

Patient Registration – Stachler ENT
www.stachlerent.com

Please Furnish Insurance Cards and a Picture ID / Driver's License

Patient Name _____ Age _____ Birth Date _____

Primary Care Physician: _____ City: _____ Zip Code: _____ Office Phone: _____

Please Circle: Male / Female _____ Social Security#: _____ Marital Status: S M D W Other _____

Patient's Home Address: _____ City _____ State _____ Zip Code: _____

Patient's Home Phone: _____ Cell Phone: _____

Patient Email Address: _____ FaceBook: _____

Patient's Employer: _____ Work Phone: _____

Work Address: _____ If self-employed, name of business: _____

Spouse Name: _____ Birthdate: _____ Social Security#: _____

Spouse Employer: _____ Work Phone: _____

If patient is under parent/guardian's insurance:

Patient/Guardian Name _____ Birthdate: _____ Social Security#: _____

Address: _____ City: _____ State: _____

Phone: _____ Cell Phone: _____ Email: _____

Employer: _____ Work Phone: _____

Other Parent/Guardian Name: _____ Birthdate: _____ Social Security#: _____

Employer: _____ Work Phone: _____

Insurance Information

Name of Primary Insurance: _____ Contract# _____

Subscriber's Name: _____ Patient Relation to Subscriber: _____

Secondary Insurance (Supplemental Policy): _____ Contract# _____

Emergency Contact Name: _____ Phone: _____ Relation: _____

I / We authorize the physician to:

- 1.) Leave a message on my/our home phone. Yes No
- 2.) Speak to a family representative Yes No

regarding test results and subsequent recommendations. Exceptions are: _____

Under our professional and ethical obligations we are required to maintain physician-patient confidentiality and your privacy. Privacy policies of the Gramm-Leach-Bliley Act insure our professional and ethical obligations to you. Any release of information requires a separate written and signed authorization from the patient or legal guardian. _____ (Initial)

Signing of this document provides only consent for treatment at this time and forward until revoked in writing by the patient or legal representative. _____ (Sign & Date)

I hereby authorize payment directly to the physician for the medical and/or surgical services. I understand that if the physicians of this office are not providers of my insurance, or if I am not covered by insurance, then payment for services are my full responsibility. I agree to pay bank, credit bureau and office billing expenses for any delinquent accounts. I authorize the physicians of this office to release any information in the course of treatment to only the insurance company. I have read and fully understand this insurance assignment and agreement.

Patient Signature /or Legal Guardian if patient is a minor _____ Date _____

Please Circle: Mr. Mrs. Miss Ms Patient Name: _____ Date of Birth _____

Referred By: _____ Primary Care Physician _____

Review of Systems

Yes	No	<u>Cardiovascular</u>	Yes	No	<u>Hepatic (Liver)</u>	Yes	No	<u>Hematologic (Blood)</u>
<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell
<input type="checkbox"/>	<input type="checkbox"/>	Angina (Chest Pain)	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Disorder
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<u>Endocrine</u>	<input type="checkbox"/>	<input type="checkbox"/>	Transfusion
<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Other
<input type="checkbox"/>	<input type="checkbox"/>	Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<u>Pediatric (if applies)</u>
<input type="checkbox"/>	<input type="checkbox"/>	Irregular Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>	Abnormalities at birth
<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	<u>Neurologic</u>	<input type="checkbox"/>	<input type="checkbox"/>	Premature
<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Birth weight _____
		<u>Respiratory</u>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	How early _____
<input type="checkbox"/>	<input type="checkbox"/>	Asthma or wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>	Sleep Apnea (Breath holding)
<input type="checkbox"/>	<input type="checkbox"/>	Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>	<u>Gastro-Intestinal</u>	<input type="checkbox"/>	<input type="checkbox"/>	Snoring
<input type="checkbox"/>	<input type="checkbox"/>	Chronic Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	Hiatal Hernia/Reflux	<input type="checkbox"/>	<input type="checkbox"/>	<u>Allergy</u>
<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Bowel Obstruction	<input type="checkbox"/>	<input type="checkbox"/>	Previous Allergy Testing
<input type="checkbox"/>	<input type="checkbox"/>	Snoring	<input type="checkbox"/>	<input type="checkbox"/>	GI Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Previous Allergy Shots
<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>	Environmental (dust, mold)
		<u>Renal (Kidney)</u>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Seasonal (trees, grass, pollens)
<input type="checkbox"/>	<input type="checkbox"/>	Kidney Failure	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Food Allergies
<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	

Past Medical and Social History

Please list all medications currently taking _____

Preferred Pharmacy _____

_____	_____
_____	_____
_____	_____
_____	_____

Please list any medication allergies and the reactions you've had to them: _____

Past Surgical History: _____

Are you currently pregnant? _____ Are you HIV positive or at risk? _____

Do you use alcohol? _____ How often? _____ Do you sleep well? _____

Do you smoke? _____ How often? _____ Have you had cancer? _____

Reason for visit: _____

Patient Signature / Legal Guardian if patient is a minor _____

Date _____



Due to new government mandates, the following information needs to be added to your patient profile. Please circle, only one, which you identify primarily.

Primary Language:

- | | |
|------------------|--------------------|
| Mandarin Chinese | English |
| Spanish | Russian |
| French | Hindi / Urdu |
| Arabic | Portuguese |
| Bengali | Japanese |
| German | Decline to specify |
| Other: _____ | |

Race:

- American Indian or Alaska Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- White
- Decline to specify
- Other: _____

Ethnicity:

- Hispanic or Latino
- Not Hispanic or Latino
- Decline to specify

Patient Signature

Date

Patient Name

Account Number

STACHLER ENT CENTER
ROBERT J. STACHLER, M.D.
(248) 325-9653

**ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES**

Patient Signature

Date

Form S115

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO FAMILY MEMBER(S), GUARDIAN, AND OTHERS

First & Last Name of Patient: _____

Date of Birth: _____

I hereby authorize medical providers to discuss and/or release my protected health information with: (Please note that if the patient is a minor, each parent or guardian needs to be listed.)

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

STACHLER ENT
Head and Neck Surgery, Voice, Sinus & Allergy
Robert J. Stachler, MD, FACS

PATIENT INFORMATION AND CONSENT

Patient Name: _____

Date of Birth _____

Please initial all boxes and sign on the signature line

Thank you for choosing Stachler ENT. We take your healthcare very seriously. In order to take care of you in the best way and according to your wishes we need your permission for several different things. Please initial each section to indicate consent. Please inquire with staff if you wish to receive a full copy of the consent.

_____ I give permission to be treated by the providers and staff at Stachler ENT. Initialing indicates that you give us permission to provide you care. No means we are unable to treat you and you will not be brought into an exam room.

_____ I give permission to Stachler ENT to check my prescription eligibility and prescription history.

_____ I give permission to Stachler ENT to bill my insurance and acknowledge that I have been notified of the billing policy at Stachler ENT. This allows us to furnish your information to your insurance company for purposes of payment for services rendered. It also allows us to collect from you and funds not covered by your insurance such as co-pays and deductibles. Please be aware, we are unable to know in advance how your individual policy will handle the charges given the terms of your policy. Some common office-based care may be applied to a higher co-pay or be applied to your deductible. These portions of your charges will be your responsibility. Not initialing here would make you responsible for the full amount of the charges related to the services you receive according to our billing policy.

_____ If I am a member of a managed care health plan, I understand I have an obligation to obtain a referral from my primary care physician. If a referral is not obtained, I may be responsible for payment of services. Not initialing here would make you responsible for the full amount of the charges related to the services you receive according to our billing policy.

By signing this form I acknowledge that I am requesting evaluation and treatment from Stachler ENT. If I am a member of a managed care health plan, I understand I have an obligation to obtain a referral from my primary care physician. If a referral is not obtained, I may be responsible for payment of services. Referrals, copayments and deductibles for services rendered are your responsibility. Office procedures may be required to provide you appropriate care. Procedures might include nasal endoscopy, excision of lesions, biopsies, removal of impacted ear wax, and flexible fiberoptic laryngoscopy, or other office procedures deemed necessary by the provider. Some insurance companies bill these procedures under their "surgery" guidelines. You may be responsible for separate copay or deductible for "surgical" procedures after insurance payments and adjustments. I have the right to notify the provider prior to a procedure if I choose not to have the procedure; otherwise, my signature on this form represents consent for these commonly done procedures. I will assume liability if a diagnosis is delayed or missed due to my refusal.

This agreement is valid for the duration of your care for any of the providers at Stachler ENT. Please feel free to ask questions if you have any concerns regarding this agreement. You are responsible for the timely payment of your account.

Effective Period. This Consent Form will remain in effect until the day you withdraw your authorization, submit a written request revising your consent(s), or until such time as Stachler ENT ceases, whichever is sooner.

PLEASE READ THE ENTIRE CONSENT FORM BEFORE SIGNING BELOW

Signature of Patient or Patient's Legal Representative: _____ **Date:** _____

Patient's Printed Name: _____

Patient's Legal Representative Name (If Applicable): _____

STACHLER ENT
Head and Neck Surgery, Voice, Sinus & Allergy
Robert J. Stachler, MD, FACS
PATIENT CONSENT AND ACKNOWLEDGEMENT FORM

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

I consent to have Stachler ENT disclose my protected health information for payment, treatment and healthcare operations, and for such other purposes that are permitted under HIPAA regulations without written authorization. Notice of Privacy Practices available upon request.

OFFICE PROCEDURES/FINANCIAL POLICIES

I hereby give consent to Stachler ENT to provide treatment and service(s) the assigned provider may deem necessary. I authorize any holder of medical information about me to release to any appropriate insurance company and its agent's information needed to determine these benefits payable for related services.

- I understand and agree that (regardless of my insurance status); I am ultimately responsible for any balances on my account for professional services rendered.
- I understand that if Any insurance company requires a co-payment, it is my responsibility and is due at the time of service, otherwise a charge of \$10 will be incurred.
- I understand that I am responsible for charges not covered by my insurance policy, such as deductibles and or coinsurance.
- I understand that I am responsible for a fee of \$25.00 for any returned check.
- I understand that I am responsible for a fee of \$50.00 for not canceling an appointment 24 hours prior to the appointment time, or for a "no show" appointment.
- I understand that I should need private disability forms filled out by my provider that I am responsible for a fee of \$30.00.
- I understand that if my account becomes assigned to collection agency, I agree to pay a 25% collection fee, interest in the amount of 6%, court costs, and attorney fees, as allowed by law

RELEASE OF CONFIDENTIAL INFORMATION & AUTHORIZATION

I hereby consent and grant permission for Practitioners employed by Stachler ENT to discuss my Medical treatment with my referring physician, primary care physician, and or any other healthcare practitioner, relating to my care and treatment. I hereby authorize any practitioner examining and/or treating me, to release to any third party (such as an insurance company or governmental agency) any medical information and records concerning the diagnosis and treatment when requested for use in determining payment of claims. I understand that this is a lifetime release of information. I hereby consent and authorize Stachler ENT to file claims for treatment, electronically or manually, to my insurance carrier(s) for services rendered to.

ASSIGNMENT OF BENEFITS

I hereby consent and authorize payment to be paid directly to Stachler ENT for any services rendered for treatment. Any services for which assignment is accepted but are not covered under my insurance policy are acknowledged as being my full and complete financial responsibility.

I have read, understood, and agreed to all the above.

<hr/> Patient's Signature	<hr/> Patient's Printed Name	<hr/> Date Signed
<hr/> Representative's Signature	<hr/> Representative's Printed Name	<hr/> Date Signed

****Disclaimer: Failure to sign this form will discontinue submission of claims(s) to the appropriate insurance company and the patient will be responsible for payment at time of service.**