EAR NOSE & THROAT CLINIC | FAIRBANKS HEARING & BALANCE CENTER | BOREALIS MEDSPA

Patient Registration

Patient Name: _____ Social Security #_____

DOB: _____ Age: _____ Preferred Language: _____

Ethnicity & Race: _____Employer: _____

Address: _____

City/State/Zip: _____

Primary Phone#_____ Home Phone#_____

Work Phone#_____ Email Address: _____

Current Medications: _____

_____

Drug Allergies: _____ Preferred Pharmacy: _____

Emergency Contact:

Name: _____ Relationship: _____

Address: _____ Phone#_____

Insurance

Primary Insurance: _____ Secondary Insurance: _____

Insured Through Employment: Yes / No Employer: _____

Responsible Party of Child / Family Member

Responsible Party: _____ Relationship: Parent /Guardian/ Spouse/ Other: _____

Name: _____ Social Security #_____

DOB: _____ Employer: _____ Age: ___ Preferred Language: _____

Responsible Party Same as Above: Yes / No

Address: _____

City/State/Zip: _____

Primary Phone#_____ Home Phone#_____

Work Phone#_____ Email Address: _____

Signature: _____**Date:** _____

1919 Lathrop St Fairbanks, AK 99701 Phone# 907-456-7768 Fax# 907-456-4045
www.fairbanksent.com

AUTHORIZATION TO USE AND/DISCLOSE PROTECTED MEDICAL HEALTH INFORMATION

PLEASE CIRCLE ONE: SELF PARENT/LEGAL GUARDIAN

Please check all that apply and list names of spouse, children, and others involved in care as applicable.

- ○ You have permission to leave information on my answering machine regarding my medical care and test results.
- ○ Provide chart notes and Imaging reports/Imaging Discs
- ○ ER and Urgent care records
- ○ Pathology and laboratory records
- ○ Immunotherapy records
- ○ Billing statements and records
- ○ Audiometric studies
- ○ Phone correspondence
- ○ Individuals checked below, 18 years or older may bring my child to an appointment at the Ear, Nose, and, Throat Clinic and Fairbanks Hearing and Balance Center.
- ○ Individuals checked below, 18 years or older may make medical decisions on my behalf for my child.

  Please check all that apply to individuals 18 years and older, allowed to bring your child to an appointment.

  - ○ Name_____Relationship_____Contact#_____ DOB: _____
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  - ○ Name_____Relationship_____Contact#_____ DOB: _____
  - ○ Name_____Relationship_____Contact#_____ DOB: _____
  - ○ Name_____Relationship_____Contact#_____ DOB: _____

By signing below, I authorize the disclosure and permission to enact/fulfill all of the following information, unless otherwise specified. I understand that I may revoke this authorization at any time by giving written notice to the medical records department. Unless revoked, **this authorization will be in effect as of the date of signing and valid for only 1 year.**

Patient Name: _____ DOB: _____

Signature: _____ Date: _____

CHECK AUTH DATE ONLY VALID FOR 1 YEAR PLEASE UPDATE YEARLY

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Patient Financial and Payment Policy

This financial payment policy is an agreement between our clinic and you, the patient, or responsible party. By signing you are acknowledging that you understand and agree to our financial payment policy.

- You must provide us with a current insurance card and billing information. Your insurance policy is a contract between you and the insurance company. It is your responsibility to know your insurance benefits. We will bill all insurance plans, but we do not guarantee coverage. We will bill you for any remaining portion due after insurance processes your claim.
- Be prepared co-pays and deductibles are due at time of service. For medical care not covered by your insurance, payment in full is due at time of service
- Self-pay patients must pay $150 down towards the cost of their visit to be seen, any further charges beyond $150 will be billed to you or the responsible party.
- The Ear, Nose, and, Throat clinic is a preferred provider and in-network for AETNA and BLUE CROSS INSURANCES, and not any other insurances. Our office is happy to file claims, however payment in full is expected for all services that are not covered through insurance.
- If the patient is a minor (18 years or younger), the parent or guardian must sign below. The parent or guardian is responsible for any payment due at time of service, bringing the necessary referrals and insurance cards.
- If you don't present your insurance card(s) at the time of service your account will be set to self-pay and you will be responsible for any charges that may arise.
- If you have any questions about your insurance, we are happy to help you. Specific coverage issues, however, should be directed to your insurance company member services department (the phone number is usually on the back of the insurance card).
- A $50.00 fee will be charged for all no-show appointments. If an appointment is not cancelled within 24 hours before the appointment time a $50.00 fee will be charged.
- Our practice believes that a good provider/patient relationship is based upon understanding and good communication. Questions about financial arrangements should be directed to the management office.
- Workers Compensation Plans: We don't accept these plans, You the patient will be responsible for payment of our bill, and you will need to seek reimbursement from the other party.
- Auto Accident Claims: we do not bill your auto insurance policy, You the patient will be responsible for payment of our bill, and you will need to seek reimbursement from the other party.

I understand that I am financially responsible for all charges regardless of third-party involvement. I agree to pay any deductible, co-insurance, or any services deemed a non-covered benefit by my insurance company. I understand that failure to pay outstanding balances within 90 days of receiving my first statement will result in submission of my account to an outside collection agency. If the debt remains after being transferred to the outside agency, the debt may be reported to credit bureaus and your credit rating may be affected. In addition, failure to pay delinquent balances may result in termination of care.

Patient Name:_____ **DOB:**_____

Signature:_____ **Date:**_____

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PATIENT CONSENT FORM

I, the patient or responsible party, hereby authorize the employees, agents, and staff of the clinic to perform, and hereby consent to such medical treatments and examinations, including diagnostic procedures and audiometric studies, as may in the opinion of the patient's physician be necessary.

I hereby authorize Ear, Nose, and Throat Clinic to release Information acquired during my examination and treatment to centers of Medicare/Medicaid services (CMS) and its agents, Medigap, or any other 3rd party, as necessary, to secure payment of any benefits due. I hereby assign payment of said benefits to include Medicare and Medigap directly to Ear, Nose, and Throat Clinic/Fairbanks Hearing and Balance Center, for any medical procedures performed. I understand that I am responsible for all charges regardless of insurance status. I agree that this authorization shall be valid until rescinded in writing or replaced by one of a later date. I have read the above and fully understand the terms thereof.

I understand that, under the Health Insurance Portability & Accountability act of 1996 (HIPAA), I have certain rights to privacy regarding my Protected Health Information (PHI), I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow up care among multiple health care providers who may be involved in my treatment, directly or indirectly.
- Conduct normal healthcare operations such as physician certifications and quality assessments.

I have been informed by you of your Notice of Privacy Practices, as well as how to obtain a more complete description of the uses and disclosures of my health information. I have been given a copy of the Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its policy from time to time and that I may contact you to obtain a current copy. I understand that I may request in writing that you restrict how my private information is used or disclosed and that you are not required to agree to my requested restrictions, but if you do agree than you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

PATIENT NAME: _____

SIGNATURE: _____

RELATIONSHIP TO PATIENT: _____

DATE: _____

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