Welcome to our practice. Please complete the following information and return it to the receptionist.
Thank you!

Today's Date ________________________________

PEDS PATIENT INFORMATION ***********************************

Name: ____ ______________ ____

First   Middle Initial   Last   Nick Name

Address____

City: ____ State:______________ Zip: ____________

Date of Birth: __________________ Circle one: Male / Female Social Security #: ____________________________

Race: ________ Language:_____________ Preferred Communication for appointment reminders: TEXT MESSAGE/PHONE CALL

Primary Care Physician: ______________________________**AND** Practice Name: _____________________________________ □

IF Referred: Referring Provider: _____________________________ And Practice Name:____________________________________

PARENT CONTACTS

Mother's Name ____Date of Birth__________________________

First   MI   Last

Address:____,City:_________________State:__________Zip_____

Phone: Home:_____________________________Cell:____________________________Work:_______________________________

Email:____ Send statements to this address: yes / no

Father's Name ____Date of Birth__________________________

First   MI   Last

Address:____,City:_________________State:__________Zip_____

Phone: Home:_____________________________Cell:____________________________Work:_______________________________

Email:____Send statements to this address: yes / no

** **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 Medical Records @ Cary Office. Your notice will not apply to actions taken by the requesting person/entity prior to the date they receive your written request to revoke authorization.

________________________________. ________________________
Signature Date

________________________________. ________________________________
Mann ENT Rep- Print Mann ENT Rep- signature

Acknowledgement of Receipt

Of Notice of Privacy Practices

Patient Name & 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