ADVANCED
EAR NOSE THROAT
ASSOCIATES

Dr. Kunal Thakkar

1560 Roberts Drive
Jacksonville Beach, FL 32250

4205 Belfort Road
Joe Adams Building,
Suite 2005
Jacksonville, FL 32216

Phone: (904) 339-0350
Fax: (904) 339-0351

www.jacksonvilleadvancedent.com

Dear Patient of Advanced Ear, Nose, Throat Associates,

Enclosed please find forms to be filled out **prior to your visit** with Advanced Ear, Nose, Throat Associates. Please complete the forms and **bring them with you along with your insurance card to your visit.**
If you have had any recent tests, x-rays or lab work that may be pertinent to your visit, call us and let us know so we may call for your results. You may have the results of your tests, x-rays or lab work faxed to us at (904) 339-0351. If you have had a CT scan or an MRI please bring the film/disc in with you.

Our offices are open Monday through Friday, 8 am to 5 pm should you have any questions concerning your visit, please give us a call at (904) 339-0350.

Thank You,
Advanced Ear, Nose, Throat Associates

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# PATIENT INFORMATION FORM

Date:_____

Patient Name: (**Last, First**) _____ Birth date: _____

SSN: _____ Marital Status: Married ( ) Single ( ) Divorced ( ) Widowed ( ) Separated ( )

Mailing Address:_____

City: _____ St_____ Zip _____Home Phone: _____ Cell Phone:_____

**E-mail Address:** _____ **Pharmacy:** _____

**Employer Information:**

| | |
|---|---|
| Patient or Responsible party (if minor or student) employed by: _____<br>Occupation: _____<br>Business Phone: _____ | Spouse Name: _____<br>Spouse employed by: _____<br>Occupation: _____<br>Business Phone: _____ |

**Health Insurance Information:**

| **Primary Insurance:** | **Secondary Insurance:** |
|---|---|
| Company Name:_____ | Company Name:_____ |
| Policy/ID #: _____ | Policy/ID #: _____ |
| Group #: _____ | Group #: _____ |
| Claims Address: _____<br>_____ | Claims Address: _____<br>_____ |
| Subscriber Name: _____ | Subscriber Name: _____ |
| Relationship to patient: _____ | Relationship to patient: _____ |
| Subscriber SSN: _____ | Subscriber SSN: _____ |
| Subscriber Birth Date: _____ | Subscriber Birth Date: _____ |

Primary Care Physician: _____ Referred By: _____

Other family members seen by our Physicians: Name: _____

I hereby authorize Advanced ENT Associates, to bill my insurance company directly for these services. I understand I am financially responsible for charges not covered by my insurance company.

I authorize any holder of medical or other information about me to release to the social security administration or intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical benefits either to myself or the party who accepts assignment.

Signature of patient or guardian _____

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# AUTHORIZATION TO RELEASE INFORMATION

## TO FAMILY/ FRIENDS (PLEASE BE SPECIFIC)

I, _____authorize my information to be given to:
(Patient Name)

Name: _____ Phone : _____ ☐ Please check here if you wish to make emergency contact.

Name: _____ Phone : _____ ☐ Please check here if you wish to make emergency contact.

Name: _____ Phone : _____ ☐ Please check here if you wish to make emergency contact.

regarding the **initialed** items below. I understand that by signing this form **only** the person(s) designated above is/are allowed to obtain my information and they are **only** allowed to obtain information regarding the items that I have designated below. By **initialing** beside **All Information** I understand that the person listed above will have availability to all of my medical and personal information that the office of Advanced Ear, Nose, Throat Associates has on file. I understand that this written authorization will remain in my permanent record and will not change at any time unless I issue a written consent to discontinue and / or change this authorization.

_____ APPOINTMENT DATES/ TIMES
_____ TEST RESULTS
_____ OFFICE NOTES
_____ SURGERY INFORMATION
_____ INSURANCE INFORMATION
_____ ALL INFORMATION
_____OTHER_____

X_____ _____
Patient Signature Date

X_____ _____
Witness Signature Date

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# OFFICE PROCEDURE COVERAGE ACKNOWLEDGEMENT

I, _____, understand that if the physician performs
(Patient Name)
a procedure, such as a nasal endoscopy or laryngoscopy with a fiberoptic telescope, I may be responsible to pay more than just the standard office visit co-payment or co-insurance for this service. This payment may be in the form of a deductible or higher than normal co-payment.

_____ _____
(Patient/Guardian signature) (Date)

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AUTHORIZATIONS AND ACKNOWLEDGEMENTS

We are committed to providing you with the best possible care, and we are please to discuss our professional fees with you at any time. Please ask us if you have any questions about our fees, financial policy, or your payment responsibility.

All new patients will be asked to provide patient information prior to being seen by the physician. We also may ask to make a copy of any type of picture identification to remain a permanent part of your chart.

**INSURANCE INFORMATION**

- If you are covered by Medicare or any of our managed plans, we will file your insurance claim. You are responsible for any co-pay, co-insurance, deductible, or non-covered services at the time of our visit. If we do not participate with your insurance company, you will be responsible for full payment at the time of your visit.
- All self pay patients are expected to pay for services in full at the time that services are rendered.
- In the event your insurance company does not pay the full balance within 90 days, we will notify you so that you may contact your insurance carrier. Please remember that ultimately payment responsibility rests with the patient. Please advise our office personnel of any changes in your insurance or mailing address.
- Should it ever become necessary to use the services of a collection agency to collect your account, you would be responsible for any costs incurred for that purpose.

**UNACCOMPANIED MINORS**

The parents (or guardians) will be responsible for full payment unless covered by a participating managed plan. Authorization to treat an unaccompanied minor must be on file.

**COMPLETION OF FORMS**

Advanced Ear, Nose, Throat Associates reserves the right to charge a nominal fee for the completion of disability and/or Family Medical Leave forms.

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I hereby authorize Advanced Ear, Nose, Throat Associates to bill my insurance company directly for these services. I understand I am financially responsible for charges not covered by my insurance company. I authorized any holder of medical or other information about me to release to the Social Security Administration or intermediaries any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical benefits either to myself or to the party who accepts assignment. I certify that the insurance information is currently correct.

| _____ | _____ | _____ |
|---|---|---|
| Responsible Party Signature Patient's Name (Please Print) | Birth Date | Date |

**NOTICE OF PRIVACY PRACTICES**

I acknowledge receipt of a copy of the Advanced Ear, Nose, Throat Associates Notice of Privacy Practices (NPP) either at this time or previously, By accepting services at Advanced ENT, I authorized Advanced ENT to use and disclose information from and release copies of my (the patient's) medical records in accordance with Advanced ENT's policies and privacy practices, which are summarized in the NPP, including disclosure to my (the patient's) past, present and future healthcare providers.

_____

PATIENT or PARENT (GUARDIAN)