Ear Nose &Throat Associates of Manatee, P.A.

Patient Information - PLEASE PRINT in all fields Date _____

Last Name _____ First: _____ Middle: _____ Suffix: _____

Gender: ☐ Female ☐ Male Other _____ Preferred Language: _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Partner Other _____

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Refused Other _____

Race: ☐ Asian ☐ Black/African American ☐ Caucasian ☐ American Indian Other _____

Social Security Number: _____ Date Birth: _____/_____/_____

Preferred phone # for patient contact: ☐ Home ☐ Work ☐ Mobile Is it OK to leave a detailed message? ☐ Yes ☐ No

Home Phone: (_____) _____ Mobile Phone: (_____) _____

Personal Email Address: _____

Florida Mailing Address: _____ Apt/Lot/Unit # _____

City: _____ State: _____ Zip Code: _____

Florida Resident Start Date: _____ End Date: _____ Permanent Florida Resident

Out-of-State Address: _____ Apt/Lot/Unit # _____

City: _____ State: _____ Zip Code: _____

Out-of-State State Date: _____ End Date: _____

Employer's Name: _____ Occupation: _____ Retired: ☐ Yes ☐ No

City: _____ State: _____ Work Phone: (_____) _____ Ext: _____

Is Your Visit Related to an Accident? ☐ Yes ☐ No **Date of Accident**: _____

Emergency Contact: Name: _____ Relationship: _____

Phone: _____

Responsible Party (if patient is a minor): _____ SSN: _____

Relationship to Patient: Parent Other _____ Date of Birth: _____

Address (if different from patient) _____ Apt/Lot/Unit # _____

City: _____ State: _____ Zip Code: _____

Contact phone same as parent ☐ Yes ☐ No Phone #: _____ Work #: _____

Primary Care Physician Name: _____ Phone _____

Address: _____ City: _____ State: _____

Referring Physician Name: _____ Phone _____

Address: _____ City: _____ State: _____

Primary Insurance Name: _____

Are you the Policy Holder: ☐ Yes ☐ No If No, complete information below

Policy Holder Name: _____ Birth Date: _____/_____/_____

Relationship: _____ SSN: _____ Phone: _____

Secondary Insurance Name: _____

Are you the Policy Holder: ☐ Yes ☐ No If No, complete information below

Policy Holder Name: _____ Birth Date: _____/_____/_____

Relationship: _____ SSN: _____ Phone: _____

INSURANCE AUTHORIZATION, ASSIGNMENT AND PATIENT BILLING:

- **I understand that Commercial HMOs and Medicare Advantage HMOs may need a Primary Care Physician (PCP) referral through my insurance payer. HMO or PPO services that are not authorized will be rescheduled. If I have questions about referrals or authorizations, I will contact my insurance payer's Member Services Department or, if applicable, my Primary Care Physician. Depending on the services I need, I may be required to make a deposit or sign a payment agreement for estimated charges prior to treatment.**
- **I understand that I am responsible for amounts not covered or authorized by my insurance payer for all office or surgical charges. If I fail to provide my current medical insurance card(s) at the time of my visit, or when my insurance coverage has changed, I agree to be fully responsible for payment of all charges if denied by my insurance payer. I understand I have the right to ask about additional costs for any services. I understand that procedures are separately billed in addition to the office visit and my insurance payer may apply deductible, co-insurance or copays to any service. I understand and agree that I am responsible for timely payment of co-insurance, copays, and deductibles as determined by my insurance payer and billed to me by Ear, Nose & Throat Associates of Manatee.**
- **I hereby authorize Ear, Nose, & Throat Associates of Manatee, PA, to furnish information to insurance payers concerning my illness and treatment, and I hereby assign to the physician(s) all payments for medical services furnished to myself or dependents.**

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION:

Is it ok to release your medical information to anyone other than yourself? ☐ YES ☐ NO

Please list who we may speak with regarding your medical care; we cannot speak with anyone that is not listed below:

Name:_____ **Phone Number:**_____

Relationship to Patient: ☐ **Spouse** ☐ **Parent** ☐ **Child** ☐ **Friend** ☐ **Other**

Name: _____ **Phone Number:**_____

Relationship to Patient: ☐ **Spouse** ☐ **Parent** ☐ **Child** ☐ **Friend** ☐ **Other**

I have been offered a copy of the Patient Privacy and Office Policies, and I have been given an opportunity to read it and ask questions (Brochure). ☐ YES ☐ NO

To the best of my knowledge the contact and insurance information I have provided is complete and accurate.

Print Patient Name _____ **Patient Date of Birth:** _____

Sign: _____ **Date:**_____

Patient's Name _____ Date of Birth _____

CONSENT FOR TRANSFER OF BIOLOGICAL SPECIMEN

FLORIDA LAW PROHIBITS THE SALE OR TRANSFER OF A PERSON'S BIOLOGICAL SPECIMEN FROM WHICH DNA CAN BE EXTRACTED TO A THIRD PARTY WITHOUT THE EXPRESS CONSENT OF SUCH PERSON.

During the course of your care at Ear, Nose & Throat Associates of Manatee, PA, it may be medically necessary to obtain a blood, tissue or other type of biological specimen for analysis. This analysis **will not** involve the examination of your DNA to identify the presence and composition of genes in your body. After the analysis has been performed and the same is no longer needed, it will be stored as medical waste and then transferred to a third party for disposal in accordance with all local, state, and federal requirements.

It may also be the case that a biological specimen (such as blood, hair, bodily fluids, etc.) from you may be deposited on medical instruments, bedding, clothing, or other objects. These objects may then be transferred to a third party for cleaning or disposal.

By signing this document, you affirmatively state that it is your intentional decision to consent to the transfer of any and all biological specimens collected by or deposited with Ear, Nose & Throat Associates of Manatee, PA to a third party as set forth above. This consent does not authorize the sale or transfer of a biological specimen for the purpose of DNA analysis.

_____

Printed Name of Patient or Guardian

_____ _____

Signature of Patient or Guardian Date

Today's Date: _____

Medical History Intake Form

Patient Name: _____

Date of Birth: _____

Pharmacy & Location: _____

Primary Care Doctor: _____

Referring Doctor: _____

Height:_____ Weight:_____

What is the reason for today's visit?

Social History

Do you currently use Tobacco? _____

Did you previously use Tobacco? _____

Do you consume alcohol? _____

If yes how many per day? _____

Occupation: _____

Have you received a pneumonia vaccine? _____

In the event of additional testing please answer the following questions.

Do you have a pacemaker? _____

Do you have metal implants? _____

Are you claustrophobic? _____

Ear
Nose
&Throat
Associates
of Manatee, P.A.

Medical Conditions

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Major Surgeries
(Please include previous ENT surgeries)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Current Medications

_____Dose____ _____Dose____

_____Dose____ _____Dose____

_____Dose____ _____Dose____

_____Dose____ _____Dose____

_____Dose____ _____Dose____

Drug Allergies

_____ Reaction_____

_____ Reaction_____

_____ Reaction_____

_____ Reaction_____

_____ Reaction_____

Ear
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&Throat
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OFFICE POLICIES

Welcome to Ear, Nose & Throat Associates of Manatee. We are thankful that you have chosen us. We are committed to providing the highest quality care to our patients.

Identification

All patients are required to produce a government issued photo identification card along with their insurance cards. A photo of the patient will be taken and stored in their electronic medical record.

Scheduled Appointments

Every effort is made to keep patient waiting time to a minimum. We ask all patients to arrive well ahead of their appointment time as to facilitate any additional paperwork. To expedite the process, information can be updated through the patient portal. Please bring a list of all prescribed and over the counter (OTC) medications you are presently taking to each office visit. *If any testing has been done since your last visit, bring both the films and all reports for your doctor to review.* Patients who arrive 15 minutes or more after the appointment time maybe asked to reschedule for the next available opening.

Same Day Appointments

If you believe a "same day" appointment is required, please call the office as early as possible beginning at 8:00am. If your doctor does not have an available appointment but another has an opening, we may offer an appointment with another doctor within our group.

Cancellation/No Show Policy

If you are unable to keep a scheduled appointment, we ask that you call at least 24 hours in advance so that we may be able to accommodate another patient that may need immediate attention. There will be a NO SHOW charge of $50 for an office visit or $100 for procedures which will have to be paid before your next scheduled visit.

Communication with Your Doctor

We encourage all our patients to contact our office and access specific portions of their medical record via their patient portal. Instructions for registering, accessing, and recovering your portal account are available. Your communication goes directly to your healthcare team and in most cases, your doctor will be the one to answer your email message. This is the fastest and most reliable means of communicating with your doctor.

Prescription Refills

Refills will not be handled outside office hours and request can take as long as three (3) business days to complete. *Call your pharmacy regarding refills well in advance to allow sufficient time for the pharmacy, and your doctor, to receive and respond to your request before you run out of your medication.* If you are out of refills, you may need to schedule a follow-up appointment with your doctor.

After Hours

If you have a life-threatening emergency, call 911, or go to the nearest emergency room. Otherwise, please call the office on the next business day or send a message via the patient portal.

Referrals

Incoming and outgoing referrals can take time to obtain the necessary authorizations from your primary care doctor and/or your insurance company. We will make every effort to keep you informed of our progress with all those requiring authorizations.

Medical Records

We assure the privacy and confidentiality of your medical records. No information will be released by our office to any parties other than your doctors without your consent. Please request a records release form if you are aware of any medical record transmission requirements.

Forms (FMLA, Disability, etc.)

Some forms are extensive; we access a fee of $25 at the time of request for completion. There are some forms that may require an appointment prior to completion. Completed forms will not be returned until payment is received. Due to the complexity of many forms, please allow up to (2) weeks.

Financial Policy

Our group participates with most major insurance carriers. It is your responsibility to check with your insurance to find an in-network doctor. *It is imperative that the office has your correct insurance information on file at all times.* ***It is ultimately your responsibility to know the benefits provided under your insurance plan.*** As a courtesy to our patients, we file insurance claims for those insurances with which we participate. Accounts with outstanding balances over 120 days may be sent to collections.

Payment

Payment will be required at the time the services are rendered. Please note that your insurance company may process the claim with a higher patient responsibility. You may receive a statement for any outstanding balance.

Non-Covered Services

Your insurance company may deem some services are non-covered by your policy. It is your responsibility to know what services are non-covered by your plan. You will be fully responsible for these services per your insurance company. Your insurance plan may determine that some services are not medically necessary, and you may be billed for those services as well. Please check with your insurance carrier with additional questions.

Self-Pay Uninsured Policy

We will gladly offer a self-pay **UNINSURED** discount rate. However, payment is due when services are rendered. By accepting this discounted rate, you are stating you have no insurance and agree to the cash price as **PAID IN FULL** and will not seek reimbursement from any outside entity.

Standards of Behavior

We have a strict Standards of Behavior policy. We would appreciate every effort on the part of you, your family and friends to help the atmosphere within our facility remain calm and respectful. Anyone who is disruptive, disrespectful, use abusive or profane language, etc., will be asked to leave and immediately dismissed from the practice.

We appreciate your selection of our office to provide you care, and we will work hard to serve your needs. After your visit, a Patient Satisfaction Survey is sent to the email you provide. Your satisfaction and experience in our practice is important to us. We would appreciate your feedback.