Patient Registration

Referred to our office by: ______________________________ Patient Account #: ____________
(Office use only)

Patient Name: ____
(Last Name) (First Name) (Middle Initial)

Patient Soc Sec #: ______________________ Patient Date of Birth: ____________ Age: _____

Patient Gender: M / F Patient Marital Status: __S __M __D __W Patient Preferred language: ____________

Patient Race: ________________ Patient Ethnicity: ________________

Patient Home Address: ____

City: ______________________________ State: ________ Zip Code: ____________

Home Phone #: ______________________ Alternate #: ________________ Cell___ Work __

Email address: ____

Insurance Information

(Please provide information for the insured/person who provides the coverage **Please have cards ready to scan)

Name of **Primary** Insurance: ________________________ Policy / ID #: ________________

Group # (if any): ____________ **Policyholder's Employer**: ________________________

Name of Policyholder: ________________________ Policyholder's DOB: ________________

Policyholder's SS #: ________________________ Relationship to patient: ________________

Name of **Secondary** Insurance: ________________________ Policy / ID #: ________________

Group # (if any): ____________ Policyholder's Employer: ________________________

Name of Policyholder: ________________________ Policyholder's DOB: ________________

Policyholder's SS#: ________________________ Relationship to patient: ________________

Emergency Contact

Name: ____________________ Phone #: ________________ Relationship: __________

Insurance Assignment / Billing policy of the office

I hereby authorize payment directly to the physician for medical and/or surgical benefits. I acknowledge that if this office is non-participating with my insurance, that I am responsible for payment on the date of service. I understand that I am responsible for any amount not covered by insurance including co-pays, deductible or co-insurance set forth by my insurance company. I understand co-pays are due on the date of service. I authorize the physicians of this office to release any information in the course of treatment to ONLY my insurance company upon their request. I understand this office will not engage in matters involving third party personal billing resulting in custody, court order or personal circumstances (if patient is a minor). I understand that if my insurance is an HMO, that I must obtain a referral from my primary care physician prior to services being rendered. I fully understand the insurance assignment and billing policies of this office. I certify that all information provided is accurate and correct.

____ ____________

Patient Signature or Legal Guardian if patient is a minor Date of signature

Patient Name: ____ DOB: ____/____/____

Primary Care Doctor: ________________________________ PCP phone #: _______________________

Medications that you are CURRENTLY taking: ____

____

____

Medication Allergies (list all and reactions): ____ ( ) None Known

____

Patient Height: _________ Weight: _________ Pharmacy name & phone#: _______________________________

Past medical history (check all that apply)

___ Hypertension ___Gastroesophageal reflux disease (GERD) ___Asthma

___Diabetes (type I___ type II___) ___Hepatitis (A or B or C) ___Liver disease

___Coronary artery disease ___Atrial Fibrillation ___Sleep apnea

___Thyroid disease ___Emphysema ___Psychiatric condition

___Seizure ___Migraine headaches ___Stroke

___Kidney disease/failure ___Malignant hyperthermia ___Cancer (site ________________)

Please note any other medical conditions: ____

____

Review of systems (check all that apply)

___fevers ___constipation ___Incoordination ___nipple discharge

___chills ___diarrhea ___lightheadedness ___vaginal discharge

___itchy skin ___nausea or vomiting ___spinning sensation ___runny nose

___frequent colds ___difficulty hearing ___shortness of breath ___nose bleeds

___swollen glands ___light sensitivity ___chronic cough ___nasal obstruction

___headaches ___change in vision ___coughing up blood ___sinus infections

___heartburn ___blood in urine ___easy bleeding/bruising ___neck stiffness

___difficulty swallowing ___blood in stool ___enlarged lymph nodes ___neck pain

___change in voice ___limb weakness ___change in sleep pattern ___CPAP use

Past surgical history and approximate date(s): ____

____

Are there illnesses that run in your family? (yes / no) What? _____________________________________

Are you on a blood thinner? (yes / no) Name: ____

Do you use tobacco products? (yes / no) Have you ever used tobacco products in the past? (yes / no)

What product, how much, low long ago, and (if applicable) how long have your quit? __________________

Do you drink alcohol? (yes / no) Do you use recreational drugs? (yes / no) If so, what? _______________

Have you had a flu shot this year? (yes / no) If so, approximate date? ______________

Have you seen another physician for the condition you're being seen for today? ______________________

Are there any imaging studies (xr-ays/CT/MRI) performed for this condition? (yes / no) If so, where? ____________

______________________________________ ______________ Physician Reviewed _________

Signature of patient or legal guardian Date Date______________

OAKLAND ENT

6900 Orchard Lake Road, #314, West Bloomfield, MI 48322 (248) 855-7530 Fax (248) 855-5639
4600 Investment Drive, #170, Troy, MI 48098 (248) 267-5004 Fax (248) 267-5007

Office Billing Policy:

(This form requires a signature)

Insurance copays will be collected on the date of service. If you are not able to pay your copayment today, please reschedule your appointment. For your convenience, our office accept checks, Visa, Mastercard, Discover, American Express and cash.

There will be a $5.00 per month statement fee that will be charged to your account each month if our office has to mail a statement to collect for an office copay.

It's our office policy to verify eligibility for ALL insurances on the date of service. If we determine your policy is in the "grace period," you will be informed and have the option to reschedule your appointment. Our office reserves the right to collect IN FULL for services rendered on the date of service and thereafter, if there's a lapse in coverage and/or termination of the plan.

We reserve the right to collect ANY and ALL balances IN FULL on the date of service, prior to being seen.

Private pay (no-insurance) must pay IN FULL on the date of service, prior to being seen.

Our returned check fee is $35.00. In addition, there will be a $5.00 statement fee.

****There is a $50.00 charge for ALL scheduled appointments that you DO NOT show for.**

We require 24 hour notice for cancelled and/or rescheduled appointments. The office reserves the right to refuse rescheduling future appointments after several cancelled and/or rescheduled appointments.

If after 90 days, we have not received payment from your insurance company, our office reserves the right to send the entire bill to the patient for payment. It will be your responsibility at that point to contact your insurance company with any questions or concerns regarding your bill.

Due to many changes to insurance policies, it is no longer an easy task to interpret each individual policy. Although we try to stay on top of these changes, it is not always possible. **It is your responsibility to know the special terms, deductibles and/or copays of your insurance coverage.** Failure to notify us will result in non-covered expenses which will be your responsibility.

If your insurance (HMO) requires you to have a written referral, it is the responsibility of the patient to obtain PRIOR to the appointment. If you do not have the referral, you will need to reschedule your appointment.

Please remember your insurance policy is between you and your insurance company and not with the insurance company and your doctor.

The intention of this notice is to clarify our office policies and procedures and promote good communication between our patients and our office.

I understand the billing procedures associated with this office and completely understand additional charges will be incurred if I fail to comply. I agree to pay ANY balance IN FULL as set forth by my insurance company and/or charges set forth by this office.

______________________________ ____________________________________
Print patient name Signature of patient and/or guardian if under 18 yrs old

_______________________ __________________
Relationship to patient Date of signature

HIPAA OMNIBUS RULE

Patient Acknowledgement of Receipt of Notice of Privacy Practices And Consent / Limited Authorization & Release Form

You may refuse to sign the acknowledgement & authorization. In refusing, we will not be allowed to process your insurance claims.

Date: ____________________

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for the healthcare providers of this office. A copy of this signed, dated document shall be as effective as the original. **My signature will ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTORS AND/OR FACILITY IN THE FUTURE.**

________________________________ ________________________________

Please PRINT patient name Signature of Patient and/or Legal Guardian

____

Signature of Witness / Office Representative

Comments (if any) regarding Acknowledgment of Consent: ________________________________

____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes Parent(s), Step-parent(s), Grandparent(s), Sibling(s) and any other Caregiver(s) who can have access to patient's protected health information):

Spouse: ________________________________ ___Yes ___No

Parent: ________________________________ ___Yes ___No

Other: ________________________________ ___Yes ___No Relationship: ______________

Other: ________________________________ ___Yes ___No Relationship: ______________

I authorize contact from this office to CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFO via:
___ Cell phone ___Home phone ___Work phone ___ Email ___ Facsimile ___ **ALL INCLUDED**

I authorize INFORMATION ABOUT MY HEALTH be conveyed via:
___Cell phone ___Home phone ___ Work phone ___Email ___ Facsimile ___**ALL INCLUDED**

In signing this HIPAA Patient Acknowledgment Form, you have acknowledged and authorized, that this office may recommend products or services to promote your improved health. We understand current HIPAA Omnibus Rule and provide you this information with your knowledge and consent.

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Office Use Only: I attempted to obtain written authorization of receipt of Notice of Privacy Practices, but acknowledgement could not be obtained because: ___ Individual refused to sign ___ Communication barrier ___ Emergency situation occurred with patient ___ Other (explain): ________________________________

________________________________ (Signature of Privacy Official)