PATIENT INFORMATION - Please complete all fields

Patient Name _____ Birth date _____
First Initial Last

Last Four of SS # _____ Sex ☐ M ☐ F Race _____

Ethnicity _____ Preferred language _____

Marital Status _____ Employer _____

Patient Address _____ Please check the box to indicate your preferred contact number

_____ ☐ Home Phone _____

City / State / Zip _____ ☐ Cell Phone _____

Email Address _____ ☐ Work Phone _____

Emergency Contact and Phone # of Person Not Living With Patient _____

FAMILY CARE / PEDIATRICIAN / REQUESTING PHYSICIAN (Dr that requested you see Buckhead ENT)

Name _____ Street Address _____

Practice Name _____ City / State / Zip _____

Phone _____ Fax _____

PARENT / GUARANTOR INFORMATION - Please fill out completely for all responsible parties

Primary Contact Parent / Guarantor

Name _____

Relationship to Patient _____

Social Security _____ Birth date _____

Address _____

_____

Home Phone _____

Work Phone _____

Can you receive calls at work? ☐ Yes ☐ No

May we leave you a voice mail message? ☐ Yes ☐ No

Email address _____

Occupation _____

Employer _____

Secondary Contact Parent / Guarantor

Name _____

Relationship to Patient _____

Social Security _____ Birth date _____

Address _____

_____

Home Phone _____

Work Phone _____

Can you receive calls at work? ☐ Yes ☐ No

May we leave you a voice mail message? ☐ Yes ☐ No

Email address _____

Occupation _____

Employer _____

INSURANCE INFORMATION - failure to complete all fields may prevent us from filing a claim on your behalf

Primary Insurance

Insurance Name _____

ID # / Group # _____

Subscriber Name _____

Relationship to Patient _____

Subscriber Birth date _____

Secondary Insurance

Insurance Name _____

ID # / Group # _____

Subscriber Name _____

Relationship to Patient _____

Subscriber Birth date _____

I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in the above information. I authorize the release of any medical information necessary to process an insurance claim and request that payment of benefits be made to the physician unless my account has been paid in full. **I have received Buckhead ENT's notice of privacy practice.**

Responsible Party Signature: _____ ***Date:*** _____

BUCKHEAD ENT

PATIENT INSURANCE FORM

(Please Print)

(Current/Valid Insurance Card Required)

Buckhead ENT **MUST** have a copy of your current insurance card or you will be expected to PAY IN FULL at the time of service. If your insurance changes and you fail to give a current Insurance ID card, you will be responsible for service(s) that were rendered before we receive a current ID card. We will not resubmit your insurance for any date(s) of service. However, you may file those claims yourself so that you may be reimbursed.

Guarantee of Payment for Services & Assignment of Benefits

It is the policy of this office that payment must be received when services are rendered, except in case of surgery. If this applies to you, we will file your claim and you will be expected to pay only the portion that is not covered by your insurance. Please ask about this before leaving the office, if you have any questions.

- In the event that any of the above-named companies or individuals fail to make prompt payment, I hereby give my personal guarantee of payment for all charges herein occurred. If this account is placed with attorney or outside collection agency, the undersigned parties agree to pay all reasonable attorney fee and cost of collection. **Initial** _____

- I hereby authorize insurance benefits to be paid directly to the physician and I am financially responsible for non-covered services. I also authorize the physician to release any information in the processing of this claim. **Initial** _____

I hereby attest that I have read and understand the statements, guarantee of payment and assignment of benefits outlined above completely.

_____ _____

Signature of Patient or Personal Representative | Date:

_____ _____

Printed Name of Patient or Personal Representative | Relationship to Patient

Original must be on file

PATIENT FINANCIAL RESPONSIBILITY AGREEMENT

Thank you for choosing BUCKHEAD ENT as your healthcare provider. We are committed to providing you with the best medical care available at a cost that is both fair and reasonable. Please read our Patient Financial Responsibility Agreement carefully.

ACCEPTABLE METHODS OF PAYMENT: CHECK, MONEY ORDER, DEBIT CARDS, OR CREDIT CARDS

APPOINTMENTS

- **WE WILL REQUEST TO PHOTOCOPY YOUR INSURANCE CARD(S) AND PHOTO ID FOR YOUR FILE.**
- IN-OFFICE VISIT: We require 24 hour advance notice for cancellation/rescheduling of an appointment. If proper notification is not provided, a $75.00 cancellation fee will be added to your account. No fee will be applied for appointments that are rescheduled for a later date.
- SURGERY: Surgery cancellation/rescheduling is subject to 48 hour advance notice. If proper notification is not provided, a $250 rescheduling/cancellation fee will be billed and a statement will be forwarded to the address we have on file.
- REFERRALS/AUTHORIZATIONS: If your insurance plan requires a referral authorization from a primary care physician, you are responsible for presenting this at your initial visit. If you do not have the required referral prior to your appointment, we will gladly reschedule your appointment. If you request an office visit without a referral authorization, your insurance plan may deem this as "out of network" or "non-covered" treatment, and you will be responsible for all of the charges that is not authorized by your insurance plan. You acknowledge that it is your responsibility to be aware of what services are covered and you agree to pay for any service deemed to be non-covered or not authorized by insurance plan.

Terms and Conditions

Your insurance is a contract between you and your insurance company. BUCKHEAD ENT contracts with most major insurance plans; however, it is your responsibility to understand your coverage and benefits.

- INSURANCE CLAIMS: As a courtesy, we will submit claims with your PRIMARY insurance carrier. As a result, you must agree to allow our practice to "accept assignment" of benefits and to receive payment direct from your insurance carrier. **Any payments not paid and/or not covered by your insurance plan will be billed directly to you within 30 days of your date of service.**
- MEDICARE: BUCKHEAD ENT is a participating provider with the Medicare program and accepts as payment the Medicare allowable, patient deductible and/or 20% co-insurance. Medicare or secondary carriers do not cover some procedures and supplies. Please make certain you understand which aspects of your treatment are covered before proceeding. You understand that you will be responsible for your annual deductible, the co-payment, and any non-covered services specified by Medicare. **Medicare Lifetime Signature on file: I request that payment of authorized Medicare benefits be made on my behalf of BUCKHEAD ENT for any services furnished to me. I authorize any holder of medical information about me to be released to BUCKHEAD ENT needed to determine benefits payable for related services. This information will be used for the purpose of evaluating and administering claims of benefits.**
- SELF-PAY PATIENTS: If you do not have health insurance or we are not contracted with your insurance plan, you will be considered a self-pay patient and our fee(s) will be due—in full--at the time of service.
- CO-PAYMENT/DEDUCTIBLE/COINSURANCE: Our contract with your insurance company requires that we collect any co-payment, deductible or coinsurance; as a result, we are unable to waive these payments as they are due at the time of service and your visit may have to be rescheduled.
- THIRD PARTY INSURANCE: We will not bill third-party insurance. If your visit(s) are covered by Workers Compensation or Disability Insurance, you will be responsible for all charges at the time of service. We will provide you with a copy of your encounter detailing your visit to submit for reimbursement.
- OUT OF POCKET EXPENSES: Some insurance plans do not cover miscellaneous supplies or administrative work. In addition, we do not contract with insurance companies for coverage of hearing aids and related services/supplies.
  - SUPPLIES: Any supplies you receive from our office must be paid **in full** at the time of service.
  - HEARING AIDS: We will not bill for services related to hearing aid consultation or purchase of hearing aid. However, we will provide you with a copy of your encounter detailing your visit to submit for reimbursement.
  - TESTING: Specialized testing performed by audiologists may not be covered by your insurance plan. As a result, you will be responsible for payment **in full** at the time of service.
  - FORMS: Forms for Disability, FMLA, Leave of Absence and/or any requested correspondence that is not associated with reimbursement of a claim is subject to a $75.00 fee which will be due prior to completion of such form.
  - MEDICAL RECORDS REQUEST: See separate MEDICAL RECORDS REQUEST FORM
- MINOR PATIENTS: The parent/guardian of a minor is responsible for payment of the minor's account balance. A minor who is not accompanied by a parent/guardian will be denied any nonemergency treatment unless charges for the treatment have been pre-authorized. Responsibility for payment of treatment of minor children, whose parents are divorced, rests with both parents. Any court-ordered responsibility judgment must be determined between the individuals involved, without the inclusion of BUCKHEAD ENT.

- AUTHORIZATION TO CONTACT: You authorize BUCKHEAD ENT personnel to communicate by mail, answering machine messages, and/or e-mail according to the information provided in your patient registration information. BUCKHEAD ENT, or any agent or servicer of your patient account, may use any information you have provided, including contact information, e-mail addresses, cell phone numbers, and landline numbers, to contact you for purposes related to your account, including debt collection. You authorize BUCKHEAD ENT to use this information in any manner consistent with the information you have provided, including mail, telephone calls, e-mails, or text messages. You expressly consent to any such contact being made by the most efficient technology available, including automatic dialing/e-mailing or similar equipment, or pre-recorded or other messages, even if you are charged for the contact.
- NON-PAYMENT ON ACCOUNT: **We only accept payment by check, money order, debit cards or credit cards.** Should collection proceedings or other legal action become necessary to collect an overdue or delinquent account that exceeds more than 60 days for receipt of payment, BUCKHEAD ENT has the right to disclose to an outside collection agency or attorney all relevant personal and account information necessary to collect payment for services rendered. You, the patient, will be responsible for all costs of collection including, but not limited to: (i) late fees and charges and interest due as a result of such delinquency; (ii) all court costs and fees (but only to the extent allowed by law); and (iii) a collection fee to be charged under separate agreement with a third-party collections agency, either as a flat fee or computed as a percentage of the total balance due up to the maximum allowed by applicable law, and to be added to the outstanding balance due and owing at the time of the referral to the third party collection agency. You acknowledge that any such interest assessed on the account will be a late fee as a result of default or delinquency on your account, and is not deemed interest as part of a credit transaction. If your account is referred to a collection agency, attorney, court, or the past due status is reported to a credit reporting agency, it may have an adverse effect on your credit history; and related portions of your account, including the fact that you received treatment at our offices, may become a matter of public record. Failure to comply with any of these policies may also result in Withdrawal of Care. By signing below, you agree, on behalf of yourself, your legal representatives and/or relative, that the jurisdiction, venue, and choice of law of any dispute or state court action related to the health care services or the billing provided by BUCKHEAD ENT shall, at the option of BUCKHEAD ENT, be subject to the exclusive jurisdiction of (i) the appropriate court in the state where the provider of the disputed services is physically located when the services are rendered or (ii) where you reside.
- PAYMENT BY CHECK: If payment is made by check and it is returned or declined for any reason, your account will be charged a surcharge of $35.00 or up to the applicable state maximum legal limits, whichever is lower, in addition to any costs assessed or charged by any depository institution. When you pay by check you also authorize BUCKHEAD ENT, if your check is dishonored or returned for any reason, to electronically debit your account for the amount of the check plus a processing fee of up to the state maximum legal limits (plus any applicable sales tax).
- PAYMENT BY CREDIT CARD/DEBIT CARD: You may pay with a credit card or debit card, including American Express, VISA, MasterCard, and other major credit cards. Your payment with a credit card may be made in person, by mail, or by calling the number provided on your billing statement. All regular credit card rules will apply. Once authorization on the submitted information is received, your credit card will be charged. If your charge is not accepted, you will be notified. You are responsible for all late charges or penalties resulting from the late receipt of any payment. Your information is used solely to process your payment.

By signing below, each of the undersigned acknowledges that: (i) I have been provided a copy of the BUCKHEAD ENT'S PATIENT FINANCIAL RESPONSIBILITY STATEMENT; (ii) I have read, understand, and agree to their provisions and agree to the specified terms; (iii) I agree to pay all charges due (or to become due) to BUCKHEAD ENT for the below Patient's care and treatment, including co-payments and deductibles, as required or provided pursuant to my insurance plan and/or the insurance plan of another, as applicable; (iv) benefits, if any, paid by a third-party will be credited on the Patient account; (v) regardless of my insurance status or absence of insurance coverage, I am ultimately responsible for the balance on the account for any services rendered; (vi) if I fail to make any of the payment(s) for which I am responsible in a timely manner, I will be responsible for all costs of collecting the money owed, including court costs, collection agency fees, and attorneys' fees (to the extent allowed by law); and (vii) failure to pay when due may subject me to late payment charges and can adversely affect my credit report. I further agree that a photocopy of this Patient Responsibility Financial Statement shall be as valid as the original. ONCE I HAVE SIGNED THIS AGREEMENT, WHETHER BY ORIGINAL, FACSIMILE OR ELECTRONIC (".PDF") SIGNATURE, I AGREE TO ALL OF THE TERMS AND CONDITIONS CONTAINED HEREIN AND THE AGREEMENT SHALL BE IN FULL FORCE AND EFFECT.

Patient/Guardian Signature

DATE

General Consent for Care and Treatment Consent

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By Signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of Patient or Personal Representative	Date:
Printed Name of Patient or Personal Representative	Relationship to Patient
Printed Name of Witness	Employee Job Title
Signature of Witness	Date

Buckhead ENT

Ear, Nose & Throat
www.buckheadent.com

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

You have been given the Notice of Privacy Practices for Buckhead ENT and its Physicians. This Notice describes your legal rights regarding your health information and will inform you of the legal duties and privacy practices of Buckhead ENT with respect to health information created for services generated by Buckhead ENT. If you receive services by your physician or other health care providers at a different location, you may want to ask about that office or clinic's health information privacy policies and notices because they could be different.

Your name and signature below indicates that you have been provided with a copy of this Notice of Privacy Practices.

If you have a question regarding any of the information set forth in this Notice of Privacy Practices, please do not hesitate to call our Privacy Officer at (404) 350-7966.

■ **CONTACTS:** Please list other persons that we may inform about your health information.

_____ _____

_____ _____

■ **PHONE NUMBERS:** At which phone numbers would you like to receive calls about appointment, financial or medical condition information? ***[check all that apply]***

☐ Home Phone ☐ Cell phone ☐ Work Phone ☐ Other Phone: _____

■ **VOICE MAIL:** May appointment, financial or medical information be left on your answering machine or voice mail?

☐ Yes ☐ No

■ **EMAIL:** When responding to an Email, may we include appointment, financial or medical condition information?

☐ Yes ☐ No

Patient Name: _____

Signature of Patient
Or Responsible Party: _____

Date: _____

Patient Consent for Use of Email Communication

To better serve our patients, Buckhead ENT allows patients to communicate with our staff via email. Prior to doing this, you must read through and sign this email policy. Email should only be use for routine matters that do not require an immediate response. Should you require urgent or immediate attention, email is NOT appropriate. We strive to respond to all email communication within 2 business days. If a response is not received within the expected time frame, please call our office for immediate assistance.

When communicating via email, please put the purpose of your message in the subject line so that we may process it more efficiently. Also, be sure to include your name, date of birth, and return phone number in the body of your message. We also ask that you acknowledge receipt of emails coming from our office by using the auto reply feature.

All email communications related to the health and treatment may be filed in your medical record. Buckhead ENT is not liable for improper disclosure of information or breaches of confidentiality caused by the patient (i.e., printing or forwarding emails), third parties, or technical factors beyond the Practice's control. In addition, Buckhead ENT has no control over the security or management of third-party email systems, if used. The patient understands and agrees that Buckhead ENT will make its best effort to minimize the risk of confidentiality breaches for factors within its control, but cannot guarantee that unencrypted information will not be intercepted, altered, or read by an unintended recipient.

Email is only appropriate for certain types of doctor-patient communication. Specifically, email is useful for simple, non-urgent questions. One example of an appropriate email question is asking if an over the counter medicine is OK to take with your prescription medications. Another example is asking about a news story that seems to say one of your medications is dangerous. For standard medication refill requests, you will get a faster response if you have your pharmacy fax a refill request to the office or request a refill via our Patient Portal. You can use email to request a paper prescription to be mailed to you but expect this to take several days. The Physician has the exclusive right to decide what is and is not appropriate for email. If it is determined that your question is not email appropriate, you will be informed and may need to schedule an appointment to discuss your question with the Physician.

I understand that Buckhead ENT is not responsible for information loss or delay, or for breaches of confidentiality, due to technical factors beyond the Practice's control.

I understand and agree to the above email policy.

By signing below, I am agreeing that Buckhead ENT may send medical related correspondence to me via email and, may respond to my email via email.

Signed_____

Patient Name_____Date_____

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www.buckheadent.com