Southern Missouri ENT & Allergy

Personal Information

Today's Date: _____ Account #: _____ SSN: _____

First Name: _____ MI: _____ Last Name: _____

Address: _____

Zip Code: _____ City: _____ State: _____

Date of Birth: _____ Age: _____ Marital Status: _____

Sex: _____ May we leave information on your answering machine or voicemail? ☐ Yes ☐ No

Primary Phone: (number you wish to be reached at) _____ Other #: _____

Employer: _____ Employer Phone: _____

In the event of an emergency please contact:

Name: _____ Relationship: _____ Phone No: _____

Minor Patients: Name of Parent/Guardian _____

Guardian SSN_____ Guardian Date of Birth _____ _____

Who Referred you? ☐Physician ☐Family ☐Friend ☐Phone Book ☐Insurance Co. ☐Other _____

Referring Physician's Name: _____ Phone No: _____

Race*_____ Ethnicity* _____ Preferred Language*: _____ (May choose not to answer)

Health Information Protection

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION: By signing this form you acknowledge receipt of the Southern Missouri ENT & Allergy, PC Notice of Privacy Practices and consent to our use and disclosure of protected health information about you for treatment, payment and healthcare operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent. This consent is given freely with the understanding that: 1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law. 2. A photocopy or fax of this consent is as valid as the original. 3. I may revoke this consent at any time, except where information has already been released. This consent is valid until revoked by me in writing.

NAMES OF PERSONS INFORMATION MAY BE SHARED WITH:

_____ _____

_____ _____

_____ _____

Patient/Guardian Signature Date

NOTICE REGARDING INSURANCE CLAIMS/PAYMENTS:

If we are filing insurance for your visit, we must have complete information and any required referral at the time of the visit. If you cannot provide the information, we will be unable to file your insurance, and payment in full will be required.

Payment of your charges cannot be determined until the claim is submitted to your insurance company. Payment will be based on your individual health plan, and the amount applied to your plan deductible and/or coinsurance will be your responsibility. Procedures which are excluded from coverage, based on your plan's determination of medical necessity, will also be your responsibility. Your office visit co-pay is due at the time of the visit and, in many cases, covers only the office visit charge. Any procedures performed will be considered surgery by your insurance company, and deductibles and coinsurance may apply. I understand that if my account should ever require action by a collection agency or attorney to insure payment, the fees charged including court fees may be added to the balance due. Medicare Patients: I request payment of authorized Medicare benefits made on my behalf to Southern Missouri Ear, Nose & Throat, PC for any services furnished to me by employed providers. I authorize any holder of medical information about me to release to the health care financing administration and its agents any information needed to determine these benefits or the benefits payable for related services.

For all other patients, payment is required at the time of service. We will provide you with the necessary documentation to file for reimbursement upon your request.

I have read the above information and understand that I am responsible for payment for services I receive.

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