Today's date: _____

Full Name: _____ **Social Security Number:** _____

Date of Birth: _____ **Age:** _____ **Gender:** ☐ Male ☐ Female ☐ Other _____

Address: _____ **Home Phone:** _____

_____ **Mobile Phone:** _____

_____ **Preferred contact method:** ☐ Phone ☐ Email

Email Address *(required)*: _____

Relationship Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow ☐ Other_____

Spouse's Name & Phone: _____

Race: ☐ White ☐ Black ☐ Native ☐ Asian ☐ Other: _____

Ethnic group: ☐ Hispanic ☐ Not Hispanic

Language: ☐ English ☐ Spanish Other_____

Patient Employer: _____ Phone: _____ ☐Full-time ☐Part-time

Primary Care Physician: _____ Clinic:_____

Referring Physician: _____ Clinic:_____

Pharmacy Name and City: _____

If patient is 18 years of age or younger:

Mother's Name: _____ Birth Date: _____ Phone: _____

Father's Name: _____ Birth Date: _____ Phone: _____

Social History:

Smoking: ☐Never-Smoked ☐Current Smoker-pack per/day_____ ☐Former Smoker-years smoked_____

Alcohol: ☐none ☐ less than 1 drink/day ☐ 1-2 drinks/day ☐ 3 or more/day

Women: How many times in the past year have you had 4 or more drinks/day _____

Men: How many times in the past year have you had 5 or more drinks/day _____

Do you use recreational drugs? _____

Family History:

Do you have a family history of Thyroid Disease?	Y	N	If yes, which relative? _____
Do you have a family history of skin cancer?	Y	N	If yes, which relative? _____
Family History of any anesthesia complications?	Y	N	If yes, which relative? _____

Grand Island ENT - Conditions of Office Visits

Print Patient Name: _____ **SSN:** _____ **Date of Birth:** _____

1. CONSENT FOR TREATMENT

I understand that I may have a condition requiring diagnostic procedures, physical examination and/or medical treatment. I hereby voluntarily consent to such diagnostic procedures including, but not limited to, laboratory testing, physical examination and such medical treatment as deemed necessary by my health care providers. Photos may also be taken of you and your condition and placed in your medical record for patient care purposes. I further acknowledge that no guarantees have been made to me as to the results of treatment or examination provided at GRAND ISLAND EAR NOSE THROAT.

2. AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize GRAND ISLAND EAR NOSE THROAT to furnish from my medical records any requested information or excerpts to any insurance company or third-party payer for the purpose of obtaining payment of the account, or any entity providing care to the patient (specialist, hospital, radiology, pathology, imaging clinic, skilled care facility, etc.)

3. PRIVACY PRACTICES -See also financial agreement contract

For a more complete description of the potential uses and disclosure of your health information for treatment, payment and healthcare, refer to GRAND ISLAND EAR NOSE THROAT'S Notice of Privacy Practices.

I understand that I have the right to review the Notice of Privacy Practices prior to signing the consent. The terms of the Notice of Privacy Practices may change, and you may write to our address for a revised copy.

You have the right to request that the provider restrict how your health information is used or disclosed to carry out treatment, payment, or healthcare operations; however GRAND ISLAND EAR NOSE THROAT is not required to agree to requested restrictions.

You have the right to revoke this consent in writing, except to the extent that the provider may have previously acted in reliance on it.

5. FINANCIALLY RESPONSIBLE PARTY (mandatory if patient is a minor): ☐ **Self (skip to number 6)**

Name: _____ Relationship: _____ Date of Birth: _____

Address- if different than patient: _____ Phone: _____

Employer: _____ Employer Phone: _____

6. EMERGENCY CONTACT (preferably not residing with patient)

Name: _____ Relationship: _____ Phone: _____

Can we release Protected Health Information to this person: ☐ Yes ☐ No

7. INSURANCE INFORMATION: ☐ **Self (skip to number 8)**

Subscriber's Name: _____ Date of Birth: _____ SSN: _____

Address- if different than patient: _____ Phone: _____

Subscriber's Employer: _____ Employer Phone: _____

8. OTHER INFORMATION: May we contact you or leave a detailed message regarding your health care information?

(check all that apply) ☐ Text ☐ Phone / Voicemail ☐ Email

9. APPOINTMENT POLICY:

If you are running late or need to reschedule, please call the office and we will do our best to accommodate you.

To respect the time of all our patients and providers, ONLY patients with appointments will be seen
If you are going to be more than 10 minutes late, you may be asked to reschedule
If you do not call and do not show for your appointment: First time = No charge
Any time there after = $30.00 charge

UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ THE FOREGOING AND IS THE PATIENT OR IS DULY AUTHORIZED BY OR ON THE BEHALF OF THE PATIENT TO EXECUTE THE ABOVE AND ACCEPT ITS TERMS

Signature: _____ Relationship to patient: _____ Date: _____

Financial Policy for Grand Island Ear, Nose and Throat Clinic

As a patient of **The Grand Island Ear, Nose and Throat Clinic**, you are required to sign a financial responsibility and authorization for treatment form that will be a permanent part of your file.

Forms of Payment: We accept cash, checks, Visa, MasterCard, American Express, and Discover. WE DO NOT PARTICIPATE WITH CARE CREDIT.
A returned check fee of $35.00 per check returned from your bank for non-payment or insufficient funds is assessed to the patient's account.

Copayments: Your insurance REQUIRES that we collect your designated co-pay **at the time of service.** Please be prepared to pay the co-pay at the time of each visit.

Outstanding Balances: All outstanding balances are the responsibility of the patient (after we have received payment from your insurance company). If you are unable to pay your balance in full, please contact our billing office (308-384-5700) to arrange a payment plan. Our office does not assign interest or late fees to accounts, and we expect accounts to be paid for in full within 2 years.
Payment schedule below:

$0.00-500.00	Needs to be paid within 6 months
$500.00-1500	Needs to be paid within 12 months
$1500-2500	Needs to be paid within 18 months
$2500 & above	Needs to be paid within 24 months

Estimated Surgical Deposits: Should you require surgery, you are responsible for all fees incurred. These fees can include co-payments, co-insurance, deductibles and any out-of-pocket expenses for our surgeon's fee, which your insurance company makes you responsible for. You may be required to make a partial or full deposit for the physician fee **PRIOR TO YOUR SURGERY and your account balance must be in good standing.** Our surgery coordinator will contact you with information pertaining to the amount you will be responsible for. Please be aware that our surgeons' fees are separate from the hospital or surgery center, anesthesiologist, and pathology.
FAILURE TO PAY THESE FEES CAN RESULT IN RESCHEDULING OR CANCELLATION OF YOUR SURGERY.

Insurance: We are not an AMBETTER Provider. Our office accepts most insurance and we will submit a claim to your insurance company on your behalf. Some services may not be covered, and you will be responsible for 100% of those charges.
If you decide to see one of our physicians that does not participate in your insurance plan, you will be responsible for all fees and charges. **It is the patient's responsibility to check if our physicians are in network with their insurance company.**

Referrals: If your insurance company requires a referral from your primary care physician, it is your responsibility to obtain the referral prior to your appointment and have those papers with you at the time of your appointment.

Workers Compensation: Patients will be financially responsible for services related to accidents/workers comp which are denied. Please have injury/accident information available at your appointment, such as Date of Injury, claim number, Insurance Company address, phone number and contact person.

Patient Signature/Responsible Party Date

Today's date: _____ **Patient name:** _____ **DOB:** _____

List of medications: (please include dosage and OTC drugs/supplements)

_____

_____

_____

_____

_____

Allergies: _____

_____

General Medical History: (check all that apply past or present)

☐Asthma ☐Sleep apnea ☐COPD ☐CPAP ☐Bleeding/clotting issues ☐AIDS/HIV ☐Hepatitis

☐High Blood Pressure ☐History of A-fib ☐History of stroke ☐Kidney disease

☐Diabetes ☐Migraine ☐Osteoporosis ☐Anesthesia complications_____

☐Heart surgery_____ ☐Pacemaker (please show card) ☐Joint replacement_____

☐Other_____

☐Other_____

Patients age 64 and older only:

Do you have a health care proxy? (a legal document appointing someone to make healthcare decisions on your behalf

☐ No

☐ Yes-please provide details:

Name: _____

Phone #: _____

Do you have a living will? ☐ Yes ☐ No

(a legal document that specifies the medical treatments you would or would not want to receive if you are unable to make decisions for yourself. It also outlines preferences for other medical decisions, such as pain management or organ donation)

Which statement(s) best reflects your wishes on advanced care recommendations?

☐ Do Not Intubate: I do not wish to have a breathing tube, even if it is necessary to save my life.

☐ Do Not Resuscitate: If my heart were to stop, I do not wish to have chest compressions or an automated external defibrillator to restart my heart, even if it's necessary to save my life.

☐ Full Cardiopulmonary Resuscitation: I want full cardiopulmonary resuscitation efforts to be made

Have you received a pneumonia vaccination on or after your 60th birthday? ☐ Yes ☐ No

_____

Patient Signature/Responsible Party Date