NORTH HILLS ENT

PATIENT REGISTRATION INFORMATION

If Patient cannot be billed for these services (for example, minor children), please complete RESPONSIBLE PARTY as well.

Social Security #: _____

Name: _____ / / _____
Last First MI SEX DATE OF BIRTH AGE S M D W O MARITAL STATUS

Address: _____ ( ) -
MAILING ADDRESS APT # CITY ST ZIP HOME PHONE

EMPLOYMENT STATUS (PLEASE CIRCLE ONE)
Full-Time Part-Time Retired Unemployed Student

Employer's Name: _____
Occupation: _____

Responsible Party: _____ / / ( ) - ( )
LAST NAME, FIRST RELATION DATE OF BIRTH PHONE EXT

Emergency Contact: (Please indicate a friend or relative not living at the same address.) ( ) - ( )
ALT PHONE (Cell, Mobile, Etc)

_____ _____
NAME RELATIONSHIP PHONE

PHARMACY INFORMATION

Pharmacy Name: _____
Pharmacy Address: _____ City: _____
Pharmacy Phone Number: ( ) - Pharmacy Fax Number: ( ) -

OTHER PATIENT INFORMATION

Race: (PLEASE CIRCLE ONE)
American Indian/Alaska Native Asian Hawaiian/Pacific Islander African-American White Hispanic Other_____

Language: _____

E-Mail Address: _____ Ethnicity: Not Hispanic_____ Hispanic/Latin_____

PRIMARY INSURANCE

Please provide copy of primary insurance card

Primary Insurance: _____ _____/_____
ID NUMBER GROUP NAME/NUMBER

Address: _____ Insurance Phone #: _____
_____ PCP: _____

Policy Holder: _____ / / _____
LAST FIRST MI DATE OF BIRTH SEX Relationship

Employer's Name: _____

SECONDARY INSURANCE

Please provide copy of secondary insurance card

Secondary Insurance: _____ _____/_____
ID NUMBER GROUP NAME/NUMBER

Address: _____ Insurance Phone #: _____
_____ PCP: _____

Policy Holder: _____ / / _____
LAST FIRST MI DATE OF BIRTH SEX Relationship

Employer's Name: _____

ASSIGNMENT OF BENEFITS RELEASE OF INFORMATION OF PRIVACY PRACTICES APPOINTMENT OF AUTHORIZED

Please Read

I hereby assign, transfer and set over to Geoffrey Scott, MD PA, all of my rights, title and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits, including medical, surgical, psychiatric and/or substance abuse (drug or alcohol) information. This authorization shall remain valid until written notice is given by me revoking said authorization.

I understand that this order does not relieve me of any obligation to pay such bills if not paid/covered/found medically necessary by my commercial/third party/government plan or insurance company. I am also financially responsible for any balances due after payments by my insurance company.

I appoint Geoffrey Scott, M.D. P.A. to act as my authorized representative in requesting an appeal from my insurance plan regarding its denial of services or denial of payment.

All charges are due at the time of service. If surgery is indicated, I am responsible for furnishing insurance claim forms to the office prior to surgery.

Geoffrey Scott, M.D. P.A., and its providers are committed to securing the privacy of your health information. Accordingly, we have posted our "Notice of Privacy Practices" in the reception area. You are not required to read this notice. However, we would like your acknowledgement that you have been advised that Geoffrey Scott, M.D. P.A., has such a Notice of Privacy Practices.

_____ _____ _____

RESPONSIBLE PARTY SIGNATURE RELATIONSHIP TO PATIENT DATE

HIPAA

Due to the Health Insurance Portability and Accountability Act (HIPAA) of 1996, the following information must be filled out on each patient annually.

DATE: _____

I authorize Geoffrey Scott, M.D. P.A. to release my medical information necessary to process my medical claim and coordinate or manage my healthcare.

In the event a family member/caregiver attends my office visit and is in the exam room at the time of my evaluation or treatment, I give North Hills ENT, Geoffrey Scott, M.D. P.A. and employees my permission to discuss freely my condition, treatment, or diagnosis with that individual.

HOME PHONE: _____

WORK PHONE: _____

CELL PHONE: _____

May we leave a message at one of the numbers listed above about appointments, test results, and prescriptions?

YES/NO HOME/WORK/CELL ALL OF THE ABOVE

With whom may we discuss or release information about care, treatment, or diagnosis?

Name: _____ Relationship: _____ Phone#: _____

Name: _____ Relationship: _____ Phone#: _____

Signature: _____

(Signature is valid one year from date shown above)

Printed Name: _____