PATIENT REGISTRATION FORM

PLEASE PRINT

Were you referred by another Physician? ____Yes ____No If yes, which Physician referred you? _____

PATIENT INFORMATION			**ARE YOU PREGNANT ____Yes _____No**
NAME	SEX AGE BIRTHDATE M F ____ __/__/__		MARITAL STATUS □ Single □ Divorced □ Married □ Separated □ Widowed
ADDRESS	Social Security Number		
CITY STATE ZIP	EMPLOYER		
HOME PHONE	OCCUPATION		
CELL PHONE / EMAIL ADDRESS	EMPLOYER ADDRESS		
WORK PHONE	CITY STATE ZIP		

BILLING: PLEASE COMPLETE IF PERSON RESPONSIBLE FOR BILL IS OTHER THAN PATIENT REFERENCED ABOVE

NAME	RELATIONSHIP TO PATIENT	SOCIAL SECURITY NUMBER
ADDRESS	DATE OF BIRTH	EMPLOYER
CITY STATE ZIP	OCCUPATION	WORKPHONE
HOME PHONE	EMPLOYER ADDRESS	
CELL PHONE / EMAIL ADDRESS	CITY STATE ZIP	

INSURANCE Please Circle	BLUE SHIELD	AETNA	KEYSTONE	MEDICARE	MEDICAID	WORKMEN'SCOMP	CHAMPUS	OTHER/NONE

WE NEED TO COPY YOUR INSURANCE CARD(S). PLEASE GIVE US ALL PERTINENT INFORMATION REGARDING YOUR INSURANCE COVERAGE. IF YOU HAVE COVERAGE BY MORE THAN ONE CARRIER, SUPPLY INFORMATION OF ALL CARRIERS.

*****IN ORDER TO SUBMIT A CLAIM FOR PAYMENT TO US, FOR SERVICES COVERED UNDER YOUR POLICY, WE MUST HAVE YOUR AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO YOUR INSURANCE CARRIER*****

MEDICARE AND MEDICAID I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare Claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me.

I request that payment under the medical insurance program be made either to me or to **ENT ASSOCIATES OF CENTRAL PENNSYLVANIA** on any bills for services furnished me by **ENT ASSOCIATES OF CENTRAL PENNSYLVANIA** during the next twelve (12) month period.

ALL OTHER INSURANCE: I hereby authorize **ENT ASSOCIATES OF CENTRAL PENNSYLVANIA** to submit a claim to my insurance carrier or its intermediaries for all covered services rendered by the physician(s) and authorize and direct my insurance carrier or its intermediaries to issue payment check(s) directly to the physician(s) rendering the covered services for the next twelve (12) month period.

I authorize **ENT ASSOCIATES OF CENTRAL PENNSYLVANIA** to furnish complete information to my insurance carrier or its intermediaries regarding services rendered.

_____ _____

SIGNATURE **DATE**

ENT Associates of Central PA

3341 Beale Avenue ♦ Altoona, PA 16601 ♦ Phone (814) 944-5357 ♦ Fax (814) 946-8017

PATIENT FINANCIAL REPONSIBLITY POLICY AND DISCLOSURE STATEMENT

Your signature below forms a binding agreement between ENT Associates of Central PA (the provider of medical services) and the Patient who is receiving medical services, or the Responsible Party for minor patients (patient under age 18). Responsible Party is the individual who is financially responsible for payment of all medical bills.

All charges for services rendered are due and payable at time of service. We have contracts with many insurance companies and we will bill them as a service to you. As the Responsible Party, you are responsible for all payments if your insurance company declines to pay for any reason.
The person signing on behalf of the Responsible Party must:

- Inform ENT Associates of the current address and telephone number for the Patient and the responsible Party
- Present all current insurance cards prior to each office visit
- Verify at each visit that your family physician and all other information is current
- If applicable, pay any required co-pay at the time of the visit and make sure all referrals are current
- Pay any additional amount owed within 30 days of receiving a statement from our office
- (When ENT Associates receives an Explanation of Benefits (EOB) from your insurance company, any amounts you need to pay will be billed to you.)
- Agree to pay a $35 fee for checks returned for insufficient funds

NOTE:

It is important to note that patients often require additional testing, surgical procedures, including but not limited Endoscopy, Laryngoscopy and Tubes in the office As per the National Correct Coding Initiative and our contracts with insurers, we are required to submit a bill for these services **SEPARATE** from the office visit. The fees for these procedures are in **ADDITION** to the co-pay for the office visit. The Patient or the Responsible Party is responsible for the payment of these additional fees.

Non-Payment of Account:

Should collection proceedings or other legal action become necessary to collect an overdue account, the Patient will be terminated from the practice. ENT Associates has the right to disclose to an outside collection agency all relevant personal and account information necessary to collect payment for services rendered. The Patient, or the Patient's Responsible Party, understands that they are responsible for all costs of collection including, but not limited to, all court costs, attorney fees and, collection fee, if assessed to the outstanding balance.

As the Patient or the Responsible Party, your signature below indicates that you have read, understand and accept the terms and conditions outlined in the Patient Financial Responsibility Policy and Disclosure Statement.

Patient Name (Please Print) _____

Patient Signature _____ Date _____

Responsible Party Name (Please Print) _____

Responsible Party Signature _____ Date _____

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DAVID E. HIGGINS, MD *R. CHARLES HOWELLS, MD, FACS* *ROBERT J. CAUGHEY, MD*

DATE: _____

PATIENT'S NAME: _____

PATIENT'S DATE OF BIRTH: _____/_____/_____

Due to HIPAA enactment regarding patient confidentiality issues, we cannot give or discuss information pertaining to your health with anyone other than yourself. If you would like us to be able to discuss your health with someone else (Example: Spouse, daughter, son, etc.) please list their name(s) and relationship(s) below:

_____

_____

_____

_____

This may be revoked at the patients request at any time.

_____

Patient's Signature

HIPAA Notice of Privacy Practices

Revised 2013

Effective as of April/14/2003

ENT Associates of Central PA
3341 Beale Avenue
Altoona, PA 16601
814-944-5357

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

HIPAA

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you. If we use or disclose your protected health information for fundraising activities, we will provide you the choice to opt out of those activities. You may also choose to opt back in.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION

Other Permitted and Required Uses and Disclosures will be made **only with your consent, authorization** or opportunity to object unless required by law. Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes. We may not sell your protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your protected health information. We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes.

You may revoke the authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply) – Pursuant to your written request, you have the right to inspect or copy your protected health information whether in paper or electronic format. Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

HIPAA

You have the right to request a restriction of your protected health information – This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to your requested restriction except if you request that the physician not disclose protected health information to your health plan with respect to healthcare for which you have paid in full out of pocket.

You have the right to request to receive confidential communications – You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to request an amendment to your protected health information – If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures – You have the right to receive an accounting of disclosures, paper or electronic, except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of the request.

You have the right to receive notice of a breach – We will notify you if your unsecured protected health information has been breached.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint.**

Ann Marie Bomba	814-944-5357	ambomba@entcpa.com
HIPAA COMPLIANCE OFFICER	Phone	email

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number. Please sign the accompanying "Acknowledgment" form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

Provided By HCSI