Associates in Otolaryngology

PATIENT INFORMATION AND ASSIGNMENT			
Patient's last name:	First name:		Social Security #
Mailing address:		City, State,Zip	
Home phone	Cell phone:		Work Phone
Date of Birth:	Age:	Sex: ☐ M ☐ F	Email:
Martial Status: ☐ single ☐ married ☐ divorced ☐ widowed ☐ other			
Race: ☐ Am Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ White ☐ Native Hawaiian or Other Pacific Islander			
Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino		Preferred Language:	
Employer Name and Address:			
Name of emergency contact person:	Relationship to patient:	Home phone no.: ( ) -	Work phone no.: ( ) -
Primary Care Physician	Referring Physician:		

INSURANCE INFORMATION		
Primary:	Policy holder	DOB:
Relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other, please specify:		
Secondary	Policy holder	DOB:
Relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other, please specify:		

Financial Policy, Assignment Information, and Release of Information

I authorize release of any information acquired in the course of treatment necessary to complete and file medical claims to my insurance company or Medicare on my behalf. I hereby acknowledge financial responsibility for costs of services rendered for me or for the person whose account I am acting as guarantor. I authorize (assign) any insurance or Medicare benefits to be paid directly to Associates in Otolaryngology or its assignees. I am responsible for any non-covered services, supplies, co-payments or deductibles. I am responsible for knowing how my plan works, and I request medical services at this office. This acceptance and assignment will be in force for all future services by practitioners from this office.

My relationship to Patient

_____ _____

Signature of Responsible Individual Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand that as part of my health care, Associates in Otolaryngology originates and maintains paper and/or electronic records describing my health history, symptoms, examination, and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that Associates in Otolaryngology maintains a *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures. The most recent version of this Notice is displayed in the waiting room area. I understand that Associates in Otolaryngology reserves the right to change this notice and its practices as needed and will make a reasonable attempt to inform me of any changes.

I have had an opportunity to receive and review the *Notice of Privacy Practices* of Associates in Otolaryngology Head and Neck Surgery P.C. This form acknowledges receipt of this notice.

_____ _____

Signature of Patient or Guardian date

☐ The patient refused to sign.
☐ Due to an Emergency situation it was not possible to obtain acknowledgement
☐ Other (please provide details) _____