Arkansas Ear, Nose, & Throat

Please print the completed forms and bring to your appointment.

Personal Information:

Today's Date: _____

Name: _____ _____ _____ SSN: _____
First *MI* *Last*

Address: _____ _____ _____ _____
Street *City* *State* *Zip*

Phone: _____ _____ _____
Home *Cell* *Other*

Date of Birth: _____ Age: _____ Gender: ☐ M ☐ F Marital Status: ☐ S ☐ M ☐ D ☐ W

Occupation: _____ Employer: _____

Employer Address: _____ Phone: _____

Referring Physician: _____ Phone: _____

For Minor Patients:

Parent / Guardian Name: _____ Relationship: _____

Date of Birth: _____ SSN: _____ Phone: _____

Emergency Contact:

Name: _____ Relation: _____ Phone: _____

Insurance Information:

Primary Insurance: _____ Relation to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Name of policy holder: _____ Policy holder's DOB: _____

Secondary Insurance: _____ Relation to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Name of policy holder: _____ Policy holder's DOB: _____

RELEASE OF RECORDS

I authorize the release of personal health information to the following person(s): _____

NOTICE REGARDING INSURANCE CLAIMS / PAYMENTS

I authorize Arkansas, Ear, Nose, & Throat PA to release personal health information necessary for payment purposes in accordance with HIPAA regulations. I assign the claim payment to be made to Arkansas Ear, Nose, & Throat, PA. I understand that this authorization may be revoked at any time by written notice. By signing below, I acknowledge that I will be responsible for all billable services not covered by insurance.

Patient / Guardian Signature: _____ Date: _____

PATIENT HEALTH HISTORY

In order for your doctor to provide the best possible care, it is important that we obtain this information. Please complete the information below fully and to the best of your knowledge.

Patient Name: _____ _____ _____
Last *First* *MI*

Address: _____ _____ _____ _____
Street *City* *State* *Zip*

Phone (Home): _____ **Phone (Cell):** _____

Sex: __M __F **Date of Birth:** _____ **Height:** _____ **Weight:** _____ **Marital Status**: __S __M __W __D

Employer: _____ **Occupation**: _____ **Phone**: _____

Referring/Primary Physician: _____ **Phone:** _____

Preferred Pharmacy: _____ _____ _____
Name *Location (Street & City)* *Phone*

REASON FOR TODAY'S VISIT: _____

PLEASE LIST ANY MEDICATIONS YOU ARE TAKING

Name of Medication	Dosage	How Often Taken

ARE YOU ALLERGIC TO ANY MEDICATIONS? __Yes __No

If YES, please complete the information below.	
Name of Medication	**Type of Reaction**

SURGERIES, TESTS, AND HOSPITALIZATIONS

Have you ever had any problems with anesthesia (being numbed or put to sleep)? __YES __ NO

If YES, please explain the type of problem: _____

PLEASE LIST ANY SURGERIES THAT YOU HAVE HAD

Type of surgery	Reason for surgery	Date

Have you ever been hospitalized for non-surgical reasons? __YES __NO

If YES, please explain the reason(s): _____

Immunizations	Most recent date
Influenza	
Pneumonia	
COVID-19	
COVID-19 booster	

Screening	Most recent date
Colorectal cancer	
Breast cancer	
Cervical cancer	
Prostate cancer	

COVID-19
Have you ever had COVID-19? __Y __N
If YES, when? _____
Have you been tested recently? __Y __N
If YES, when? _____ Results? _____

Financial Policy

Thank you for choosing Arkansas Ear Nose & Throat as your healthcare provider. We are committed to providing you with the best possible care. Your clear understanding of this Financial Policy is important to our professional relationship. Please do not hesitate to ask any questions that you may have about it, fees, or your responsibility.

Insurance Coverage: Your insurance coverage is a contract between you and your insurance company. We are not a party to that contract. It is important for you to understand your insurance policy's terms, limitations, rules, coverage, deductible, co-insurance, referral, and pre-authorization requirements. You should contact your insurance company for any questions regarding your coverage.

- **Payment for services is due prior to services being provided**. If your visit is covered by insurance, your co-payment is due at the time of service. If your procedure is considered non-covered, full payment in advance of the service will be required. If you do not have insurance or if we do not accept your insurance, payment in full is due at the time of service.
- **Co-payments are due prior to services being provided and will be collected at check-in**. You will also be reminded at check-in of any outstanding balances remaining on your account that must be paid in full. You can also discuss your account if you have any questions about your balances.

Usual and Customary Rates: Our practice is committed to providing the best treatment for patients and we charge what is usual and customary for our area.

- If we are a participating provider with your insurance plan, we will accept their approved reimbursement as payment for covered services **after** all owed deductibles, co-payments, and non-covered services have been paid for by you at the time of service.
- If your insurance does not pay for services as expected, including Medicare and Medicaid, for reasons such as (but not limited to) determination that the service is not medically necessary, or the maximum benefit has been exceeded you will be responsible for the balance.
- We file insurance claims as a courtesy to our patients. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, co-insurances, covered charges, secondary insurance, etc. other than to provide any information necessary. The patient is ultimately responsible for their account balance and the timely payment of their account.

Motor Vehicle Accidents: In the event you are involved in a motor vehicle accident, you are expected to pay for services when rendered. We will provide you with all the necessary paperwork to file your insurance claim with your carrier.

Missed Appointments: Patients who fail to show up for an appointment, without providing at least 24-hour advance notice, will be subject to a $50 missed appointment fee.

Nonpayment: Account balances over 60 days of billing will be considered for referral to a collection agency. As a result, you may be dismissed from the practice.

Assignment of Insurance Benefits:

I request that payment of insurance benefits be made on my behalf to Arkansas Ear Nose & Throat, PA for any services furnished to me by any provider at this clinic. I authorize any holder of medical information about me to release my information needed to determine benefits to my insurance carrier, and where applicable, to the Center for Medicare and Medicaid Services and its agents. I further authorize the clinic or its agents to verify employment date and wage data in the event collection action becomes necessary.

_____	_____	_____
Signature of patient or responsible party	Print name	Date

We accept personal **checks, cash, Discover, Mastercard and Visa** in meeting your payment obligations.