

# ALLERGY & ENT ASSOCIATES

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: \_\_\_\_\_  
Billing 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:**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Physician Telephone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_ Pharmacy: \_\_\_\_\_  
Contact Telephone #1: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_  
Contact Telephone #2: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Pharmacy Address: \_\_\_\_\_  
Pharmacy Telephone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

## BILLING INFORMATION

Person responsible for paying bill: (Please circle one) Patient Parent Spouse Other \_\_\_\_\_  
Name \_\_\_\_\_ DOB: \_\_\_\_\_ Mobile Telephone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Home Telephone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work Telephone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

## 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

# Notice Of Privacy Practices Acknowledgement

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my PHI. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices*.

Patient Name or Legal Guardian: \_\_\_\_\_

Signature: \_\_\_\_\_

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

## PRACTICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of the Notice of Privacy Practices Acknowledgement but was unable to do so as documented below:

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

Reason: \_\_\_\_\_

\_\_\_\_\_



# General Consent For Treatment

***As the patient, you have the right to be informed about your conditions and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify appropriate treatment and/or procedure for any identified condition(s).***

I request and authorize medical care as my provider, his assistant or designees (collectively called "the providers") may deem necessary or advisable. This care may include, but is not limited to, routine diagnostics, radiology and laboratory procedures, administration of routine drugs, biological and other therapeutics, and routine medical and nursing care. I authorize my provider(s) to perform other additional or extended services in emergency situations if it may be necessary or advisable in order to preserve my life or health. I understand that my (the patient) care is directed by my provider(s) and that other personnel render care and services to me (the patient) according to the provider(s) instructions.

I understand that I have the right and the opportunity to discuss alternative plans of treatment with my provider and to ask and have answered to my satisfaction any questions or concerns.

In the event that a healthcare worker is exposed to my blood or bodily fluid in a way which may transmit HIV (human immunodeficiency virus), hepatitis B virus or hepatitis C, I consent to the testing of my blood and/or bodily fluids for these infections and the reporting of my test results to the healthcare worker who has been exposed. \_\_\_\_\_ (initial)

**In order to maintain an accurate and up-to-date medical record, we request permission to query outside resources for a list of your medications. Your signature below authorizes us to do so.**

**I HAVE READ OR HAD READ TO ME AND FULLY UNDERSTAND THIS CONSENT; I HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS AND HAD THESE QUESTIONS ADDRESSED.**

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

Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Consent of Legal Guardian, Patient Advocate or Nearest Relative **if patient is unable to sign**

Consent Caregiver **if patient is unable to sign**

Name of Legal Guardian, Patient Advocate, Nearest Relative or Other: \_\_\_\_\_

Relationship: \_\_\_\_\_ Telephone: \_\_\_\_\_

Address: \_\_\_\_\_

Signature of the above: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Signature of Witness: \_\_\_\_\_ Date: \_\_\_\_\_



AdvancedHEALTH

# Release Of Medical Information

NAME (Please print): \_\_\_\_\_ DOB: \_\_\_\_\_

By Signing Below, I Authorize AdvancedHEALTH To Release My Medical And Billing Information To:

## RELATIONSHIP

## NAME OF DESIGNATED PERSON

SPOUSE  YES  NO \_\_\_\_\_

CHILDREN  YES  NO \_\_\_\_\_

IN-LAWS  YES  NO \_\_\_\_\_

CAREGIVERS  YES  NO \_\_\_\_\_

PARENTS  YES  NO \_\_\_\_\_

OTHERS \_\_\_\_\_

PATIENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

PARENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**We ask that if you have any change in this request, that you please inform the receptionist.**

---

AdvancedHEALTH may leave appointment information on my voicemail:

HOME  YES  NO

WORK  YES  NO

RELATIVE  YES  NO

PATIENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

---

I authorize the following to pick up prescriptions, X-rays, etc.

## RELATIONSHIP

SPOUSE  YES  NO \_\_\_\_\_

RELATIVE  YES  NO \_\_\_\_\_

CAREGIVER  YES  NO \_\_\_\_\_

PATIENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**We charge a \$20 flat rate for 1-5 pages plus .50 per additional page and postage.**

I understand that AdvancedHEALTH will ask for identification of the person picking up patient medical information or products.



AdvancedHEALTH

# Patient Financial Policy

*This is an agreement between AdvancedHEALTH, as creditor, and the Patient/Debtor named on this form and indicated by patient/debtor signature below.*

*In this agreement the words "you", "your" and "yours" mean the Patient/Debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we", "us" and "our" refer to AdvancedHEALTH. By executing this agreement, you are agreeing to pay for all services that are rendered.*

*Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect. A copy of your signed financial agreement will be provided to you.*

## **HEALTH INSURANCE - It is YOUR responsibility to:**

- Ensure we have been provided with the most current insurance information relative to filing your claim including insurance card, ID number, employer, birth date and patient address. This information will be located on our patient registration form.
- Ensure we are contracted with your insurance carrier to receive maximum benefits.
- Pay your co-payment or patient portion at the time of service.
- Inform us of any insurance changes made after this signed agreement/date of service. Insurance carriers have specific timely filing guidelines and pre-authorization requirements for certain services. If revised insurance information is not provided to us within your insurances' timely filing limits, you will be required to pay for services in full. If prior authorization was required for services already received and your claim is denied for lack of authorization, you will be required to pay for services in full.
- Contact your insurance company if no correspondence is received by you within 45 days of the date of service.

## **It is OUR responsibility to:**

- Submit a claim to your health insurance carrier based on the information provided by the patient/debtor at the time of service or as updated information is provided.
- Provide your health insurance carrier with information necessary to determine benefits. This may include medical records and/or a copy of your insurance card.
- Provide MVA patients a courtesy health insurance claim form for their records upon request.

**PAYMENT OPTIONS:** Per our contracted agreement with your insurance carrier, we are required to collect your co-payment on the day of service. If you do not have insurance, you are required to pay for treatment at the time of service unless other arrangements have been formally made. A separate self-pay financial agreement will be provided to you. Our office collects all copays plus estimated coinsurance and deductibles at the time of service

**We accept the following: Cash Check Credit Card (Visa, MasterCard, Discover, American Express)**

**A twenty-five dollar (\$25.00) returned check fee will be assessed to the patient account per incident.**

For convenience, payments may be made online at [www.ePayItOnline.com](http://www.ePayItOnline.com). To utilize this service you will need your account number, access code, and Code ID. This information can be found on the patient statement you will receive reflecting your balance. **Patients who no-show may be subject to a no-show fee.**

**PENDING APPROVALS FOR SERVICES:** In the event we are unable to obtain approval for services and you wish to proceed, we will not bill your insurance. Services will be reduced to the in-network insurance allowable amount and will apply to the patient's responsibility.

\_\_\_\_\_ Initials

Patient and/or Debtor Signature: \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

*Additional financial explanations are continued on the back side of this page*



**AdvancedHEALTH**

**WORKERS' COMPENSATION INJURIES:** Written approval/authorization by your employer and/or workers' compensation carrier prior to your initial visit is needed. We will contact your case manager and/or supervisor to confirm your workers' compensation injury. If this claim is denied, for any reason by your employer or your employer's workers' compensation carrier, you will be responsible for payment in full. If denial is made by workers' compensation, health insurance can be filed for these denied services and you will be held responsible for the account.

**MOTOR VEHICLE ACCIDENTS (MVA's)** – Yes, I was involved in a MVA on \_\_\_\_/\_\_\_\_/\_\_\_\_. Unless prior agreement has been reached or I am a Medicare recipient, my **health insurance** will be filed for services related to this accident. In the event I do not provide insurance information upon initial visit, I understand insurance denials may occur depending on type of service(s) received or carrier specific filing requirements. I agree, as the patient or patient's guardian, I am ultimately responsible for all balance(s) due to this facility and/or its physician(s) for services rendered regardless of insurance denial(s) or unfavorable case outcomes. If I have chosen an attorney to oversee my case, this financial agreement will serve as a Letter of Protection to my attorney. I further understand my account may be handled by an outside entity that specializes in attorney lien accounts at the facilities discretion.

\_\_\_\_ Yes, I have chosen to retain an attorney. Signed: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Attorney Name: \_\_\_\_\_ Phone: \_\_\_\_\_

### BILLING INFORMATION

#### STATEMENTS:

A statement of account will be provided to you if insurance has paid leaving a patient portion, denied or no response is received. Due to the type of service we provide, you may receive billing from more than one practice, otherwise known as split billing. The balance on your statement is due and payable within 30 days of receipt unless other arrangements are made with our billing department. The statement will be sent to the address provided at the time of service. In the event your mailing address changes after your service date and your account has not been paid in full, you are required to notify our billing office of this change by calling 615.851.6033 ext. 2067. In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child at time of service will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, court documentation is required for any guarantor address changes, otherwise, it is the authorizing/custodial parent's responsibility to collect from the other parent. Any account with a credit balance of less than <\$5.00> will not be refunded without specific request from the patient/debtor.

#### DELINQUENT ACCOUNTS:

We review past due accounts frequently and at every statement cycle. Your communication and involvement to ensure your balance is paid timely is important to us. It is imperative that you maintain communications and fulfill your financial agreement and arrangements to keep your account active and in good standing.

If your account becomes sixty (60) days past due, further steps to collect this debt may be taken. If we have to refer your account to a collection agency, you agree to pay all of the collection costs, which are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyer fees which we incur plus all court costs. In case of suit, you agree the venue shall be Davidson County, Tennessee. In addition, we reserve the right to deny future non emergency treatment for any and all debtor-related unpaid account balances.

#### WAIVER OF CONFIDENTIALITY:

You understand if your account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

#### MEDICAL RECORDS:

You will be required to request in writing or sign a medical authorization form for the release of your medical records to any organization or physician. We charge a **\$20 flat rate** for 1-5 pages plus .50 per additional page and postage.



AdvancedHEALTH