MICHIANA ENT SPECIALTY CENTER AND MICHIANA SLEEP SOLUTIONS

APPT DATE: _____ **ACCT#:** _____ **PROVIDER:** _____ **REFERRING DR:** _____

PATIENT INFORMATION: Please make any corrections and complete blank areas – * PLEASE PRINT*****

FIRST NAME: _____ **LAST NAME:** _____ **MI:** _____ **GENDER:** _____ **AGE:** _____

BIRTH DATE: _____ **MARITAL STATUS:** _____ **SSN#** _____ **FAMILY DOCTOR:** _____

ADDRESS: _____ **CITY:** _____ **STATE:** _____ **ZIP:** _____

HOME PHONE: _____ **WORK PHONE:** _____ **CELL #:** _____ **EMAIL:**_____

EMPLOYER NAME/ADDRESS:_____**OCCUPATION:**_____

EMERGENCY CONTACT:_____**RELATIONSHIP:**_____ **PHONE:**_____

PREFERRED PHARMACY/LOCATION:_____ **May we leave health info. on ans machine? Y N**

GUARANTOR ON ACCOUNT (PERSON TO BE BILLED):_____

SPOUSE or FATHER (if minor): _____ **BIRTHDATE:**_____ **SSN#**_____

ADDRESS:_____ **CITY/STATE:**_____ **ZIP:**_____ **PHONE:**_____

EMPLOYER /ADDRESS:_____ **OCCUPATION:**_____

MOTHER (if minor): _____ **BIRTHDATE:**_____ **SSN#**_____

ADDRESS:_____ **CITY/STATE:**_____ **ZIP:**_____ **PHONE:**_____

EMPLOYER /ADDRESS:_____ **OCCUPATION:**_____

INSURANCE INFORMATION: Please provide complete information - make any changes necessary

PRIMARY INSURANCE: _____ **POLICY HOLDER NAME:**_____ **DOB:** _____

RELATIONSHIP TO PATIENT: O Self O Spouse O Parent O Other_____ **SSN#**_____

POLICY#_____ **GROUP#**_____ **EMPLOYER:**_____

SECONDARY INSURANCE: _____ **POLICY HOLDER NAME:**_____ **DOB:** _____

RELATIONSHIP TO PATIENT: O Self O Spouse O Parent O Other_____ **SSN#**_____

POLICY#_____ **GROUP#**_____ **EMPLOYER:**_____

HIPAA PRIVACY INFORMATION RELEASE: I authorize the release of my medical or appointment info to the following:

NAME:_____ **RELATIONSHIP:**_____ **DOB:**_____

NAME:_____ **RELATIONSHIP:**_____ **DOB:**_____

I, the undersigned, give my authorization to be treated and assign directly to Otorhinolaryngology Associates, a Division of APoM, all payments for medical services rendered to me or my dependents. I hereby authorize the release of information necessary to secure payment of benefits. I authorize the use of this signature on all my insurance submissions. I understand that I am responsible for any amount not covered by my insurance plan. By supplying my email above, I agree to receive non private health information. I understand payment is due at time of service. A clinical summary of your office visit is available within three business days upon written request.

SIGNATURE_____ **DATE**_____ **RELATIONSHIP (if not patient)**_____

Michiana ENT Specialty Center and Michiana Sleep Solutions

Physician_____ **PATIENT HEALTH HISTORY** **Pt. Chart #_____**

In order for us to obtain a complete medical history, it is important for you to fill out this form as completely as possible. This is very important information. **Please fill out every item.** This information will be entered into the computer and you are welcomed to a copy of the report if you wish. **PLEASE PRINT.**

Social Security No (SSN) _____Marital Status_____ Appointment Date _____

Full Name _____ Male ☐ Female☐ Date of Birth _____

Reason for today's visit:_____ Date symptoms first occurred_____/_____/_____

Is this an Injury? ☐ No ☐ Yes Date of Injury_____/_____/_____ Work Related? ☐ No ☐ Yes

Pharmacy Preference (include location) _____

Name of Primary Care (Family) Physician _____City_____

Name of Referring Physician _____ City_____

Patient's Height_____ Patient's Weight _____ If not the patient, please list name and relationship to Patient:
_____

CURRENT MEDICATIONS:

Are you taking ANY kind of medication now? (This includes prescription, over-the-counter and herbal medications)
Use the back of this page if you need more room.

☐ **No** ☐ **Yes If yes, please list below *include dosages*.**

Medication Name	Dosage	How often taken

MEDICATION ALLERGIES: ARE YOU ALLERGIC TO ANY MEDICATIONS?

☐ **No** ☐ **Yes If yes, please list below.**

Name of Medication	Type of Reaction

SURGERIES AND HOSPITALIZATIONS:

Have you ever had any problems with anesthesia (being numbed or put to sleep)? ☐ No ☐ Yes

If **yes**, please list what sort of problems. _____

Have you ever had ear, nose or throat surgery?☐ No ☐ Yes If **yes**, list any surgeries and when they were done.

_____

Have you ever had Heart Related Surgery? ☐ No ☐ Yes If **yes**, list any surgeries and when they were done.

_____

Have you been hospitalized for a medical problem before? ☐ No ☐ Yes

If **yes**, list the reason for admission and the date. _____

Michiana ENT Specialty Center and Michiana Sleep Solutions
Financial Policy

We are committed to providing you with the best possible medical care. We are available to work with you if you have special financial needs. The following information is provided to avoid any misunderstanding or disagreement concerning payment for professional services. Our office participates in a variety of insurance plans, and we will bill your insurance plan as a courtesy, however **it is your responsibility to:**

- **Bring your insurance card to EVERY visit**.
- **Obtain the necessary physician referral** or pay all office fees at the time of service or completion of services. NOTE: If the referral has not been obtained, you will be asked to sign an Insurance Referral Waiver, and pay for services rendered at the time of service. We cannot obtain your referral for you.
- **Remit payment for medical care not covered under your insurance** (deductibles, co-pays, non-covered services, etc.) at time of service.
- **Be prepared to pay your copay at each visit**. Payment may be made by cash, check or credit card. (MasterCard, Visa, Discover or Care Credit) If payment is not made at time of visit, there may be a processing fee charged.
- **All patient due charges/prior balances will be due at time of service**. If payment is not made at time of visit, a processing fee of $10.00 may be added to your balance due.
- **Payment is due in full <u>at the time of service</u> for self- pay patients without insurance.**

Out of Network Insurances
If we do not participate in your insurance program, our office is willing to file your claim; however, payment in full is expected within 30 days, either from your insurance program or you. You are ultimately responsible for balance when out of network. We will require you to sign an out of network form which requires your understanding that you are responsible for the difference between our charges for services rendered and the amount your insurance company remits on your behalf; regardless of their "usual and customary" determination.

Minor Patients
For patients 17 years and younger, a parent or legal guardian must accompany them and sign below (exception: patients 17 years and younger declared emancipated minors, proof is necessary). It is the parent or guardian's responsibility to bring the necessary referrals and insurance cards and also to make any payment due at the time of service. Proof of guardianship is required. We cannot examine patients 17 years and younger without a parent or legal guardian present. (We will accept a letter of medical release from a parent or guardian from an adult accompanying the minor patient.)

Additional Information

- Our charges are determined by what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

- If you have questions about your insurance, we are happy to help you. Specific coverage issues, however, should be directed to your insurance company's Member Services Department (the number is on your insurance card).

- If we are forced to send your account for further collection action, your balance due will be increased by any fees we may incur to collect the balance due from you. If your check is returned to us by the bank for insufficient funds, your account will be charged an NSF fee of $30.00 plus any additional fees we may incur as a result of the NSF check.

Our practice firmly believes that a good physician/patient relationship is based upon understanding and communication. Questions about financial arrangements should be directed to our Billing Office. The office may be reached by dialing (574) 232-4800 or 800-992-1891.

Please sign below to indicate that you have read and agree to this Financial Policy.

I understand and agree to this Financial Policy:

_____ _____
Signature of Patient or Responsible Party Date

_____ _____
Print Patient Name Patient Acct. #