285 McDowell St.
Asheville, NC 28803

Ph: 828-252-1853
Fax: 828-259-9468

PATIENT INFORMATION

Name:____ Birthdate:________________

Gender: ☐Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Mailing Address: ____

City:___________________________________ State: ____________ Zip: ______________

Email Address : ____

Primary Phone: ____________________________ Other: ____________________________

Primary Doctor: ____

Primary Doctor's Office: ____

Referring Physician: ____

Insurance Policyholder: __________________ Relationship: __________ DOB: _________
(if other than self)

Pharmacy Name and Address: ____

Office use only: ☐Scan ☐ ET ☐ Portal ☐ Physician ☐ Pharmacy ☐ Insurance ☐ MDL

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Patient Financial Agreement

Initial each statement below

_____ I have made an informed decision to receive treatment from WNC Ear, Nose, Throat, Head & Neck Surgeons, PA. I understand the importance of being knowledgeable about my insurance benefits, whether in-network or out-of-network, co-payments, and deductibles.

_____ I understand that due to insurance regulations, the collection of co-payments, co-insurance, and deductibles is expected at the time of service. I understand that I may receive a bill for any difference in charges after insurance payment and acknowledge that failure to provide payment within 90-days will result in my account will be sent to collections.

_____ I have provided current and accurate insurance information and agree to present my current cards at every visit. I acknowledge my responsibility to promptly provide any changes in my coverage. Failure to provide updated information makes me financially responsible.

_____ I understand that I am financially responsible for all charges regardless of insurance payment. This includes and diagnostic or treatment procedures that may not be reimbursable, including but not limited to flexible laryngoscopy, needle and simple tissue biopsies, nasal cauterization, and removal or ear wax or other foreign bodies. Additionally, I am aware that I will be informed about recommended procedures and given the opportunity to consent or decline before any procedure is performed.

_____ I authorize the release of necessary information for insurance payment and allow my signature for both manual and electronic insurance submissions. Additionally, I agree to assign all benefits and insurance reimbursements directly to WNC Ear, Nose, Throat, Head & Neck Surgeons, PA for services rendered.

_____ I've received the Notice of Privacy Practices for WNC Ear, Nose, Throat, Head & Neck Surgeons, PA.

_______________________________________ _______________________
Signature Date

_______________________________________ ☐ Self ☐ Parent ☐ Other:____________
Printed Name Relationship to the Patient

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CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

Information is requested from: ____

____
(Street or PO Box)

____
(City) (State) (Zip Code)

Records are to be sent to: ____

____
(Street or PO Box)

____
(City) (State) (Zip Code)

Patient's Name: ____
(Last Name) (First Name) (Middle) (Maiden)

____
(Street or PO Box)

____
(City) (State) (Zip Code)

____
(DOB) (SSN)

FOR THE PURPOSE OF:
_____ Medical Care Attorney:________________________________
_____ Insurance Benefits Other: ________________________________
_____ Disability Determination

Dates of Treatment: ____

Type of Treatment: ____

I hereby release the above-named providers from all liability that may arise from the release of information from my medical record. I understand that this information may include reference to conditions including psychological or psychiatric impairment, drug abuse and/or alcoholism, sexual assault, or tests for HIV, ARC, and/or AIDS.
I understand I have the right to revoke this authorization at any time by sending a written notification to the Privacy contact.
I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
I understand that I have the right to inspect or copy the protected health information to be used or disclosed in this document. I can do this written notification to the Privacy Contact.
I understand that my treatment will not be conditioned on signing this authorization and that I have the right to refuse this authorization.

____ ____
Signature of Patient or Personal Representative Printed Name of Patient or Personal Representative

☐ Self ☐ Parent ☐ Other:______________________________
Description of Personal Representative's Authority (attach necessary documentation)