Middle Tennessee Ear, Nose & Throat-- New Patient Demographics

Please indicate any changes Acct #: _____ Provider: _____

First Name MI Last Name	**DOB:**	**DOS:**	**SSN:**
Mailing Address:	**Email:**	**Home Phone:**	**Cell Phone:**
Gender: M F **Other:**	**Employer:**	**Work Phone:**	**Marital Status:** M S D W
Emergency Contact: **Relationship:**	**Emergency Phone:**	**Primary Care Physician:**	**Referring Physician:**
Primary Insurance: _____ **Subscriber #_____** **DOB of Subscriber:**	**Secondary Insurance:**	***Insurance changes: please list below name &subscriber ID. Present new card to the receptionist.***	

X_____ I have verified that all of the information on this form is correct & that I will be asked to verify this every time.

As part of our effort to comply with patient centered health, we are required to gather additional demographic information for you, the patient. We appreciated your efforts to help our facility comply with MIPS government regulations.

Race: □ African American □ American Indian or Alaska Native □ Asian □ Declined to Specify

□ European □ Other Race _____ □ White

Ethnicity: □ Decline to Specify □ Hispanic or Latino □ Not Hispanic or Latino □ Refused to Report

Preferred Language: □ English □ Spanish □ Other _____

Advanced Directive: **Please CIRCLE the one that applies- (If you have a copy, please provide)**

No Advance Directive Advanced Directive Power of Attorney Do Not Resuscitate & Power of Attorney

Do Not Resuscitate Living Will Living Will & Do Not Resuscitate Living Will & Do Not Resuscitate & Power of Attorney

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Please Initial Below:

_____ MTENT HIPAA policy is posted. □ I have declined a hard copy. □ I have requested & received a hard copy.

_____ I affirm I DO NOT have any insurance coverage other than the INSURANCE(S) listed in my Patient Demographic Form.

Patient or Guardian Signature: _____ Date: _____/_____/20_____

Middle Tennessee Ear, Nose & Throat

First Name MI Last Name	DOB:	Acct #:	DOS:	Provider:

☐ **I authorize the following individual(s) to speak with MTENT regarding my information:**

Name: Relation:	Name: Relation:
Phone:	Phone:
☐ Appointments ☐ Billing ☐ Treatment/Condition	☐ Appointments ☐ Billing ☐ Treatment/Condition

Name: Relation:	Name: Relation:
Phone:	Phone:
☐ Appointments ☐ Billing ☐ Treatment/Condition	☐ Appointments ☐ Billing ☐ Treatment/Condition

☐ **I do not authorize anyone to receive or discuss any information about me regarding MTENT.**

☐ In providing Email - you agree to participate with our secure on-line patient portal

May we leave information on your voicemail regarding your account and/or condition? YES NO

DELINQUENT ACCOUNTS:

We review past due accounts frequently and at every statement cycle. Your communication and involvement to ensure your balance is paid timely is important to us. It is imperative that you maintain communications and fulfill your financial agreement and arrangements to keep your account active and in good standing.

If your account becomes sixty (60) days past due, further steps to collect this debt may be taken. If you fail to pay on time and we refer your account(s) to a third party for collection, a collection fee will be assessed and will be due at the time of the referral to the third party. The fee will be calculated at the maximum percentage permitted by applicable by law, not to exceed 18 percent. In addition, we reserve the right to deny future non-emergency treatment for any and all debtor-related unpaid account balances.

WAIVER OF CONFIDENTIALITY:

You understand if your account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

_____ _____ _____/_____/20_____

Signature of Patient or Responsible Party **Relationship to Patient** **Date**

RELEASE / RESPONSIBLE PARTY for MINOR PATIENTS ONLY – FILL IN ALL BLANKS

I consent to the treatment as necessary or desirable to the care of the minor patient first names above including, but not restricted to, whatever medication, x-ray, or other studies that may be used by Middle TN Ear, Nose & Throat, nurse, or qualified designate.

I agree to be financially responsible for any charges not covered by insurance on this minor child's account.

X_____ Date_____/_____/20_____

Signature of Parent or Guardian

Name_____Relationship to Patient_____

****(IF NOT CUSTODIAL PARENT(S), LEGAL DOCUMENTATION OF CUSTODY MUST BE PRESENTED TO RECEPTIONIST!)****

Address (*If different from above*)_____

Phone (_____)_____DOB_____/_____/_____SS#_____

Middle Tennessee Ear, Nose & Throat

First Name MI Last Name	DOB:	Acct #:	DOS:	Provider:

Please list any medications and/or supplements: _____

_____

_____

Drug Allergies (please list medication and list reaction): _____

_____

_____

Medical History: (please circle yes or no for any medical problems you have had)

Heart Attack	Y N	Cancer	Y N	Anemia	Y N
Heart Disease	Y N	Sleep Apnea	Y N	Bleeding Problems	Y N
Irregular Rhythm (A-fib)	Y N	Diabetes	Y N	Blood Clot	Y N
Hypercholesterolemia	Y N	Tuberculosis	Y N	Transfusions	Y N
Hypertension	Y N	Thyroid Disease	Y N	Arthritis	Y N
Stroke	Y N	Kidney Disease	Y N	Acid Reflux/GERD	Y N
Emphysema/COPD	Y N	HIV (AIDS)	Y N	Pollen Allergies	Y N
Asthma	Y N	Hepatitis	Y N	Animal Allergies	Y N

Other Medical Problems/Hospitalizations: _____

Surgical History: (please circle yes or no for any medical problems you have had)

Tonsillectomy	Y N	Other Ear Surgery	Y N	Abdominal	Y N
Sinus Surgery	Y N	Gall Bladder	Y N	Cancer	Y N
Ear Tubes	Y N	Carotid Surgery	Y N	Heart/Lung	Y N
Nasal Surgery	Y N	Orthopedic	Y N	Hernia Repair	Y N
Thyroid/Parathyroid	Y N	Brain	Y N	Gynecologic	Y N

Other Medical Surgeries: _____

Family History: (please circle yes or no and state their relation to you)

Hearing Loss	Y N		Diabetes	Y N		Stroke	Y N	
Thyroid Disease	Y N		Meniere's	Y N		Other	Y N	
Heart Disease	Y N		Hypertension	Y N				
Bleeding Disorder	Y N		Cancer	Y N				

Are any of these symptoms present today? Please circle Yes or No

Ear, Nose & Throat		**General**		**Respiratory**	
Difficulty swallowing	Y N	Fatigue	Y N	Cough	Y N
Ear Drainage	Y N	Fever	Y N	Hoarseness	Y N
Ear Pain	Y N	Night sweats	Y N	Shortness of breath	Y N
Hearing Loss	Y N	Weight gain	Y N	Snoring	Y N
Nasal congestion	Y N	Weight loss	Y N		
Ringing in ears/Noise	Y N				
Neurology		**Endocrine**		**Gastrointestinal**	
Headache	Y N	Heat/Cold intolerance	Y N	Nausea	Y N
Numbness/Tingling	Y N	Hot Flashes	Y N	Reflux	Y N
Vertigo/Dizziness	Y N	Thyroid Enlargement	Y N	Vomiting	Y N
Eyes		**Cardiovascular**		Heartburn	Y N
Double Vision	Y N	Chest Pain	Y N		
Blurred Vision	Y N	Irregular Heart Beats	Y N	**Hematology**	
Changes in Vision	Y N	Rapid Heart Rate	Y N	Easy bleeding	Y N
Genitourinary		**Psychological**		Easy bruising	Y N
Pain on urination	Y N	Anxiety	Y N	**Pain Management**	Y N
Frequent urination	Y N	Depression	Y N	Provider Name: _____	
Kidney Stones	Y N	Difficulty sleeping	Y N		
Integument (skin)		**Musculoskeletal**		Office Phone Number: _____	
Rash	Y N	Joint Pain/Swelling	Y N		
Skin Dryness	Y N	Muscle Pain	Y N		

Patient or Guardian Signature: _____Date: _____/_____/20_____

Middle Tennessee Ear, Nose & Throat

First Name MI Last Name	DOB:	Acct #:	DOS:	Provider:

Reason for today's visit: _____

****Pharmacy name:**_____ **Location**: _____

Social History:

Current Smoker Y N _____ packs/cig per day Former Smoker Y N _____ # of years quit

Recreational drug use Y N Chewing Tobacco Y N

Alcohol use Y N if yes how much _____ how often _____

In an effort to keep our patients better informed

There are times when an office procedure is needed to correctly diagnose problems of the Ear, Nose and Throat. Your **COPAY** covers your office visit or consultation but **likely will not** cover the **"Additional Services" listed below,** but are not limited to:

1. **Procedures such as:**
   a. Scopes for sinus or throat complaints
   b. Sinus Debridement after sinus surgery, septoplasty or turbinate reduction
   c. Ear wax removal or debridement of ear canal
   d. Incision & drainage
   e. Lesion removal
   f. Ear tubes
   g. Foreign body removal
2. **Audio testing**
3. **Injections**

The above Additional Services may be covered under your deductible/co-insurance. Insurance companies consider Procedures **A-G** as surgery, and a portion of any patient responsibility will be collected at Check-Out.

Our **Billing Department** is available to assist with questions**-615-848-9265 ext 142.**

I acknowledge and have read the above information.

_____ _____/_____/**20**_____

Patient/Guardian if Patient is a minor Date

General Consent for Treatment

As the patient, you have the right to be informed about your conditions and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify appropriate treatment and/or procedure for any identified condition(s).

I request and authorize medical care as my provider, his assistant or designees (collectively called "the providers") may deem necessary or advisable. This care may include, but is not limited to, routine diagnostics, radiology and laboratory procedures, administration of routine drugs, biological and other therapeutics, and routine medical and nursing care.

I authorize my provider(s) to perform other additional or extended services in emergency situations if it may be necessary or advisable in order to preserve my life or health. I understand that my (the patient) care is directed by my provider(s) and that other personnel render care and services to me (the patient) according to the provider(s) instructions.

I understand that I have the right and the opportunity to discuss alternative plans of treatment with my provider and to ask and have answered to my satisfaction any questions or concerns.

In the event that a healthcare worker is exposed to my blood or bodily fluid in a way which may transmit HIV (human immunodeficiency virus), hepatitis B virus or hepatitis C, I consent to the testing of my blood and/or bodily fluids for these infections and the reporting of my test results to the healthcare worker who has been exposed. _____ **(initial)**

I HAVE READ OR HAD READ TO ME AND FULLY UNDERSTAND THIS CONSENT; I HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS AND HAD THESE QUESTIONS ADDRESSED.

Name of Patient: _____

Signature of Patient: _____ Date: _____

☐ Consent of Legal Guardian, Patient Advocate or Nearest Relative **if patient is unable to sign**

☐ Consent Caregiver **if patient is unable to sign**

Name of Legal Guardian, Patient Advocate, Nearest Relative or Other: _____

Relationship: _____ Telephone: _____

Address: _____

Signature of the above: _____ Date: _____ Time: _____

Signature of Witness: _____ Date: _____

Patient Financial Policy

This is an agreement between AdvancedHEALTH, as creditor, and the Patient/Debtor named on this form and indicated by patient/debtor signature below.

In this agreement the words "you", "your" and "yours" mean the Patient/Debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we", "us" and "our" refer to AdvancedHEALTH. By executing this agreement, you are agreeing to pay for all services that are rendered.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect. A copy of your signed financial agreement will be provided to you.

HEALTH INSURANCE - It is YOUR responsibility to:

• Ensure we have been provided with the most current insurance information relative to filing your claim including insurance card, ID number, employer, birth date and patient address. This information will be located on our patient registration form.

• Ensure we are contracted with your insurance carrier to receive maximum benefits.

• Pay your co-payment or patient portion at the time of service.

• Inform us of any insurance changes made after this signed agreement/date of service. Insurance carriers have specific timely filing guidelines and pre-authorization requirements for certain services. If revised insurance information is not provided to us within your insurances' timely filing limits, you will be required to pay for services in full. If prior authorization was required for services already received and your claim is denied for lack of authorization, you will be required to pay for services in full.

• Contact your insurance company if no correspondence is received by you within 45 days of the date of service.

It is OUR responsibility to:

• Submit a claim to your health insurance carrier based on the information provided by the patient/debtor at the time of service or as updated information is provided.

• Provide your health insurance carrier with information necessary to determine benefits. This may include medical records and/or a copy of your insurance card.

• Provide MVA patients a courtesy health insurance claim form for their records upon request.

PAYMENT OPTIONS: Per our contracted agreement with your insurance carrier, we are required to collect your co-payment on the day of service. If you do not have insurance, you are required to pay for treatment at the time of service unless other arrangements have been formally made. A separate self-pay financial agreement will be provided to you.

We accept the following: Cash Check Credit Card *(Visa, MasterCard, Discover, American Express)*

A thirty dollar ($30.00) returned check fee will be assessed to the patient account per incident.

For convenience, payments may be made online at **www.ePayItOnline.com.** To utilize this service, you will need your account number, access code, and Code ID. This information can be found on the patient statement you will receive reflecting your balance. ***Patients who no-show may be subject to a no-show fee.***

PENDING APPROVALS FOR SERVICES: In the event we are unable to obtain approval for services and you wish to proceed, we will not bill your insurance. Services will be reduced to the in-network insurance allowable amount and will apply to the patient's responsibility.

_____ Initials

Patient and/or Debtor Signature: _____ Date _____/_____/_____

Additional financial explanations are continued on the back side of this page

WORKERS' COMPENSATION INJURIES: Written approval/authorization by your employer and/or workers' compensation carrier prior to your initial visit is needed. We will contact your case manager and/or supervisor to confirm your workers' compensation injury. If this claim is denied, for any reason by your employer or your employer's workers' compensation carrier, you will be responsible for payment in full. If denial is made by workers' compensation, health insurance can be filed for these denied services and you will be held responsible for the account.

MOTOR VEHICLE ACCIDENT (MVA's) – Yes, I was involved in a MVA on _____/ _____/ _____. Unless prior agreement has been reached or I am a Medicare recipient, my **health insurance** will be filed for services related to this accident. In the event I do not provide insurance information upon initial visit, I understand insurance denials may occur depending on type of service(s) received or carrier specific filing requirements. I agree, as the patient or patient's guardian, I am ultimately responsible for all balance(s) due to this facility and/or its physician(s) for services rendered regardless of insurance denial(s) or unfavorable case outcomes. If I have chosen an attorney to oversee my case, this financial agreement will serve as a Letter of Protection to my attorney. I further understand my account may be handled by an outside entity that specializes in attorney lien accounts at the facilities discretion.

_____ Yes, I have chosen to retain an attorney. Signed: _____ Date: _____/_____/_____

Attorney Name: _____ Phone: _____

BILLING INFORMATION

STATEMENTS:

A statement of account will be provided to you if insurance has paid leaving a patient portion, denied or no response is received. Due to the type of service we provide, you may receive billing from more than one practice, otherwise known as split billing. The balance on your statement is due and payable within 30 days of receipt unless other arrangements are made with our billing department. The statement will be sent to the address provided at the time of service. In the event your mailing address changes after your service date and your account has not been paid in full, you are required to notify our billing office of this change by calling 615.851.6033 ext. 2067. In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child at time of service will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, court documentation is required for any guarantor address changes, otherwise, it is the authorizing/custodial parent's responsibility to collect from the other parent. Any account with a credit balance of less than <$5.00> will not be refunded without specific request from the patient/debtor.

MEDICAL RECORDS:

You will be required to request in writing or sign a medical authorization form for the release of your medical records to any organization or physician. If the request is for a party other than the originally billed insurance and/or party, a **$20.00 medical records fee** will be required on each occasion.