SPIROS MANOLIDIS MD
OTOLARYNGOLOGY
OTOLOGY-NEUROTOLOGY
HEAD / NECK SURGERY
SKULL BASE SURGERY

PATIENT REGISTRATION INFORMATION

Patient Name: _____ **Date of Birth:** _____ **Gender:** ❑ Male ❑ Female

Race: _____ **Preferred Language:** _____ **Ethnicity:** ❑ Hispanic ❑ Non Hispanic

Address: _____

City: _____ **State:**_____ **Zip:** _____ **Phone:** _____

Email: _____

Emergency Contact: _____ **Phone:** _____

Emergency Contact: _____ **Phone:** _____

PRIMARY Insurance Carrier: _____ ❑ HMO ❑ PPO ❑ EPO ❑ POS

Insurance ID: _____ **Are you the policy holder?** ❑ Yes ❑ No

If NO, please provide information on the primary policy holder:

Name: _____ **Date of Birth:** _____ **Relationship to Patient:** _____

Claims Address: _____

SECONDARY Insurance Carrier: _____ ❑ HMO ❑ PPO ❑ EPO ❑ POS

Insurance ID: _____ **Are you the policy holder?** ❑ Yes ❑ No

If NO, please provide information on the primary policy holder:

Name: _____ **Date of Birth:** _____ **Relationship to Patient:** _____

Claims Address: _____

Patient is financially responsible unless the patient is a minor child or guardian. This is a consent prepared according to guidelines presented by the Texas Family Code (Section 35.01).

❑ I will be held responsible ❑ The patient is a minor or guardian

If the patient is a minor or guardian, please indicate the patient relationship to the responsible party:

❑ Child ❑ Other, please specify: _____ Responsible party's date of birth: _____

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ASSIGNMENT OF BENEFITS/RELEASE OF INFORMATION/NOTICE OF PRIVACY PRACTICES/APPOINTMENT OF AUTHORIZED REPRESENTATIVE

Please read:

Texas Health Care (THC), and it's physicians are committed to securing the privacy of your health information. Accordingly, we have posted our "Notice of Privacy Practices" in the reception area. You are not required to read this notice. However, we would like your acknowledgement that you have been advised that THC has such a Notice of Privacy Practices and have reviewed the office's Notice of Privacy Practices, which explains how your medical information will be used and disclosed. You are entitled to receive a copy of the Notice of Privacy Practices.

I hereby assign, transfer and set over to THC, all of my rights, title and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits, including medical, surgical, psychiatric and/or substance abuse (drug or alcohol) information. This authorization shall remain valid until written notice is given by me revoking said authorization.

I understand that this order does not relieve me of my obligation to pay such bills if not paid/covered/found medically necessary by my commercial/third party/government plan or insurance company. I am also financially responsible for any balances due after payments by my insurance company.

I appoint THC to act as my authorized representative in requesting an appeal from my insurance plan regarding its denial of services or denial of payment.

All charges are due at the time of service. If surgery is indicated, I am responsible for furnishing insurance claim forms to the office prior to surgery.

PATIENT/GUARDIAN SIGNATURE _____ **DATE** _____

PRINTED PATIENT/GUARDIAN NAME _____ **DATE OF BIRTH** _____

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CONSENT FOR DIAGNOSTIC TESTS/PROCEDURES THAT MAY BE NECESSARY TO FULLY DIAGNOSE AND TREAT YOUR CONDITION

We are pleased you have chosen Dr. Manolidis to assist in your care. He feels that a patient presenting to our office with sinus, nose, throat, hearing or voice complaints require a thorough examination of that specific area. In some cases, this can only be accomplished through the use of diagnostic tests/procedures, which he may feel is medically necessary. The tests and/or procedures are separate from the physician's office consultation and thus have a separate charge. For example, insurance companies may consider the nasal endoscopy and laryngoscopy a "diagnostic procedure" and apply them to your deductible and/or co-insurance. The following list are the most commonly performed test/procedures that Dr. Manolidis may feel is medically necessary to perform, but by no means is this a comprehensive list:

- Nasal Endoscopy (31231)
- Laryngoscopy (31575)
- Cerumen Impaction Removal (69210)
- Binocular Microscopy (92504)
- Cavity Care (69220 and 69222)
- Foreign Body Removal (69200)

Please note that we collect all co-insurance and unmet deductibles at the end of your visit. Should you have questions regarding any proposed test/procedure, potential risks and benefits, possible complications, possible risks and benefits of not undergoing this procedure, alternative methods, or your financial responsibility of the proposed test/procedure, please ask Dr. Manolidis during his explanation of the test/procedure and prior to the physician performing the test/procedure. No guarantee or assurance can be given as to the results that may be obtained from this test/procedure. Please sign below to acknowledge that you have read the above and understand your financial liability.

PATIENT/GUARDIAN SIGNATURE _____ **DATE** _____

PRINTED PATIENT/GUARDIAN NAME _____ **DATE OF BIRTH** _____