Associates in Otolaryngology

PATIENT INFORMATION AND ASSIGNMENT

Last name:	**First name:**	Social Security #
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 Am ☐ White ☐ Native Hawaiian or Oth Pac Islander

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino | **Preferred Language:**

Employer Name and Address:

Emergency Contact:	Relationship to patient:	Home phone no.: ( ) -	Work phone no.: ( ) -

Primary Care Physician: **Referring Physician:**

INSURANCE INFORMATION

Insurance:	**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: Natural Child - Insured has Financial Responsibility

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 describin my health history, symptoms, examination, and test results, diagnoses, treatment, and any plans for future care or treatment. I understand th 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) ____________