5830 Lake Underhill Rd.
Orlando, FL 32807
407.658.0228

Orlando Ear, Nose & Throat Associates, PA

8000 Red Bug Lake Rd #150
Oviedo, FL 32765
407.971.3337

Patient Information

Last Name_____ First Name_____ Middle_____

Birthdate: _____ Age:_____ SSN:_____

Address:_____Apt#_____ City:_____ State:_____ Zip Code: _____

Phone:_____ Email:_____

Single_____ Married_____ Widowed_____ Separated_____ Divorced_____ Male:_____ Female_____

Employer:_____ Occupation:_____

Business Address: _____ Business Telephone:_____

EMERGENCY CONTACT:_____ Relationship:_____ Phone #:_____

PRIMARY INSURANCE

Insurance Company: _____ Group#:_____ Subscriber #_____
Policy Card Holder Name:_____ Relation to patient:_____
Policy Holder Birthdate:_____ SSN:_____
Home address(if different) _____City:_____ State:_____ Zip:_____
Telephone:_____ Policy Holder Employer:_____
Business Address:_____ Business Telephone:_____

SECONDARY/ADDITIONAL INSURANCE (if applicable)

Insurance Company: _____ Group#:_____ Subscriber #_____
Policy Card Holder Name:_____ Relation to patient:_____
Policy Holder Birthdate:_____ SSN:_____
Home address(if different) _____City:_____ State:_____ Zip:_____
Telephone:_____ Policy Holder Employer:_____
Business Address:_____ Business Telephone:_____

ASSIGNMENT & RELEASE OF BENEFITS

I, the undersigned, certify that I (or my dependent) have insurance coverage as documented above. I assign directly to Orlando Ear Nose & Throat (Drs Bibliowicz, Harrington, Rabaja, Waizeneggar) all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges not paid by insurance. I authorize the Practice to release all information necessary to secure payment of benefits. I authorize this signature on all Insurance submissions.

Signature:_____ Relationship:_____ Date: _____

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Patient Health History

Name:_____ **DOB:**_____

Height:_____ **Weight:**_____ **Race:**_____

Preferred Language:_____ **Hispanic or Latino**_____ **Non-Hispanic or Latino**_____

Primary Care Physician: _____

Primary Care Physician address:_____ **Telephone:**_____

Pharmacy Preference :_____ **Pharmacy Phone #**_____

Pharmacy address:_____

REASON FOR TODAY'S VISIT: _____

_____

_____

Your current medications:

Name of Medicine	Dosage	Directions

Allergy to any medications?

YES_____ **No**_____

Name of Medicine	Type of Reaction

Any problems with anesthesia? **YES**_____ **NO**_____
If yes, what problem?_____
List any surgeries_____
Recent emergency room visits? **YES**_____ **NO**_____
Recent hospitalizations? **YES**_____ **NO**_____
Any recent testing/exams, scans, bloodwork, etc.? **YES**_____ **NO**_____
Where at? _____
Anything else about your health we should know? _____

_____

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Patient Financial Responsibility

Thank You for choosing Orlando Ear Nose & Throat for your healthcare needs. We are committed to providing the highest quality care. Our relationship is with you and not with your Insurance Company. Please read and sign this description of our financial policies.

INSURANCE COVERAGE:

- It is your responsibility to be aware of your Insurance coverage, policy provisions, exclusions and limitations. Many insurances require authorizations.
- We attempt to verify/validate insurance coverage at the time of your visit. If your coverage is not active, any financial responsibility is yours.
- It is your responsibility to notify the office of any changes in Insurance Coverage. Failure to do so may result in a claim denial.

CO-PAYMENT, CO-INSURANCE and DEDUCTIBLES:

- CO-PAYS are due at the time of your visit. Co-insurance and Deductibles are the patient's responsibility.
- Deductibles are determined by your Insurance Coverage.
- Any dispute regarding these payments is between the patient and Insurance, not with the Practice.
- You are responsible for services and procedures not covered by your Insurance. Non-payment for services may be forwarded to a Collection Agency. You are responsible for Attorney fees if applicable.

REFERRALS: It is your responsibility to obtain proper referrals if required by your Insurance

INSURANCE REQUESTS and PAYMENTS:

- You are responsible for responding to any request from your Insurance Company. Not doing so will result in claim denial and shift responsibility of payment to you.
- Any payments sent to you must be forwarded to our office with a copy of the supplied Explanation of Benefits (EOB).

MINOR PROCEDURES/SURGICAL SERVICES:

Our physicians frequently perform these procedures in the office as part of the process of diagnosis and treatment. These are considered medically necessary and appropriate. All Insurance companies require that we bill services using the CPT coding system. CPT coding rules are developed by the AMA to help physicians report what was done during office visits and surgery. These codes are required by all Insurance companies, Medicare, and Medicaid. Some of these codes are listed as "surgical" codes or procedures.

These common codes are frequently used for diagnostic purposes and will be listed on your Explanation of Benefits (EOB). Insurance companies will usually apply these codes to your deductible or co-insurance. We have no recourse in this, as it is a contract between you and your Insurance provider. You are responsible for services and procedures not covered by your Insurance Company.

Many of the codes used by our office are listed under the surgery coding section but do not necessarily represent surgery having been performed.

Signature _____ Print Name _____ Date _____

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Health Insurance Portability & Accountability Act

I hereby authorize the release/use of my individually identifiable health Information (protected health information) by Orlando Ear Nose & Throat Associates, PA (The Practice) in order to carry out treatment, health care operations or payment. We reserve the right to change the terms of this notice at any time. You may review and obtain a copy of the notice at any time.

You retain the right to request restrictions on how your protected health information is released or used. Our practice is not required to agree to such requested restrictions. The Practice may refuse to treat you if the Consent Form is not signed by the patient or authorized representative.

I acknowledge and agree that the Practice may disclose my protected health information and medical record information to the following individuals/parties: _____

The Practice may release information to me or my designee in the following manners:

_____Email _____

_____ Regular Mail, marked person and confidential

_____ Telephone, once identity is verified

You may request a copy of your medical record. This request must be in writing and may be subject to state mandated laws regarding copying costs.

You may also revoke this consent at any time. The revocation must be submitted in writing and shall be effective the date received. If the consent is revoked, the Practice will not provide further treatment to you except as required by law.

I have read and understand the information in this consent. I may request a copy of the consent at any time. I am authorized to sign this consent as the patient or authorized representative:

Signature _____ Print Name _____ Date _____

Have you had any CT, MRI/MRA, X-Ray, Ultrasounds, Labs or any other testing done within the last 6 months to 1 year pertaining to the medical condition you are being seen for today?

_____

Has tenido alguno CT, MRI/MRA, Radiografia, Ecografia, Laboratotio o cualquier otra prueba dentro de los ultimos 6 meses a 1 ano relacionada can las condicion medica por la que estas siendo atendido hoy?

NO: _____ Patient Name: _____

Yes/*Si*: _____

If Yes /Si es Si :

Type of Test Done / Tipo de prueba

Ct Scan _____ MRI/MRA _____ X-Ray _____ Ultrasounds _____

Thyroid Labs/Labs _____

Name of facility where test was done: _____ Phone: _____

Nobre de facilidad donde se ralizo la prueba _____

Patient Name: _____ DOB: _____