LAST NAME: _____ FIRST NAME: _____M.I.: _____

DATE OF BIRTH: _____ GENDER: _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE #: _____ CELL PHONE #: _____

OCCUPATION: _____ BUSINESS PHONE #: _____

SPOUSE'S NAME: _____ SPOUSE'S PHONE #: _____

PATIENT EMAIL: _____

PHARMACY NAME: _____ ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

EMERGENCY INFORMATION—IN THE EVENT OF AN EMERGENCY PLEASE NOTIFY:

NAME:_____ RELATIONSHIP:_____PHONE #:_____

INSURANCE INFORMATON—POLICY HOLDER:

NAME OF POLICY HOLDER: _____RELATIONSHIP: _____DATE OF BIRTH: _____

HOW WERE YOU REFERRED?/HOW DID YOU FIND OUR PRACTICE?

☐INSURANCE PLAN ☐INTERNET SEARCH ☐FRIEND/RELATIVE
☐PHYSICIAN/HOSPITAL(NAME)_____ ☐OTHER_____

CONSENT FOR TREATMENT/AUTHORIZATION FOR RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS AND FINANCIAL POLICY, RECEIPT OF PRIVACY NOTICE/HEALTH INFORMATION USE NOTICE

-**I consent to examination and treatment that may be required during my office visit. I authorize any emergency care that is deemed necessary by the physician or physician assistant during the visit. I understand that I am seeking care from a specialist in otolaryngology, who may determine that it is necessary to perform a nasal endoscopy or laryngoscopy as part of the examination.**

-I authorize University Head and Neck Associates to release to my insurance company or its representatives, any information regarding my diagnosis and/or records of any treatment or examination rendered to me that is required to process my claims for benefits.

-I authorize and request my insurance company pay directly to University Head and Neck Associates the amount due to me in pending claims for medical treatment/services, by reason of such treatments or services rendered to me. This assignment will remain in effect until revoked by me in writing.

-I understand that I am directly responsible for services rendered which are not paid by insurance, including charges allocated to my deductible and co-insurance. (See payment policy for more details.)

-I certify to the best of my knowledge, the information contained on this Patient Registration Form is correct and true. I will notify University Head and Neck Associates in the event of any changes in the information contained on any/all form(s) completed.

-I acknowledge having been provided with a copy of University Head and Neck Associates' Patient *Privacy Notice, also available on their website*. The notice provides detailed information about how University Head and Neck Associates may use and disclose a patient's protected health information. I understand the privacy practices described in the notice may change.

X_____

PATIENT OR LEGAL GUARDIAN SIGNATURE DATE

HIPAA Disclosure Form

Patient Name: _____ Date of Birth: _____

Address: _____

Cell Phone No. _____ Home Phone No. _____

Email Address: _____

Midwest Sinus Center Physician: _____

May we identify ourselves over the phone? ☐ Yes ☐ No May we leave messages? ☐ Yes ☐ No

I, the Patient, hereby authorize the doctor and/or hospital listed above to release my medical information. (appointments, lab/imaging results, diagnoses, treatments, medications, surgeries, etc.) via postal mail, telephone, fax, or email to the following family members:

Name: _____ Phone: _____ Relationship: _____
Name: _____ Phone: _____ Relationship: _____
Name: _____ Phone: _____ Relationship: _____
Name: _____ Phone: _____ Relationship: _____
Name: _____ Phone: _____ Relationship: _____

I further release my medical information to the following physicians, clinics, and/or hospitals:

Doctor: _____ Clinic: _____ Phone: _____
Doctor: _____ Clinic: _____ Phone: _____
Doctor: _____ Clinic: _____ Phone: _____
Doctor: _____ Clinic: _____ Phone: _____
Doctor: _____ Clinic: _____ Phone: _____

Signature: _____ Date: _____

University Head and Neck Associates

The Midwest Sinus Center

UNIVERSITY HEAD AND NECK ASSOCIATES' PAYMENT/BILLING POLICY

We want to thank you for choosing our practice for your Ears, Nose and Throat care. It is important to us that you are fully informed of our payment policy.

PAYMENT EXPECTED AT TIME OF SERVICE:

Payment is required at the time services are rendered unless other arrangements have been made in advance. This includes applicable co-insurance and co-payments for participating insurance companies. University Head and Neck Associates, S. C. ("UHANA") accepts cash, VISA, MasterCard and Discover. There is a service charge of $25.00 for returned checks.

Patients with an outstanding balance of 90 days or more must make arrangements for payment prior to scheduling appointments.

If your account is forwarded to collections by UHANA there will be a charge of $50 to cover administrative expenses incurred in submitting a claim to a collection agency, in addition to any amount owing.

REFUNDS:

Patient/guarantor credits in amounts less than $50 will be retained on account to be credited toward future balances unless a written request for a refund is received. Amounts of $50 or greater will be automatically refunded to the patient/guarantor.

INSURANCE:

It is the patient's responsibility to provide their current insurance card and or referral at the time of service. If you fail to provide your current insurance/referral information, it may be necessary to reschedule your appointment. We bill participating insurance companies as a courtesy to you. You are expected to pay your co-payments at the time of service. If we have not received payment from your insurance company or if payment is denied with 45 days of the date of service, you will be expected to pay the balance in full. You are responsible to be sure all charges are paid whether, by you or by your insurance carrier.

Please note your insurance plan determines your co-pay/co-insurance/deductible; your plan also determines what services it covers and does not cover. Your Explanation of Benefits should outline this information.

MANAGED CARE:

If you are enrolled in a managed care insurance plan (i.e. PPPG, HMO) you must receive a referral from your primary care physician before seeing a specialist. Retroactive referrals are not always a guarantee for payment.

MEDICAL EXPENSES RELATING TO A CLAIM AGAINST A THIRD PARTY:

Patients shall be financially responsible for medical services related to any accident, personal injury, or worker's compensation claim. It is also the patient's responsibility to notify UHANA if the service is due to such incidents. While we will assist our patients to the extent possible in such situations, UHANA does not bill any third-party insurer.

DISABILITY/FMLA/INSURANCE/ OTHER THIRD-PARTY FORMS:

A $25.00 flat fee, pre-paid will be charged for 3 or more pages. Please allow 7 – 10 business days for them to be completed.

I have read and understand the Payment Policy of UHANA. I agree to assign insurance benefits to UHANA whenever necessary. I also agree that if my account must be sent to a collection agency, in addition to the amount owed, I will also be responsible for a $50 fee.

_____

Printed Name

_____ _____

Signature of insured or authorized representative Date

University Head and Neck Associates

THE MIDWEST SINUS CENTER

24 Hour Cancellation & "No Show" Fee Policy

As a practice, our goal is to offer the best possible care to our patients, and we recognize that everyone's time is valuable. We understand that circumstances may arise which make it impossible for you to keep your scheduled appointment.

While we are understanding of such circumstances, we do require that you provide a 24-hour notice if you are unable to keep your appointment. Each time a patient misses an appointment without proper notice, another patient is prevented from receiving care.

Therefore, the physicians of University Head and Neck Associates reserve the right, at their discretion, to charge a fee of **$50.00** for all missed appointments not cancelled within a 24 hour advance notice period ("No Shows"), unless there is a compelling reason for the failure to give notice.

If you fail to provide a 24-hour notice of cancellation of an **in-office procedure** that has been scheduled in advance of your appointment, we reserve the right, at our discretion, to charge a No Show fee of **$100.00**, unless there is a compelling reason for failure to give notice.

If you fail to provide a 24-hour notice of cancellation of an **in-hospital or in-surgical center procedure** that has been scheduled in advance of your appointment, we reserve the right, at our discretion, to charge a No Show fee of **$250.00**, unless there is a compelling reason for failure to give notice.

No Show fees will be billed to the patient. These fees are not covered by insurance and must be paid prior to your next appointment. Multiple No Shows in any 12-month period may result in termination from our practice.

Thank you for your understanding and cooperation as we strive to best serve the needs of all our patients.

By signing below, you acknowledge that you have received this notice and understand this policy.

_____ _____

Printed Name **Date**

_____

Signature