PATIENT INFORMATION **CHART NUMBER:**

Name ____ Male_____ Female____
First Middle (Maiden) Last

Date of Birth_______________ Age_________ Social Security Number____________________ Marital Status___________

Address____
Street Name and/or PO Box City State Zip

Home Phone______________________ Alternate or Cell Phone_______________ e-mail Address____________________

Employer______________________ Work Phone_____________ Address______________________________

Who do we call in an EMERGENCY?_____________________________Phone_____________ Relation__________

Who is your Primary Care Doctor?____________________________________ Phone Number________________

How did you hear about us? (Ex: newspaper, family doctor, friend, sign, yellow pages)______________________________

SPOUSE OR PARENT INFORMATION

Name______________________________ Date of Birth_____________ Social Security #________________

Relation to Patient_______________ Employer__________________________ Work Phone________________

INSURANCE INFORMATION

PRIMARY INSURANCE- Please present your card to the receptionist for a copy. This will ensure proper filing of claims.

Name Policy Holder____Date of Birth______________

Social Security Number__________________________ Employer____________________________________

Name of Insurance Company____

Policy Number?________________________________ Group Name or Number____________________________
Does your insurance require a referral? Yes or No If yes, do you have a referral? Yes or No Who is your Doctor?_________

SECONDAY INSURANCE- Please present your card to the receptionist for a copy. This will ensure proper filing of claims.

Name Policy Holder(if other that patient)___________________________________Date of Birth_________________

Social Security Number__________________________ Employer____________________________________

Name of Insurance Company____

Policy Number?________________________________ Group Name or Number____________________________
Does your insurance require a referral? Yes or No If yes, do you have a referral? Yes or No Who is your Doctor?_________

I understand that I am responsible for all the charges and services rendered to me or my family. I authorize the release of any information in my records necessary to process insurance claims. I also authorize payments be made directly to Dr. Quinn from my insurance if there is a balance on my account.

Signature: **Date:**

****Please Complete Information on Back****

MEDICAL HISTORY

What **Medications** do you take?____

____

Are you allergic to any medications? **YES ________ NO _________**

If yes, what medications are you allergic to?____

Have you ever had or currently have any of these conditions? Please Check…

Medical Problem	**Yes**	**No**	**Comment**
Diabetes			
High Blood Pressure			
Heart Disease			
Asthma			
Lung Disease			
Allergies			
Stroke			
High Cholesterol			
Thyroid Problems			
Seizures			
Headaches			
Glaucoma			
Stomach Problems			
Kidney Problems			
Bleeding Problems			
Eye Problems			
Ear Problems			
Prostate Problems			
Sinus Problems			
Spinal Injuries			
Neurological Problems			
Hearing Problems			
Do you wear hearing aids			
Have you worked in a noisy environment?			
PLEASE LIST ANY OTHER MEDICAL PROBLEMS/CONDITIONS:			

List any surgeries you have had?____

____

Do you use tobacco? Yes No What kind? Cigarettes Pipe Smokeless Other__________

Number of Packs per Day_________________ How Long?_____________________________________

Dr. Robert Quinn, Ear, Nose, & Throat

Notice of Privacy Practices

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 and sign. This will become part of your medical record.

TREATMENT. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory test and procedures will be available in your medical record to all health professions who may provide treatment or who may be consulted by staff members.
PAYMENT. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.
HEALTH CARE OPERATIONS. Your health information may be used as necessary to support the day-to-day activities and management of Dr. Quinn, Ear, Nose, & Throat.
LAW ENFORCEMENT. Your health information may be disclosed to law enforcement agencies, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.
PUBLIC HEALTH REPORTING. Your health information may be disclosed to public health agencies as required by law.

Other uses and disclosures require your authorization. Disclosure of you health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before your notified us in writing of your decision.

Your information may also be used to remind you of your appointments, to send you information about your treatment/condition, services that may be of interest of your condition, and public relations or sales related information.

- You have certain rights under the federal privacy standards, These include:
- The right to request restrictions on the use and disclosure of your protected health information.
- The right to receive confidential communications concerning your medical condition and treatment.
- The right to inspect and copy your protected health information.
- The right to receive an accounting of how and to whom your protected health information has been disclosed.
- The right to receive a printed copy of this notice.

We at Dr. Quinn, Ear, Nose, & Throat are required to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices as outlined. As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

As permitted by federal regulations, we require that request to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records or submit a complaint about our privacy policies. Contact the **MEDICAL RECORD PRIVACY OFFICER at 25 Lake Concord Road, Concord, NC 28025.** If you believe that your privacy rights have been violated, you should call the matter to our attention at the above address.

Your protected health information will be used by Dr. Quinn, Ear, Nose, & Throat or disclosed to others for the purposed of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice. You may request a restriction on the use or disclosure of your protected health information. If Dr. Quinn, Ear, Nose, & Throat agree 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. 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. Dr. Quinn, Ear, Nose, & Throat reserves the right to modify the privacy practices outlined in the notice.

I have reviewed this consent form and give permission to Dr. Quinn, Ear, Nose, & Throat to use and disclosure my health information in accordance with it.

____ ____________________________

Signature of Patient Date of Signature

Please fill out the information and sign the first line. This will be your sign-in sheet. You will sign and VERIFY your information on every visit.

Name____

Address____
street City Zip

Email Address___________________________________Phone_______________________________

Work or Alternate Phone_______________________ Primary Care Doctor__________________________

Emergency Contact____ Phone _________________

Insurance Company _______________________________________Policy Holder_________________

CO-pay Amount_______________

I verify that all of the above information is correct and valid. I understand that I am responsible for all charges from services rendered. I authorize the release of any information concerning any office visits to properly process insurance claims.

I also authorize payments from the insurance company to be paid directly to Dr. Quinn, Ear, Nose & Throat if there is a balance on my account or insurance requires it. I understand that this facility will not be responsible for nonpayment from insurance due to changes in insurance status, absence of referrals from primary care physician or any noncompliance with insurance requirements.

Signature	Date	Signature	Date
X			

Dr. Quinn Ear, Nose, & Throat
Financial Policy

Dear Patient;

We hope that you understand that our credit and collection policies are a necessary part of our practice to provide health care services for all of our patients. Therefore, as a service to you, we will gladly submit charges to your primary insurance company with each visit if you provided us with complete accurate information. Co-payments and deductibles are due at the time of service and payable at check in. If we do not participate in any program with your insurance carrier or third party administrator you must pay the total balance of the visit at the time of service. It is your responsibility to make sure we are a provider with your insurance. If we do participate with your insurance we will file a claim to them and bill you for the amount they deem your responsibility. You will have thirty days to pay the remaining balance.

It has been our experience that submission of one claim is sufficient to generate payment. However, there are times that we must resubmit a claim. We make every effort to refile all claims in a timely manner. To assist us in receiving payment from your insurance please call us if you do not receive a statement from your insurance company within eight weeks from the date of service to let us know to file again. Also, call us after you receive a statement from your primary insurance carrier saying they paid us, let us know to file your secondary insurance. WE DO NOT AUTOMATICALLY FILE THE SECONDARY. YOU MUST LET US KNOW. The Secondary will not pay until the primary has paid. Therefore, we cannot file them at the same time.

It is your responsibility to be familiar with your insurance policy. Please let us know when you make your appointment if your policy requires special authorization and inform us of any and all changes in your insurance, address, & phone number at each visit. Failure to do so will result in your full responsibility for payment of services. We will do all we can to obtain the proper authorizations or referrals if we know they are required.

We accept cash, checks, Visa and Mastercard. If unusual circumstances should make it impossible for you to meet our credit terms or if you have questions about your account, we encourage you to call us and discuss the matter. This will help keep your account in good standing. Delinquent accounts may be referred to an outside collection agency for collection and could affect your credit rating.

If you have a worker's compensation injury, we will need the name of the person in charge of all insurance claims for your company, a case number and insurance carrier name and address prior to your visit. The visit must be approved by the worker's compensation supervisor at your place of employment before the visit.

Our office does not bill for personal injury cases such as automobile accidents or liability cases. You will be responsible for payment in full at the time of service when seen in our office.

If you are unable to keep your appointment, please give at least 24 hours notice of cancellation. This enables us to help as many sick people as possible and keeps cost down. Thank you for your cooperation. We are glad you have chosen Dr. Quinn, Ear, Nose, & Throat. Please let us know if we can better serve you.

I have read , understand and agree to the above financial policy for payment of services rendered. I understand that I am ultimately responsible for all professional fees.

Signature   Date