**VIRGINIA ENT – PATIENT INFORMATION FORM** **Patient#: _____**

| Patient Name (First, MI, Last): | Date of Birth: | Sex: | Social Security No. |
|---|---|---|---|
| | | | |

| Street Address: | City | State | Zip Code |
|---|---|---|---|
| | | | |

| Primary Care Physician: | Referring Physician: |
|---|---|
| | |

| Virginia ENT staff have my permission to leave messages which may contain medical information on my preferred phone below; please place a check mark in the box next to your preferred phone: *(Initial)*_____ | *Please answer:*<br>May we contact you by phone? Y N<br>May we contact you by email? Y N |
|---|---|

| Home Phone: ☐ | Work Phone: ☐ | Cell Phone: ☐ | Email Address: |
|---|---|---|---|
| | | | |

| Primary Insurance: | Policy ID: | Policyholder Name: | Policyholder DOB: |
|---|---|---|---|
| | | | |

| Name of Emergency Contact: | Relationship to Patient: | Phone Number: |
|---|---|---|
| | | |

## PATIENT OR RESPONSIBLE PARTY INFORMATION

| Name: | Date of birth: | Phone Number | Social Security No. |
|---|---|---|---|
| | | | |

| Street Address: | City: | State: | Zip code: |
|---|---|---|---|
| | | | |

| Employer Name: | Address: | Phone #: |
|---|---|---|
| | | |

**Authorization Form for Use & Disclosure of Protected Health Information**

Our Notice of Privacy Practices provides information about how we may use and disclose protected Health information (PHI) about you. We have explained that disclosures may be made to family and friends related to patient's Health. It has also been explained that we will only disclose information relevant to current treatment. By signing below, I authorize Virginia ENT to disclose Health care information to the following individuals:

***PEDIATRIC PATIENTS – Please list parents and name(s) and contact information for anyone who may bring a child to an appointment and have access to your child's medical record information.***

| FATHER: | Phone Number: |
|---|---|
| | |

| MOTHER: | Phone Number: |
|---|---|
| | |

| GRANDPARENT(S): | Phone Number: |
|---|---|
| | |

| OTHER (Rel. to Patient): | Phone Number: |
|---|---|
| | |

***ADULT PATIENTS – Please list name(s) of anyone who may have access to your medical record information.***

| NAME: | Relationship to Patient: | Phone Number: |
|---|---|---|
| | | |

| NAME: | Relationship to Patient: | Phone Number: |
|---|---|---|
| | | |

_____ _____

***Signature of Patient or Patient's Representative/Parent*** ***(Date)***

_____ _____

***Printed Name of Patient or Responsible Party*** ***(Relationship to Patient)***

**Virginia Ear, Nose & Throat Associates, P.C.**

**Patient Name: _____ Patient #:_____**

## Notice of Privacy Practices

_____
*(Initial)*

I have received a copy of the "**Notice of Privacy Practices**" for Virginia Ear, Nose & Throat Associates, P.C. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy. This notice (is posted in our offices, on our website and copies are available at any time. I understand that I may ask questions of Virginia ENT if I do not understand any information in the Notice of Privacy Practices.

## Consent for Treatment, Assignment of Benefits & Financial Policies

- **Consent For Treatment**
  I authorize Virginia Ear, Nose & Throat Associates to provide medical treatment to myself or my dependent.

- **Assignment of Benefits**
  I request that payment of authorized Medicare, Medicaid or applicable private insurance benefits be paid directly to Virginia Ear, Nose & Throat Associates for services provided under their care.

- **Release of Medical Information**
  I authorize Virginia Ear, Nose & Throat Associates to release necessary medical information to my insurance company, its agents, or any third party payer in order for payable benefits for these services to be determined.

- **Collection of Co-Pays and Deductibles**
  Per our agreement with your insurance carries, you are required to pay any applicable copayments at the time of service. In addition, if you are insured with a high deductible insurance plan and have not met your deductible, we will collect **$100** for new patients and **$60** for established patients at time of service.

- **Financial Responsibility**
  I understand that Virginia Ear, Nose and Throat Associates will file my insurance claims as a courtesy; however, I am ultimately responsible for full payment of all charges. Should collection proceedings or other legal action become necessary to collect an overdue account, the patient or the patient's responsible party, understands that Virginia ear, Nose & throat Associates has the right to disclose to an outside collection agency all relevant personal and account information necessary to collect payment for services rendered. The patient, or the patient's responsible party, understands and agrees to pay all attorney fees in the amount of thirty-three and one-third percent (33 1/3 %) of the total unpaid balance due, plus court costs and filing fees incurred by Virginia ear, Nose & Throat Associates. I understand and agree that should Virginia ear, Nose & throat Associates be awarded judgment relating to this agreement or any debt incurred thereof, I will pay a service charge of one and one-half percent (1 ½ %) per month, eighteen percent (18%) per annum, beginning on the date of judgement.

- **Referrals/ Authorizations**
  I understand if my insurance company requires a referral, I am responsible for obtaining a referral prior to my visit. If I do not have a referral I will be required to sign a waiver before being seen by the physician and payment in full for services rendered will be collected at the check-out desk.

- **Missed Appointments**
  We require at least 24 hours' notice if you must cancel an appointment, failure to do so may result in a $35 "no show" fee.

- **Returned Checks**
  Our office will charge $25 for any check that is returned for insufficient funds.

**I have read the above statements and I understand my responsibilities. I acknowledge that Virginia Ear, Nose & Throat Associates, PC, will scan this document and destroy the original, and agree the scanned document is the same as the original.**

_____ _____
***Signature of Patient or Responsible Party*** ***(Date)***

_____ _____
***Printed Name of Patient or Responsible Party*** ***(Relationship to Patient)***