The Mann Ear, Nose & Throat Clinic

Est. 1991

Today's Date _____

WELCOME TO OUR PRACTICE********PLEASE FILL OUT THIS ADULT PATIENT INFORMATION SHEET**

Name: _____ _____ _____ _____
First Middle Initial Last Nick Name

Address_____

City: _____ State:_____ Zip: _____

Home Phone #: _____ Cell Phone #: _____ Work Phone #: _____

Preferred Communication for Appointment reminders: Text Message / Phone Call

Date of Birth: _____ Circle one: Male / Female ; Circle one: Married / Single / Divorced / Widowed

Race: _____ Language:_____ Religious affiliation : _____

Social Security #: _____ E-mail address: _____

Employer: _____ Occupation: _____

Primary Care Physician: _____**AND** Practice Name: _____ NONE

IF Referred: Referring Provider: _____ And Practice Name:_____

**********EMERGENCY CONTACTS**********

Emergency Contact Name _____ Home Phone:_____

Cell Phone: _____DOB:_____Relationship:_____

**********BILLING INFORMATION **********

Guardian /Person Responsible for Bill: _____

Address_____

Home Phone #: _____ Work Phone #: _____

********** INSURANCE INFORMATION **********

Insurance Company: _____

Policyholder's Name: _____ Policyholder's DOB: _____
(This is the person with whom the insurance is purchased through their work)

Policyholder's SS #: _____ Policyholder' Employer: _____

****

REASON FOR VISIT: _____

DRUG ALLERGIES: _____

MEDICATION: _____

PHARMACY NAME & NUMBER: _____

****

HOW DID YOU FIND OUT ABOUT MANN ENT?

Primary care physician	Internet	Wellness article	Yellow pages
Insurance book	TV Commercial	Walk-in	Cary News

Patient Referral: _____ Another doctor: _____

Chart # **Patient's Name:**

Disclosure: By signing this document I am stating that I have been given a copy of the Mann ENT HIPAA form. I also have the opportunity to authorize others to access my information according to the HIPAA.

I,_____, give permission to Mann ENT to
(Print)
disclose the following protected health information to the following(this will allow us to discuss information including but not limited to: appointments, payments, insurance coverage). PATIENT'S THAT ARE UNDER ANOTHER FAMILY MEMBERS INSURANCE AND/OR PATIENT'S THAT RELY ON OTHERS FOR TRANSPORTATION NEED TO FILL THIS PORTION OUT.

FAMILY:_____Relationship:_____

Name:_____Relationship:_____

Name:_____Relationship:_____

Legal Representative:_____Papers Presented Date:_____

OTHER_____

Information to be disclosed (check all that apply):

	Medical Records		Billing information
	Treatment Records		Leave Detailed Voice Mail
	Diagnostic Records		Email

Other: _____

_____

This authorization expires _____ (OPTIONAL)
This signature is good for the life of the patient's care at Mann ENT unless otherwise stated.
[Specify (1) date or (2) event that relates to the purpose of this use or disclosure]

Finally, you may revoke this authorization in writing at any time by sending written notification to the Medical Records Department at our Cary Office (919-859-4744). Please note that your new notice of revocation will not apply to actions taken prior to the date we receive your written request to revoke authorization.

_____. _____
Signature Date

_____. _____
Mann ENT Rep- Print Mann ENT Rep- signature

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Acknowledgement of Receipt

Of Notice of Privacy Practices

Patient Name: _____

Patient Address: _____

_____

I have received a copy of the Notice of Privacy Practices for the above named practice.

_____ _____

Signature Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- ❑ An emergency existed & a signature was not possible at the time.
- ❑ The individual refused to sign.
- ❑ A copy was mailed with a request for a signature by return mail.

Unable to communicate with the patient for the following reason:

_____

Other:_____

Prepared By _____

Signature _____

Date _____

Mann ENT Financial Policy

We are committed to providing you with the highest quality of medical care in a transparent and cost effective manner. We feel that a clear understanding of our financial policies will help foster this goal. Please do not hesitate to contact us if you have any questions regarding our policy.

Your Plan	What You Do	What We Do
All contracted Plans	**Bring your insurance & ID to every visit. Obtain referrals from your PCP.**	**We will file your insurance for you. Obtain authorization for procedures as needed by your insurance company.**
All contracted plans + supplemental policies	**Bring your insurance & ID to every visit. Obtain referrals from your PCP.**	**We will file your insurance for you. Obtain authorization for procedures as needed by your insurance company.**
Non contracted plans and Self pay	**Pay 100% at time of service.**	**No insurance is filed.**

Credit Card on File Service:

All co-pays, co-insurances, deductibles and past due balances are due at check in. In order to streamline patient out of pocket expenses, our practice now has implemented credit card on file system. All patients will be asked to participate.

Procedure/Test Notification

Please note that some tests and procedures performed at Mann ENT are considered "surgical" or "diagnostic" by your insurance plans, even though there is no actual surgery involved. Examples include, but are not limited to:

- Allergy Testing
- Nasal Endoscopies
- CT Scans
- Videostrobe Test
- ABR/VNG (Special Testing)
- Sinus Debridement (before and /or after surgery)
- Ear procedures including removal of cerumen(ear wax)

Your insurance plan may require you to pay a surgical co-insurance or deductible for the procedure or test. Please note that this is **not a billing error** on our part, Mann ENT is following all guidelines set by the American Medical Association (AMA) and your insurance plan.

Additional Charges:

- No Show Charge $50.00 if not notified within 24 hours prior to your office appointment.
- No Show Charge $150.00 if not notified 1 week prior to your office or hospital procedure/surgery.
- Return Check (Insufficient Funds) $40.00 in addition to the amount of the returned check, which is collected by cash or money order only.
- Completion of Forms $25.00 for Disability and FMLA.
- Medical Records Requests are charged according to state law and are $10.00 for the first 13 pages and $0.75 for each additional page.

Assignment of Benefits: I hereby request that payment of authorized Medicare, Medicaid and all other insurance benefits be made on my behalf to Mann ENT for any services provided to me and or my dependants. I authorize any holder of medical information about me or my dependants to release to the appropriate entity and its agents any information needed to determine these benefits payable for related services.

Note to custodial parent/guardian: Responsibility for payment of services rendered to any dependent children lies with the parent who physically brings minor to the visit, regardless of any court documents assigning responsibility.

Guarantee of Payment: I hereby agree to be responsible for any co-pays, co-insurance, deductibles and /or non covered services deemed by my insurance contract. In the event that I default on payment of my account, I understand that I am responsible for any and all costs incurred on the collection of my account. This may include, but not limited to court costs, reasonable attorney's fees. If the debt is assigned to a third party collection agency, I will be responsible for the **$10.25 collection fee** incurred on the account.

I acknowledge that I have reviewed and had an opportunity to ask questions concerning the practice's financial policy and agree to the terms of payment due.

Print Patient Name	Patient Date of Birth
Patient's Signature	Date
Responsible Party Signature	Relationship to Patient

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HIPAA RELEASE OF INFORMATION AUTHORIZATION

Consent for access to Protected Health Information:

I give consent to the staff at Mann ENT Clinic to communicate with the person(s) listed below regarding my medical treatment. I consent to the use of my protected Health Care Information when communicating with the person(s) below. Mann ENT Clinic may communicate in person, by telephone, mail, e-mail, fax, or other means. I may withdraw this consent at any time by notifying Mann ENT Clinic in writing. Any communication prior to such notice will be considered to have been authorized by me.

Patient Signature_____ **Date** _____

PLEASE LIST NAMES OF PERSONS OR FAMILY YOU AUTHORIZE TO RECEIVE INFORMATION ABOUT YOU.

Name: _____ Relationship: _____

Name: _____ Relationship_____

Name: _____ Relationship_____

Patient Rights:

- I have the right to revoke this authorization at any time in person or in writing
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases when the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.
- I understand released information may include a communicable disease diagnosis such as HIV or a diagnosis related to mental health or substance abuse.

REVOKED
How: □ in person on _____ (Date) If in person, signature is required.
Signature of Patient or Personal Representative: _____

□ in writing

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