ENT ASSOCIATES OF SOUTHERN INDIANCE, P.C.
PATIENT REGISTRATION FORM

Please Print Clearly

AGE___________________

DRUG ALLERGIES____ **DATE**______________________________

Patient's Legal Name____ Sex_____ Birthdate_______________________________

Patient's Social Security #______________________________________ Occupation_______________________________________

Address____ City,State_____________________________ Zip______________

Home Phone #__________________________ Work Phone #__________________________ Cell #____________________________

Email Address____

May we leave a message on answering machine? YES___NO___ Contact you at work? YES___NO___

Employers Name & Address____

Marital Status: Single___ Married ___ Widowed ___ Divorced ___ Separated ___

If patient is a minor, live with ____ Relationship_________________________

Referred by: ____ Family or Primary Physician_________________________________

Have any of your family members seen our physicians before? Please list names: ____

RESPONSIBLE PARTY: IF OTHER THAN PATIENT

Name____ Relationship to patient____

Address____ City,State_____________________________ Zip______________

Home Phone #__________________________ Work Phone #__________________________ Cell #____________________________

Birthdate_______________ Social Security # ___________________________ Employers Name_______________________________

Employers Address____ Employers Phone #_____________________________

Spouse's Name ______________________________ Birthdate________________ Social Security #____________________________

Employers Address____ Employers Phone #_____________________________

Non-Custodial Parent's Name____ Relationship_________________________________

Address ____ City, State_________________________ Zip__________________

Home Phone #__________________________ Work #___________________________ Cell #_________________________________

Nearest Relative Not Living With Patient

Name____ Relationship____________________________________

Complete Address ______________________________________ City, State_________________________ Zip__________________

Phone # ____

Person's Authorized for disclosing of Protected Health Information and Financial Information

Name____ Relationship____________________________________

Name____ Relationship____________________________________

Name____ Relationship____________________________________

PRIMARY INSURANCE COMPANY:

Insurance Name: ______________________________
Address: ______________________________
____
Name of Policy Holder: ______________________________
Policy Holder's Birthdate: ______________________________
ID # ______________________________
Group or Policy # ______________________________
Relationship to Patient ______________________________
Insurance Co. Phone # ______________________________
Employer: ______________________________

SECONARDARY INSURANCE COMPANY

Insurance Name: ______________________________
Address: ______________________________
____
Name of Policy Holder: ______________________________
Policy Holder's Birthdate: ______________________________
ID # ______________________________
Group or Policy #______________________________
Relationship to Patient ______________________________
Insurance Co. Phone # ______________________________
Employer: ______________________________

CONSENT TO USE AND DISCLUSURE OF PROTECTED HEALTH INFORMATION

Use and Disclosure of Your Protected Health Information
Your protected health information will be used by ENT Associates of Southern Indiana, PC or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operation of the practice.
Notice of Privacy Practices
You should review the Notice of Privacy Practices for a more complete description of how you protected health information may be used or disclosed. You may review the notice prior to signing this consent.
Requesting a Restriction on the Use or Disclosure of Your Information
You may request a restriction on the use or disclosure of your protected health information. ENT Associates of Southern Indiana, PC may or may not agree to restrict the use or disclosure of your protected health information. If ENT Associates of Southern Indiana, PC agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.
Revocation of Consent
You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.
Reservation of Right to Change Privacy Practices
ENT Associates of Southern Indiana, PC reserves the right to modify the privacy practices outlined in the notice.
Surgery Rescheduling, Cancellation Fee or Delinquent Account Service Charge
There will be a $150.00 Surgery Rescheduling or Cancellation Fee charged for any scheduled surgery rescheduled or cancelled by patient due to any reason other than death in the family that can be verified or a medical condition that is documented and verified by note from the physician. There will be a Delinquent Account Service Charge of $5.00 per month for any patient balance due after 120 days.

Self Referral Disclosure Notice
The physicians of ENT Associates of Southern Indiana, PC are all, along with numerous other surgeons in Bloomington minority owners (2 – 5 %) in the Southern Indiana Surgery Center. The Southern Indiana Surgery Center is a joint venture between local surgeons and Bloomington Hospital (50% owner). This is to notify you that our physicians do have an ownership interest in this facility and refer the vast majority of our patients in need of outpatient surgical procedures to this facility. We are happy to honor requests for surgery to be done at a facility in which we do not have a financial interest (i.e. Bloomington Hospital, or other locations based on the individual surgeon's hospital privileges). Please let our surgery-scheduling department know of your preferences regarding the location at the time that you are called to schedule your surgery.

The physicians of ENT Associates of Southern Indiana, PC own a CT Scan machine within our office. This is to notify you that our physicians do have an ownership interest in this machine and refer the vast majority of our patients in need of CT Scan within our own facility. We are obligated to inform our patients that you have other locations for this testing to be done, including Bloomington Hospital, SIRA, IMA and Monroe Hospital. We have no control over the price, interpretation or excessive radiation exposure you may receive at these other locations. Please inform our staff if you wish to do your testing at another facility.

The physicians of ENT Associates of Southern Indiana, PC sell hearing aids within our office. This is to notify you that our physicians do have an ownership interest in this service and refer the majority of our patients to our Audiology department. We are obligated to inform our patients that you have other locations for this service. Please inform our staff if you wish to do this service at another facility.

Signature
I have review this consent form and give my permission to ENT Associates of Southern Indiana, PC to use the disclose my health information in accordance with it. I acknowledge responsibility for payment for medical service rendered on my behalf or my dependent. If for any reason the account should become delinquent, I agree to pay for all collection and legal fees.

______________________________ ______________________________ ____________________
Signature of Patient or Patient Representative **Relationship to Patient** **Today's Date**