

# Tallahassee Ear, Nose & Throat-Head & Neck Surgery, P.A.

**TODAY'S DATE:** \_\_\_\_\_ **FOR TODAY'S VISIT YOU WILL BE PAYING:** \_\_\_ Cash \_\_\_ Check \_\_\_ Credit Card

## **PATIENT INFORMATION:**

Primary Care Physician: \_\_\_\_\_ Referring Physician: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_ Age: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Birthdate: \_\_\_/\_\_\_/\_\_\_\_\_ Gender: M F X Marital Status: \_\_\_

Address: \_\_\_\_\_ Apt #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Race: \_\_\_\_\_ Ethnicity: Hispanic / Non-Hispanic Language: \_\_\_\_\_  
(Please circle one above)

Day/Best #: (\_\_\_\_) \_\_\_\_\_ Cell #: (\_\_\_\_) \_\_\_\_\_

ALT #: (\_\_\_\_) \_\_\_\_\_ Home #: (\_\_\_\_) \_\_\_\_\_

Email: \_\_\_\_\_

## **CONFIRMATION PREFERENCE:**

**TEXT**

**CALL**

**EMAIL**

*Chose  
one  
option*

## **PRIMARY INSURANCE CARRIER:**

Insured's Name: \_\_\_\_\_

Insured's Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_ Zip: \_\_\_\_\_

Insured's DOB: \_\_\_/\_\_\_/\_\_\_\_\_

## **SECONDARY INSURANCE CARRIER:**

Insured's Name: \_\_\_\_\_

Insured's Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_ Zip: \_\_\_\_\_

Insured's DOB: \_\_\_/\_\_\_/\_\_\_\_\_

**Please submit insurance card for scanning. If no insurance card is available, please complete the following information:**

Insurance Co: \_\_\_\_\_ Insurance Co: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Policy Number: \_\_\_\_\_

## **PARENT/LEGAL GUARDIAN INFORMATION**

**If the patient is under the age of 18 or insurance is maintained by someone else; please complete the following:**

**If you are the grandparent or step-parent do you have legal guardianship of the patient?** Yes No

**\*\*You must have court ordered paperwork on hand in order for the patient to be seen. Please submit paperwork so it may be filed in the chart and complete the information below:**

Name: \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_\_\_ SSN: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_ Zip Code: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ Ext \_\_\_\_\_

Relationship: (please circle one) Mother Father Grandparent Step-Parent Legal Guardian Other \_\_\_\_\_

**AUTHORIZATIONS**

I authorize the release of any medical information necessary to process the insurance claim form for services and/or quality assurance activity required by your plan or entity rendered by Tallahassee Ear, Nose & Throat-Head & Neck Surgery, P.A. I also request payment of government benefits to the party who accepts assignment. I do authorize payment of medical benefits to Tallahassee Ear, Nose & Throat Physicians/Providers.

**FINANCIAL RESPONSIBILITY:**

Patient/Responsible party shall pay to Tallahassee Ear, Nose and Throat such sums as are now or may become due for services rendered to the patient and for which the patient's health maintenance organization or insurer is not liable for payment for fees to TENT. Guarantor must sign for all minors or dependents. An administrative fee will be assessed should the account require collection efforts. The guarantee of the account hereby assumes full financial responsibility for payment for all medical services by the named patient in accordance with the terms as set forth in the Authorization above.

**Please be aware that collections made by our office staff at the time of check-out are only an estimate for services rendered. Our policy is to bill and collect any balances due for services rendered by Tallahassee Ear, Nose and Throat.**

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**RECEIPT OF PATIENT PRIVACY NOTICE:**

A copy of the Patient Privacy Notice from Tallahassee Ear, Nose & Throat-Head & Neck Surgery, P.A has been made available to me as printed and/or posted in the office or available on the website for my review. My Protected Health Information may be used for treatment, payment and general practice operation.

**USE AND DISCLOSURE:**

Patient/Provider relationship only begins at the time of the visit. No notes are reviewed prior to this visit. If you are scheduled with an Advanced Practice Registered Nurse in our office, you understand that they are not a physician and work with the support of the physicians in our practice. I understand that as part of my health care, Tallahassee Ear, Nose and Throat originates and maintains a paper and/or electronic record describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. The use and disclosure of Protected Health Information for treatment, payment or operations is described in the Patient Privacy Notice. Your records may be shared with your other providers electronically or via phone, fax, or health information exchange.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**DISCLOSURE OF OWNERSHIP:**

Audiology Associates of North Florida, a division of Tallahassee Ear, Nose & Throat, is the only local audiology group able to coordinate your hearing services with physicians on-site. Please be advised that the following physicians own an interest in the audiology and CT services offered on-site by Tallahassee Ear, Nose & Throat - Head & Neck Surgery, P.A.: Spencer E. Gilleon, M.D., Adrian P. Roberts, M.D., Marie O. Becker, M.D., Joseph C. Soto, M.D and Graham T. Whitaker, M.D. We feel the availability of both physicians and doctors of audiology in our group is advantageous to our patients, **but should you wish to have an alternative provider for these services, we will provide a list upon request.** In addition, these same physicians have ownership in the Red Hills Surgical Center. **Upon your request, you may select any facility for surgical services where we are credentialed. I acknowledge this disclosure of ownership and my freedom to request any facility.**

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**MEDICARE ASSIGNMENT:**

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to the party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act U.S.C. 3801-3812 provides penalties for withholding information). Regulations pertaining to Medicare assignment of benefits also apply.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**MEDICATION REPOSITORY:**

Any pharmacy that participates with a central repository will have an updated list of your medications. In order to provide you with the best possible care, the providers would like your permission to access this repository.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_