WNC Ear Nose Throat Head & Neck Surgeons, PA

BARRY R. PATE, JR., MD

Otolaryngology
Head and Neck Surgery
Maxillofacial Surgery
Board Certified
Diplomat American Board of Otolaryngologists

Audiology
Hearing Aids
Hearing conservation
Tinnitus Management

PATIENT INFORMATION

NAME:_____ BIRTHDATE:_____

GENDER: MALE or FEMALE

MARITAL STATUS: SINGLE MARRIED WIDOWED DIVORCED SEPARATED

MAILING ADDRESS:_____

CITY:_____STATE_____ZIP_____

EMAIL ADDRESS:_____

PRIMARY PHONE:_____ OTHER:_____

PRIMARY DOCTOR:_____

PRIMARY DOCTOR'S PRACTICE: _____

REFERRING PYHSICIAN:_____

PHARMACY NAME AND ADDRESS:_____

MINOR'S GUARDIAN:_____

INSURED PARTY: _____ BIRTHDATE: _____

As part of the Federal and State reporting requirements, please answer the following questions:

- **RACE: WHITE AFRICIAN AMERICIAN/BLACK ASIAN NATIVE AMERICIAN/ALASKIAN OTHER:_____ DECLINE TO ANSWER**
- **ETHNICITY: LATINO NON LATINO DECLINE TO ANSWER**
- **LANGUAGE: ENGLISH SPANISH RUSSIAN FRENCH GERMAN OTHER:_____**
- **SMOKING STATUS: CURRENT SMOKER FORMER SMOKER NEVER SMOKER**

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Please initial each statement for acknowledgement then sign, date and print your name at the bottom. Thank you.

ASSIGNMENT OF BENEFITS

_____ I, the undersigned, have insurance and assign directly to WNC Ear Nose Throat Head & Neck Surgeons, PA all benefits, if any, otherwise payable to me for services rendered.

RELEASE OF MEDICAL INFORMATION

_____ I hereby authorize the office to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions whether manual or electronic.

FINANCIAL AGREEMENT

_____ I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parents / guardians are responsible for all fees and services rendered for treatment of a minor / child. I accept full responsibility for all charges not covered by insurance.

_____ I understand that I am financially responsible for all charges regardless of insurance payment. Further, I understand that I consent to certain diagnostic and treatment procedures that may not be reimbursable and this will be my financial responsibility as part of my insurance and deductible agreement. This includes but is not limited to flexible laryngoscopy, needle and simple tissue biopsies, nasal cauterization and removal of ear wax and other foreign bodies.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

_____ I have received a copy of the Notice of Privacy Practices for WNC Ear Nose Throat Head & Neck Surgeons, PA.

_____ _____

Signature Date

_____ _____

Printed Name Relationship to the Patient

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

Information is requested from: _____

_____

(Street or PO Box)

_____

(City) (State) (Zip Code)

Records are to be sent to: _____

_____

(Street or PO Box)

_____

(City) (State) (Zip Code)

Patient's Name: _____

(Last Name) (First Name) (Middle) (Maiden Name)

Date of Birth: _____ _____

(Street or PO Box)

_____ _____

(Social Security #) (City) (State) (Zip Code)

FOR THE PURPOSE OF:

_____ Medical Care ___ Attorney: _____

_____ Insurance Benefits ___ Other: _____

_____ Disability Determination

Dates of Treatment: _____

Type of Treatment: _____

I hereby release the above-named providers from all liability that may arise from the release of information from my medical record. I understand that this information may include reference to conditions including psychological or psychiatric impairment, drug abuse and/or alcoholism, sexual assault, or tests for HIV, ARC, and/or AIDS.

I understand I have the right to revoke this authorization at any time by sending a written notification to the Privacy contact.

I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to inspect or copy the protected health information to be used or disclosed in this document. I can do this written notification to the Privacy Contact.

I understand that my treatment will not be conditioned on signing this authorization.

I understand that I have the right to refuse to sign this authorization.

_____

Signature of Patient or Personal Representative

_____

Print or Type Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority (attach necessary documentation)