Kentuckiana Ear, Nose & Throat Patient Information

Please Print

Patient Name ___________________________________ SS#___________________________________

Address ____

City ________________________________ State ___________________ Zip ______________________

Phone # (___) ____________________________ Cell # (____) ___________________________________

Date of Birth __________________ Age __________ Martial Status W Sex

Email Address____

Employer ___________________________________ Phone # ___________________________________

Address____

Race (Mark Only One) □American Indian or Alaskan Native □Asian □Black or African American □Native Hawaiian or Other Pacific Islander □Some Other Race □White □Decline to State

Ethnicity (Mark Only One) □Hispanic or Latino □Not Hispanic □Latino □Decline to State

Preferred Language (Mark Only One) □English □Spanish □Other ______________________

****

□ Address same as above

Spouse/Responsible Party Full Name ____

Address ____

City ________________________________ State ___________________ Zip ______________________

Phone (____) _____________________ SS# ______________________ DOB ______________________

Employer ____ Phone # (____) ____________________

Address ____

Relationship to Patient ____

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Person to contact in case of emergency (not living with you) ____________________________________

Address ________________________________ City______________ State __________ Zip ___________

Phone (___) ____________________ Relationship ____

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Primary Insurance ____

Primary Insurance Claims Address ____

Subscriber ID # _____________________________________ Group # _____________________________

Effective Date _____________________________________ Is referral needed? ______________________

Policy Holder's Name ____

Policy Holder's DOB ____________________________ Policy Holder's SS # _______________________

Policy Holder's Place of Employment ____

Policy Holder's Relationship to Patient ____

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Secondary Insurance ____

Secondary Insurance Claims Address ____

Subscriber ID # ___________________________________ Group # _______________________________

Effective Date _____________________________________ Is referral needed? ______________________

Policy Holder's Name ____

Policy Holder's DOB __________________________ Policy Holder's SS # _________________________

Policy Holder's Place of Employment ____

Policy Holder's Relationship to Patient ____

OFFICE POLICY
KENTUCKIANA EAR, NOSE & THROAT, PSC

Your co-payment is due at the time services are rendered. You may pay by check, cash, MasterCard, Visa, American Express, or Discover Card.

We will file insurance for covered services for all plans with which we participate. If you are covered by insurance, you will need to be prepared to pay your deductible and copayment amounts at the time of your visit. Please contact your insurance carrier for your benefit information and whether or not services will be covered in our office. If your insurance requires a referral you will need to obtain the referral from your primary care physician prior to your visit in order for us to see you. For scheduled surgery, our billing department will determine your estimated patient responsibility and request this payment prior to your scheduled surgery.

Any claim filed to secondary insurance, if not paid in 30 days, will become the responsibility of the patient / guarantor.

You will be asked to complete a registration form at your visit and every new year thereafter. We recognize the "Responsible Party" to be the parent / legal guardian who typically brings the child(ren) in to see the doctor - regardless of who the insured might be. If you anticipate a grandparent or someone other than yourself will EVER bring the child(ren) in, please sign consent for care to be provided in your absence (at the end of this agreement). We DO NOT bill exes and / or noncustodial parents without a full copy of a court order indicating such persons' 100% responsibility of medical expenses.

We participate with Medicare and will file your Medicare claims for you. If you have a Medigap secondary policy, Medicare will automatically submit your secondary insurance for you. If you have a secondary policy other than Medigap, you will need to provide your secondary insurance information in order for your claim to be filed. You will need to be prepared to pay all deductible, coinsurance and copay amounts determined by your insurance and charges for Medicare noncovered services at the time of your visit.

Any balance on your account not paid by insurance within 60 days will become your responsibility and payment will be due from you. We do all we can to provide pertinent medical information on your claim. However, we are unable to act as an intermediary between you and your insurance carrier. Please contact the customer service representative of your insurance plan, if you are dissatisfied with your claim denial and feel your service should be covered.

Refills: Prescriptions may be refilled during business hours Monday thru Friday only. The patient records are not available once the office is closed, therefore refills cannot be given on weekends. We may refuse to refill medications if we have not seen you in six months or if you have missed several appointments.

If you have any question concerning our financial policy, please call our billing department at 894-9753. Our staff is always pleased to be of service to you.

Signature________________________________Date______________

INSURANCE AND BILLING AUTHORIZATION

I understand that I am financially responsible to Kentuckiana Ear, Nose & Throat for any charges incurred for services performed regardless of insurance coverage.

I understand that Kentuckiana Ear, Nose & Throat will file a claim for my services but that I am responsible for any and all amounts not covered and not paid by my insurance carrier. **If my insurance requires a referral for my office visit, I understand that it is my responsibility to obtain this and present it at the time of my visit (if not before).**

I hereby authorize Kentuckiana Ear, Nose & Throat to submit a claim to my Insurance Carrier or it's intermediaries for all covered services rendered by Kentuckiana Ear, Nose & Throat and direct my insurance carrier or it's intermediaries to issue payment check directly to Kentuckiana Ear, Nose & Throat.

Initial ______ Date _______

CONSENT FOR CARE AND TREATMENT OF DEPENDENT

I certify that I am the parent or legal guardian of ________________________________
Dependent's Name

I give my consent to the physicians of Kentuckiana Ear, Nose & Throat to examine and render treatment as appropriate for the above-named patient.

I understand that I am responsible for any balances owed (i.e. co-pays, deductible, co-insurance, etc.).

I also understand that it is my responsibility to furnish this office with current insurance information should there be any change in my insurance coverage or I will be responsible for any charges incurred.

Initial of parent or guardian __________________ Date ___________

Relationship to Patient ___________________________________

MEDICARE AUTHORIZATION

I authorize the physicians of Kentuckiana Ear, Nose & Throat to submit all information necessary to the Federal Medicare Carrier and my Medigap carrier in order to file a claim for services provided to me.

I understand that Medicare will only pay for services that it deems medically necessary.

I understand that there are also a number of services that Medicare considers noncovered and / or not medically necessary and that Medicare will not make payment for these services. These include hearing loss, hearing aids, cosmetic surgery and other services and supplies.

I understand that my physician has reason to believe that Medicare may not cover part or all of the services rendered. I agree to be financially responsible for and pay for all services for which Medicare does not pay.

Initial _________________ Date _____________

Minor Office Procedure Notification
At Time of Service

Dear Patient:

Your insurance company requires that we bill the services we provide to you using a coding system known as CPT (Current Medical Terminology). The codes used to describe some of the services we provide in our office as part of your evaluation and treatment are found in the “surgery” section of the CPT codebook. This does not mean we are implying that you are having an operation. This is merely the way the CPT codebook is organized for ease of use by insurance companies and physicians alike.

According to CPT guidelines, the procedures listed below may be shown on your Explanation of Benefits (EOB) form from your insurance company (after your visit) as a surgical procedure. As such, your insurance company may apply a surgical co-payment, deductible or out-of-pocket/co-insurance amount over and above your regular office visit co-payment as your responsibility. Unfortunately, we do not know what your specific insurance company will and/or will not cover until after the provided services are rendered and billed.

We are providing this form to notify you of what you may see on your statement from your insurance company. Please know that we do correctly perform and document services that we render as required by the CPT coding guidelines.

Ear Procedures:	Debridement of mastoid cavity (CPT 69222) Removal of impacted cerumen (CPT 69210)
Nasal Procedures:	Nasal endoscopy (CPT 31231) Nasal cautery (CPT 30901)
Throat Procedure:	Fiberoptic laryngoscopy (CPT 31575)

If you have any questions regarding this notice, please ask your physician or his medical assistant for further clarification. Thank you for allowing us to participate in your care.

Sincerely,

Bruce A. Scott, M.D.
Mark A. Severtson, M.D.
Sammy S. Sohi, M.D.
Thomas S. Higgins, M.D.
Sean M. Miller, M.D.

____
Patient/Guarantor Signature

____
Date

____
Acct. No. (Office Use Only)

Office Use Only

Pulse____________________Blood Pressure___________________ Misc. ____

KENTUCKIANA EAR, NOSE & THROAT
PATIENT HEALTH HISTORY

In order for us to obtain a complete medical history, it is important for you to fill out this form in its entirety. It is important for your doctor to know you have carefully reviewed every area of this form. Please fill out every item and print clearly. If an item does not apply to you, write n/a in the space. This information will be entered into the computer and you are welcome to request a copy of the report if you wish.

Patient's Last Name_______________________________________**First**______________________________**MI** __________

Date of Birth: ____________________________________ **Sex** ☐ **Male** ☐ **Female**

Name of Primary Care Physician: ____

Name of Physician who referred you to us:____

Do you have other family members that see our physicians? ____

Preferred Pharmacy Name/phone number____

Preferred Pharmacy Address (include City/State)____

What is your ☐**Height**__________☐**Weight** ____________

REASON FOR TODAY'S VISIT: ____

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING:

Name of Medication	Dosage	How Often Taken

ARE YOU ALLERGIC TO ANY MEDICATION? ☐ Yes ☐ No. If yes, please list below:

Name of Medication	Type of Reaction

SURGERIES AND HOSPITALIZATIONS:

Have you ever had any problems with anesthesia (being numbed or put to sleep)? ☐ Yes ☐ No

If yes, please list type of problems: ____

____

____

List any surgeries you have had (including dates):

____

____

____

____

____

____

____

Have you ever been hospitalized for non-surgical reasons? ☐ Yes ☐ No

If yes, list reasons for hospitalizations ____

____

Most Recent Diagnostic/Screening Tests: mark all that apply (you can approximate the date if needed).
□Colonoscopy ______/______ (month/year)
□Fecal Occult Blood Testing (FOBT)________/_______(month/year)
□Sigmoidoscopy - Flexible________/_______(month/year)
□Pap Smear________/_______(month/year)
□Mammography________/_______(month/year)

Immunizations: mark all that apply (you can approximate the date if needed).
□Influenza (Flu) – Has received this vaccine_______/_______(month/year)
□Influenza (Flu) – Never received this vaccine
□Influenza (Flu) – Declined vaccine
□Pneumonia (PPV) – Vaccine given as an adult________/_______(month/year)
□Pneumonia (PPV) – Revaccination________/_______(month/year)

CURRENT OR MOST RECENT OCCUPATION: ____