State: ____ Zip: _____

Mailing Address: _____ City: _____ State: ____ Zip: _____

INSURANCE INFORMATION (Please present your insurance cards to the receptionist upon check-in)

Primary Insurance

Insurance Company Name: _____

Name of Policyholder (subscriber): _____

Date of Birth of Policyholder: _____/_____/_____

Social Security #: _____-_____-_____

Patient's relationship to insured: Self / Spouse / Child / Other

Secondary Insurance

Insurance Company Name: _____

Name of Policyholder (subscriber): _____

Date of Birth of Policyholder: _____/_____/_____

Social Security #: _____-_____-_____

Patient's relationship to insured: Self / Spouse / Child / Other

I AGREE THAT THE INFORMATION CONTAINED ON THIS FORM IS UP TO DATE AND ACCURATE, TO THE BEST OF MY KNOWLEDGE.

/ /

Signature of Patient or Legal Guardian **Date: Month / Day / Year**

Patient HIPAA Acknowledgement and Consent Form

Patient Information:

First Name: _____ Last Name: _____ DOB: _____

Notice of Privacy Practices

_____ (Patient Initials) I acknowledge that Allergy & ENT Associates of Middle Tennessee, P.C. has provided, for my review, a copy of the Notice of Privacy for Protected Health Information. Copies of the HIPPA Policy are located in the lobby, as well as provided on the first visit. Additional copies can be obtained at any time by requesting them at the check-in or check-out desks. This notice describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures. I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy Practices.

Release of Information

_____ (Patient Initials) I hereby permit practice and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

- Healthcare information regarding a prior admission(s) may be made available to subsequent admitting facilities to coordinate patient care or for case management purposes. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf, in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.
- If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.
- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors. In order for these individuals and entities to share my health information with one another to accomplish goals that may include, but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions,

genetic information, chemical dependency conditions and/or infectious disease including, but not limited to, blood-borne diseases, such as HIV and AIDS.

Marketing Consent

_____ (Patient Initials) I hereby permit practice and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information to permit third party organizations (e.g. pharmaceutical companies, product vendor companies) to notify me or market to me health-related or non-health-related products, treatments, services or opportunities. I understand that sometimes third party organizations subsidize the cost of such notification on behalf of the company. I understand that I may revoke this authorization at any time by providing my written revocation to the practice. My revocation will not apply to information already retained, used, or disclosed in response to this authorization. If the person or entity receiving my protected health information is not a health care provider or health plan covered by federal privacy regulations, my protected health information may be disclosed by such recipients to other individuals or institutions and no longer protected by federal privacy regulations.

Please sign here if you wish to DENY this Marketing consent: _____

Pharmacy Benefit Management (PBM) Consent

Electronic Prescribing (E-Prescribing or E-Rx) is defined as a physician's ability to electronically send an accurate, error-free, and understandable prescription directly to a pharmacy. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. Your Medication History Transactions provide the physician with the information about the medications that the patient is already taking prescribed by any provider, to minimize the number of adverse drug events.

_____ (Patient Initials) I hereby permit practice and the physicians or other health professionals involved in my care to request and use my prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

Please sign here if you wish to DENY this PBM consent: _____

Disclosures to Family Members and/or Friends

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM?

_____ (Patient Initials) I hereby permit practice and the physicians or other health professionals involved in my care to disclose my Protected Health Information for the purposes of communicating results, findings and care decisions to the family members and others listed below:

Name: _____ Relationship: _____ Contact Number: _____

Name: _____ Relationship: _____ Contact Number: _____

Name: _____ Relationship: _____ Contact Number: _____

Patient may revoke or modify this specific authorization and that revocation or modification must be in writing.

Consent for Communications

Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information. If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email or text address from the Practice.

_____ (Patient Initials) consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request will apply to all future appointment reminders/feedback/billing/health information unless I request a change in writing (see revocation section below)

( )_____-_____ This is the cell phone number that I authorize to receive the text message communications listed above.

_____ This is the email address that I authorize to receive the messaged communications listed above.

The practice does not charge for this service, but standard text messaging rates apply as provided in your wireless plan (contact your carrier for pricing plans and details)

Revocation
I hereby revoke my request for future communications via email and/or text.
_____ (Patient Initials) I hereby revoke my request to receive any future appointment reminders, feedback, billing and general health via text messages.
_____ (Patient Initials) I hereby revoke my request to receive any future appointment reminders, feedback, billing and general health via email
NOTE: This revocation only applies to communications from this Practice.

Patient Name: _____ Patient/Representative Signature: _____

Witness: _____ Date: _____ Time: _____
Please note that it may take up to 3 business days to process this request. Communications may occur during this time.

Consent for Photographing or Other Recording for Security and/or Health Care Operations

_____ (Patient Initials) I consent to photographs, videotapes, digital or audio recordings, and/or images of me being recorded for security purposes and/or the practice's healthcare operations purposes (e.g., quality improvement activities). I understand that the facility retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used without a specific written authorization from me or my legal representative unless it is for treatment, payment or healthcare operations purposes or otherwise permitted or required by law.

Please sign here if you wish to DENY this Photo/Recording consent: _____

Prescription Order Pick Up

There may be times when you need a friend or a family member to pick up a prescription order from our office. In order for us to release a prescription to your family member or friend, we will need to have a record of their name. Prior to the release of the prescription, your designee will need to present valid photo identification and sign for the prescription.

_____ (Patient Initials) I wish to designate the following person(s) to pick up an order on my behalf:

Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

_____ (Patient Initials) I **DO NOT** want to designate anyone to pick up my prescription order.

Patient Bill of Rights/Financial Responsibilites

_____ (Patient Initials) I acknowledge that Allergy & ENT Associates of Middle Tennessee, P.C. has provided, for my review, a copy of the Financial Agreement and the Patient Bill of Rights and Responsibilities. I understand that knowing what my insurance policy covers, or does not cover, is my responsibility. I further understand that I agree to pay for all services rendered by this office, as a result of the determined diagnosis and/or treatment plan.

Signature Acknowledgement

By my signature below, I acknowledge that I have initialed the sections above noting my agreement or disagreement with the policies described within.

Signature: _____Date:_____

Relationship to Patient: _____

Name: (Please Print) _____

Consent to Treatment of a Minor When Parents/Guardians Are Temporarily Unavailable

Child's First Name: _____ Child's Last Name: _____ DOB: _____

The undersigned parent or legal guardian of the above named child authorizes the person(s) listed below to consent to treatment of the child, including, but not limited to, emergency, x-ray, anesthetic, or surgical services when I am not immediately available in person, or by a telephone call to _____.
(Phone Number)

It is understood that this consent is given in advance of any specific diagnosis or treatment and allows the physician/provider to diagnose and treat the child even when the parent or guardian is not present.

1. Person(s) ***other than parent/legal guardians*** who may consent to treatment on your behalf (please print):

   Name: _____Relationship to Child: _____Phone: _____

   Name: _____Relationship to Child: _____Phone: _____

   Name: _____Relationship to Child: _____Phone: _____

2. Medical concerns: _____
3. Known allergies: _____

Name of Parent or Legal Guardian: _____Relationship to Child:_____
(Print Name)

Contact Number(s): _____

Address: _____City, State, Zip: _____

Signature: _____ Date: _____

This consent is effective until withdrawn in writing by the child's parent or guardian.

Allergy & ENT Associates of Middle Tennessee, P.C.

PATIENT BILL OF RIGHTS AND RESPONSIBILITIES

We want to encourage you, as a patient at Allergy & ENT Associates of Middle Tennessee, P.C., to speak openly with your health care team, take part in your treatment choices, and promote your own safety by being well informed and involved in your care. Because we want you to think of yourself as a partner in your care, we want you to know your rights as well as your responsibilities. We invite you and your family to join us as active members of your care team.

Your Rights

- You have the right to receive considerate, respectful and compassionate care in a safe setting regardless of your age, gender, race, national origin, religion, sexual orientation, gender identity, or disabilities.
- You have the right to receive care in a safe environment free from all forms of abuse, neglect, or mistreatment.
- You have the right to be told the names of your doctors, nurses, and all health care team members directing and/or providing your care.
- You have the right to have someone remain with you for emotional support during your visit, unless your visitor's presence compromises your or others' rights, safety or health.
- You have the right to be told by your doctor about your diagnosis and possible prognosis, the benefits and risks of treatment, and the expected outcome of treatment, including unexpected outcomes.
- You can expect full consideration of your privacy and confidentiality in care discussions, exams, and treatments.
- You, and family, and friends with your permission, have the right to participate in decisions about your care, treatment and services provided, including the right to refuse treatment to the extent permitted by law. If you refuse medical care, against the advice of your doctor, the practice and doctors will not be responsible for any medical consequences that may occur.
- You have the right to communication that you can understand. Information given will be appropriate to your age, understanding, and language. If you have vision, speech, hearing, and/or other impairments, you will receive additional aids to ensure your care needs are met.
- You have the right to receive detailed information about your physician charges.
- You can expect that all communication and records about your care are confidential, unless disclosure is permitted by law. You have the right to see or get a copy of your medical records. You may add information to your medical record by contacting the Medical Records Department. You have the right to request a list of people to whom your personal health information was disclosed.
- You have the right to voice your concerns about the care you receive. If you have a problem or complaint, you may talk with your doctor, nurse or the Practice Administrator, Tricia Long. Contact information: 615-889-8802 or info@myallergyent.com.

Your Responsibilities

- You are expected to provide complete and accurate information, including your full name, address, home telephone number, date of birth, Social Security number, insurance carrier and employer, when it is required.
- You are expected to provide complete and accurate information about your health and medical history, including present condition, past illnesses, hospital stays, medicines, vitamins, herbal products, and any other matters that pertain to your health, including perceived safety risks.
- You are expected to ask questions when you do not understand information or instructions. If you believe you can't follow through with your treatment plan, you are responsible for telling your doctor. You are responsible for outcomes if you do not follow the care, treatment and services plan.

- You are expected to treat all staff, other patients and visitors with courtesy and respect; abide by all practice rules and safety regulations; and be mindful of noise levels, and privacy.
- You are expected to provide complete and accurate information about your health insurance coverage and to pay your bills in a timely manner.
- You have the responsibility to keep appointments, be on time, and call your health care provider if you cannot keep your appointments.

Allergy & ENT Associates of Middle Tennessee, P.C. has adopted this Patient Bill of Rights and we pledge to uphold our obligation to provide that your needs are met as they pertain to "Your Rights" listed above. We expect that you, our patient, will uphold "Your Responsibilities", also listed above. Should you not uphold those responsibilities, Allergy & ENT Associates reserves the right to dismiss you from the medical care of the physicians in our practice. Should dismissal become necessary, you will be notified as required by law.

FINANCIAL AGREEMENT

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time.
Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy or your financial responsibility.

PATIENTS MUST FILL OUT PATIENT INFORMATION FORMS PRIOR TO SEEING THE DOCTOR. WE WILL REQUEST TO PHOTOCOPY YOUR INSURANCE CARD(S) AND PHOTO ID FOR YOUR FILE.

- **APPOINTMENTS** – 24 hours notice must be provided in the event you cannot keep an appointment. Should you not provide this notice, a cancellation fee of $25 may then be added to your account.
- **INSURANCE** – ALL insurance cards must be presented at the time of your visit. If you do not provide us with accurate insurance information, we cannot file claims in a timely manner and are likely to not get paid by your insurance company. If you have failed to provide us with the necessary information or you provide us with inaccurate information, YOU will be responsible for the unpaid balance on your account. In order to receive maximum benefits from your insurance company, it is highly recommended by our office that you verify that Allergy & ENT Associates and its providers are in-network with your plan or if you are eligible for out-of-network benefits. By your signature below, you authorize us to file claims and provide any necessary documentation requested to your insurance company on your behalf.
- **OUT OF NETWORK BENEFITS** – You will be responsible for any balance your plan indicates as due on their explanation of benefits form. We will adjust the charges to coincide with your plan's UCR (Usual, Customary and Reasonable) charges. All patients will be responsible for their co-insurance and deductible. Should you receive payment from your insurance carrier, please forward it to the physician's office.

  Private Insurance Authorization for Assignment of Benefits/Information Release: I, the undersigned, authorize payment of medical benefits to Allergy & ENT Associates of Middle Tennessee, P.C. for any services furnished. I understand that I am financially responsible for any amount not covered by my contract. I also authorize any holder of medical information about me to release to my insurance company (or their agent) information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.
- **REFERRALS** – If your plan requires a referral from your primary care physician, it is YOUR responsibility to obtain it prior to your appointment and have it with you at the time of your visit. If you do not have your referral, YOU WILL BE REQUESTED TO SIGN A FINANCIAL WAIVER stating that you will be personally responsible for that day's services if your referral is not received.

- **CO-PAYMENTS** – By law, we MUST collect your carrier designated co-pay. This payment is expected at the time of service. Please be prepared to pay the co-pay at each visit. If you are unable to pay your co-payment at the time of service, we will be happy to reschedule your appointment.
- **SELF-PAY PATIENTS** – Payment is expected at the time of service unless financial arrangements have been made prior to your visit.
- **PROCEDURES/TESTING** – Your physician may deem it necessary for you to receive procedures or testing in-office that may fall under "surgery" or other categories by some insurance plans. These may be covered at a different rate than your standard office visit (common use of this may include nasal endoscopy, laryngoscopy, wax removal, allergy and audiology testing). By your signature below, you are acknowledging that you understand this and that you agree to be responsible for the charges deemed payable by your insurance company.
- **"GLOBAL" PERIODS OF COVERAGE** – Surgeries and some procedures may fall under "Global" periods of coverage. These windows of time are designed to allocate time for follow-up care without incurring additional office visit fees. They vary greatly in length of time, as do the accompanied procedures. Please note that the no-fee coverage is ONLY as it relates to the procedure or surgery the patient has had. Should the patient be seen with an additional medical concern, not relating to the global procedure, there may be a co-pay or co-insurance required. Please see your specific health plan for your coverage.
- **NON-MEDICALLY NECESSARY/DELUXE/NON-COVERED ITEMS –** Most insurance companies do not cover/reimburse the cost of non-medically necessary or "deluxe" items. These items may include, but are not exclusive of, hearing aids, hearing aid accessories, hearing aid batteries, swim earplugs, Somnoguard, Sublingual immunotherapy, etc. Should you wish to purchase items deemed non-medically necessary or non-covered, you will be responsible for the charge.
- **MEDICARE** – We will submit claims to Medicare. The patient will be responsible for the deductible and the 20% co-insurance, which can be billed to a secondary insurance if you have one.

  Medicare Lifetime Signature on File: I request that payment of authorized Medicare benefits be made on my behalf to Allergy & ENT Associates of Middle Tennessee, P.C. for any services furnished to me. I authorize any holder of medical information about me to release to the CMS (and its agents) any information to determine these benefits payable for related services. This information will be used for the purpose of evaluating and administering claims of benefits.
- **DIVORCED/SEPARATED/OTHER PARENTS OF MINOR PATIENTS** – The parent who consents to the treatment of a minor child is responsible for payment of services rendered. Allergy & ENT Associates of Middle Tennessee, P.C. will not be involved with separation or divorce disputes. Should someone other than the parent have legal guardianship of a patient, it is the responsibility of said guardian to provide legal proof of guardianship to us.

You are responsible for the timely payment of your account. Should it become necessary for us to use an outside agency to collect payment from you, you will be additionally responsible for whatever charges we incur as a result of this.

WE ACCEPT CASH, CHECKS, MASTERCARD, VISA, AMERICAN EXPRESS OR DISCOVER CARD.

THANK YOU for taking the time to review our policies. Please feel free to ask any questions or share with us special concerns.