ENT OF OKLAHOMA
EAR • NOSE • THROAT

Referring Physician: _____ Patient #: _____

Patient Name: _____
LAST FIRST MI

Mailing Address: _____ _____ _____ _____ _____
STREET APT CITY STATE ZIP CODE

Age: _____ M_____ F_____ SSN: _____ Date of Birth: _____

Single _____ Married _____ Widowed _____ Minor _____

Race: African American ___ American Indian ___ Asian __ Caucasian ___ Pacific Islander ___ Other ___

Ethnicity: Hispanic or Latino _____ Not Hispanic or Latino _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Patient's Email: _____

Preferred Pharmacy: _____ Location: _____

Patient Employer: _____ Occupation: _____

Responsible Party
Name: _____ Relation to patient: _____
Address (if different from above): _____
Date of Birth: _____ SSN: _____ Phone: _____ ( )Home ( )Cell
Employer: _____ Occupation: _____
Work Phone: _____

In Case of Emergency:
Contact: _____ Relation: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____

Patient Privacy Notice:
I have received a copy of *ENT of Oklahoma's* Patient Privacy Notice. Please initial _____
May we contact you at work? **YES NO** Do you have a Living Will? **YES NO**
Please list any individual(s) you give permission to receive your medical information/history: _____
_____

INSURANCE INFORMATION: Primary Insurance: _____
ID Number (Sponsor SSN if Tricare): _____
Policy Holder (Sponsor): _____ SSN: _____ DOB: _____ Employer: _____

Secondary Insurance: _____ ID Number (Sponsor SSN if Tricare): _____
Policy Holder (Sponsor): _____ SSN: _____ DOB: _____ Employer: _____

** If Medicare is secondary, please mark one: _____ Working age _____ Disabled beneficiary under 65

Patient/Guardian Signature: _____ **Date:** _____

I authorize the release of any medical or other information to process my medical claims. I authorize Dr. Snell/Dr. Kaiser to release information required for filing medical claims to the insurance companies listed above. I also certify that the information above is accurate to my knowledge. I authorize payment of medical benefits to ENT of Oklahoma for medical services.

ENT of Oklahoma

FINANCIAL POLICY

This information is provided to assist patients in regard to the financial expectations relating to the care that is received at ENT of Oklahoma. If any questions arise with your account, please contact our Billing Department at (580) 531-0022, option 2.

- **Co-payment will be required at the time of service.** The responsible party will be required to pay all co-payments, per the insurance contract. The receptionist will ask for the co-payment at the time of the visit. Should payment not be made at this time, an additional co-pay collection fee of $5.00 will be applied to the account.
- **Self-Pay.** Self-pay patients will be responsible for payment in full on the day of service.
- **Patients are responsible for charges that are not covered by the filed insurance plan.** This includes co-pays, deductibles, co-insurance, balances resulting from non-payment of ACA policy premiums, and non-covered services including lab tests that may not be covered. It is the patient's responsibility to notify ENT of Oklahoma if there are any changes to one's insurance plan.
- **Routine and Non-covered services.** Not all insurance companies pay for routine services. If a service is performed that is considered a "NON Covered Benefit," the patient will be financially responsible for the payment of those services. We will not change the diagnosis for the visit. Claims will be filed in accordance with the documentation charted by the physician. We advise all of our patients to check with their insurance carrier to see if the plan pays for any routine care: i.e., annual exams, hearing exams, in-office procedures, etc. This will help avoid any unexpected charges.
- **All charges will be expected to be paid in full within 30 days.** Please contact our billing department at (580) 531-0022, option 2 with any questions regarding payment.
- **Patients are responsible for the cost of collection efforts.** If payment is not received in accordance with the above guidelines: the account will be turned to a collection agency in 30 days. The patient will be responsible for any collection fees, attorney fees, and the costs involved in collecting the debt. In order to re-establish care, the outstanding balance must be paid in full, along with a $50.00 reinstatement fee.

We sincerely appreciate the opportunity to provide your care. Please sign and date this form in agreement to the above document.

Name: _____ Date: _____

PATIENT PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS OF THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

At the office of ENT of Oklahoma, we value your relationship, and want you to know we respect your privacy. We are committed to protecting your private and personal medical information, and we will only disclose your personal medical information as necessary to provide you with health care services.

The purpose of this notice is to help you understand our legal duties to protect your medical information and how we use and disclose this information. We will use and disclose your protected medical information as necessary in providing treatment to you, obtaining payment for services provided to you, and for the day-to-day operations of this practice. We take the obligations described in this notice very serious, because we are legally required to comply with this notice, and because we respect you and your right to privacy.

Who will follow this notice:
This notice describes our office's practices and that of any health care professional authorized to enter information into your file or record, as well as all other employees, staff, and other personnel. All of these entities and locations sited follow the terms of this notice.

Individual Rights:
The Health Insurance Portability and Accountability Act of 1966 (HIPAA), provides you with several rights related to your protected medical information.

- The right to request restrictions of the use and disclosure of your protected medical information.
- The right to receive confidential communications concerning your medical condition and treatment.
- The right to inspect and copy your protected medical information.
- The right to amend or submit corrections to your protected medical information.
- The right to receive an accounting of how and to whom your protected medical information has been disclosed.
- The right to receive a printed copy of this notice.

*As permitted by federal regulation, we require that these requests be submitted in writing. When required, you must provide a reason that supports your request. We will accommodate all the reasonable requests. You may obtain a form to request access to your records from the receptionist or by contacting our office at: **5402 SW Lee Blvd., Lawton, OK (580)531-0022.**

*We are not required to agree to your request. If we do not agree, we will reply to you in writing. If we do agree, we will comply with your requests unless the information is needed to provide you emergency treatment.

Uses and Disclosures:

Treatment – Your medical information may be used by staff members or disclosed to other healthcare professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. We may disclose your medical information to doctors, nurses, technicians, medical students, or other personnel who are involved in your care. We may also share your medical information in order to coordinate lab work, x-rays, and prescriptions.

Payment – Your medical information may be used to seek payment from your health plan, from other sources of coverage or from credit card companies that you must pay for services.

Health Care Operations – Your medical information may be used as necessary to support the day-to-day activities and management of ENT of Oklahoma.

Appointment Reminders – Our staff may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care.

As Required By Law – We will disclose medical information about you when required to do so by federal, state, or local law.

Public Health Reporting – Your medical information may be disclosed to public health agencies as required by law:

a. To prevent or control disease, injury or disability.
b. To report child abuse or neglect.
c. To report vulnerable adult abuse.
d. To report certain communicable diseases.
e. To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.
f. To report domestic abuse.

Military – If you are a member of the armed forces, we may release your medical information as required by military command authorities.

Lawsuits and Disputes – We may disclose information about you in response to a subpoena or court order. We will make efforts to contact you if these requests are made.

Inmates – We may release your medical information to the correctional institution or law enforcement officials.

Other Uses and Disclosures:
Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information prior to your notification.

Duties:
We are required by law to maintain the privacy of your protected medical information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices:
As permitted by law, we reserve the right to amend or modify our privacy polices and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next visit. These revised policies and practices will be applied to all protected medical information that we maintain.

Effective 07/01/2016

Phone (580) 531-0022 • Toll free (800) 805-0003 • Fax (580) 531-0026
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www.lawtonent.com