



Southwestern Colorado Ear, Nose & Throat Associates

Patient Registration Form

PATIENT

Legal Name: _____ Preferred Name: _____
 Date of Birth: _____ Social Security# : _____ Birth Sex (m/f): _____ Identified Sex: _____
 Mailing Address: _____ City: _____ State: _____ Zip: _____
 Physical Address: _____ City: _____ State: _____ Zip: _____
 Primary Phone#: _____ Secondary Phone # _____ Email: _____
 Name of Employer: _____ Marital Status: _____ Primary Care Provider _____

EMERGENCY CONTACT

Name: _____ Relationship : _____ Phone # _____

INSURANCE INFORMATION (Please give your insurance cards to the receptionist to copy. Thank you.)

Primary Insurance Company _____ Insurance ID# _____
 Secondary Insurance Company _____ Insurance ID# _____
 Cardholder Name: _____
 Cardholder Date of Birth: _____

GUARANTOR INFO (PERSON RESPONSIBLE FOR PAYMENT):

Name: _____ Relationship to Patient: _____
 Date of Birth: _____ Social Security # _____ Phone #: _____
 Mailing Address: _____ City _____ State _____ Zip _____

FILL OUT THIS SECTION ONLY IF PATIENT IS UNDER 18 YEARS OF AGE

Father's Name _____ Phone # _____
 Mother's Name _____ Phone # _____
 Responsible Party _____ Phone # _____

- I understand that I am responsible for all charges not paid by my insurance company. I authorize the release of medical information to my insurance company. If insurance company claims are filed through this office (for surgeries, office visits, etc), I authorize medical benefits for those services to be paid to this office.

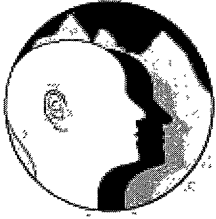
- If my insurance company (including Medicaid) requires a prior authorized referral, it is my responsibility to obtain this referral from my primary care physician prior to visiting Southwestern Colorado Ear, Nose and roat Assoc.

- In the event that I choose to be seen without prior authorization, I understand that I will be responsible for services rendered.

- I further understand that payment; co-payments and deductible payments for all office services are due at time of visit. If payment or co-payment is not made at the time of service, an additional fee may be added to my bill.

Signature _____ **Date** _____

If signature is other than patient's, please mark your relationship to the patient: Spouse _____ Parent _____ Child _____ Other _____



SOUTHWESTERN COLORADO EAR, NOSE, AND THROAT ASSOCIATES

Gregory M. Schackel, MD • Rachel B. Cain, MD

Erin Hamlin, PAC • Wendy Stapleton, PAC • Tevan Trujillo, AUD., CCC-A

Morgan Manulik, PAC • Lua Azmak, AUD., CCC-A

Financial Responsibility Agreement

(Please read and sign full name at the bottom)

This is a legally binding agreement between Southwestern Colorado Ear, Nose and Throat Associates, and you, as the patient. It describes your financial obligation. You must read this, sign it and return it to us prior to your first treatment. The term "SCENT" means Southwestern Colorado Ear, Nose and Throat Associates. The terms "I", "me", "my", "you", or "your" refer to the patient.

SCENT is committed to give you the best care. In return, I agree to be financially responsible for payment of SCENT's services. Acceptable forms of payment are cash, check, Visa, Mastercard, or (if over \$200.00) CareCredit.

As a courtesy, SCENT will file your insurance claim. Insurance cards are copied regardless of the type of visit. I agree to be responsible for payment of SCENT's services, regardless of whether the services are covered by my insurance and regardless of the extent of payment, if any, by my insurance. I agree to pay any balance remaining on my account for any reason within 120 days after my claim has been filed.

I agree to give SCENT complete and accurate insurance information for primary and secondary insurance coverage including referral forms from other providers (if applicable) and all identification and benefit cards/documents required for claim accuracy. I understand that failure to supply complete and accurate information may result in denial of my claim or delay payment. I agree to pay any balance remaining on my account for any reason within 120 days after my claim has been filed.

Referrals are my responsibility. I agree that if my health plan requires me to furnish a referral and the referral is not in place prior to my appointment, I agree to pay in advance a non-binding estimate of SCENT's charges or reschedule my appointment.

All services provided in SCENT's office are deemed medically necessary by the provider. I agree to pay any balance remaining on my account for any reason after my insurance has been processed.

I understand that my insurance may or may not agree with the UCR (usual, customary and reasonable) charges for the local area and my benefit plan may not cover all services or may even deny payment for services that have been authorized in advance. I agree to pay any balance remaining on my account for any reason within 120 days after my claim has been filed.

If I do not have insurance or have not met my deductible, I agree to pay for services at the time of my visit.

I understand that if SCENT has a contract with my insurance, SCENT will receive payment from my insurance company for covered services to the extent provided by my insurance. I agree to pay co-payments at the time of service. I agree to pay deductibles and co-insurance amounts at time of service and/or upon receipt of a statement.

I understand that any invoice or receipt issued by SCENT at the time of service is a non-binding estimate only and additional charges may apply depending upon the services rendered. I agree to pay any balance remaining on my account for any reason upon receipt of a statement.

(over)

**Mercy Medical Plaza • One Mercado Street, Suite 205 • Durango, CO 81301
phone 970-385-7272 • fax 970-385-7299 • www.swcoent.com**

DIRECT PAYMENT AUTHORIZATION

I HEREBY AUTHORTIZE DIRECT PAYMENT OF MEDICAL BENEFITS AND/OR SURGICAL BENEFITS, INCLUDING ALL MEDICAL BENEFITS TO WHICH I AM ENTITLED TO SOUTHWESTERN COLORADO, EAR, NOSE AND THROAT ASSOCIATES. THIS AUTHORIZATION WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING. A COPY OF THE AUTHORIZATION IS AS VALID AS THE ORIGINAL.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES, SURCHARGES, LATE FEES, INTEREST OF 18%, ATTORNEY FEES, NO SHOW FEES AND COLLECTION CHARGES, WHETHER OR NOT THEY ARE PAID BY MY INSURANCE.

(A no show fee may be charged when an appointment is not cancelled by 4 pm the working day before the appointment is scheduled.)

I hereby authorize Southwestern Colorado Ear, Nose and Throat Associates to release all medical information necessary to obtain payment.

Patient Signature _____

Print Name: _____

Date: _____

Southwestern Colorado Ear, Nose & Throat Associates

History and Physical

PATIENT'S NAME: _____ AGE _____ TODAY'S DATE: _____

PRIMARY PROVIDER: _____ Referred: _____

Symptoms: _____ Date of Onset: _____

WHAT DIAGNOSTIC TESTS HAVE BEEN DONE related to the symptoms above?

X-ray, CT Scan, MRI, Ultrasound, Swallow Study, Allergy Testing, Hearing Test, Biopsy, Other _____

PAST HISTORY (Please answer the following questions)

1. Do you suffer from allergies such as hayfever? Y N Asthma? Y N Eczema? Y N
Food Allergies? Y N Latex Allergies? Y N
2. Are you allergic to any medicine or have you had a bad reaction to any medicine?
Y N If yes, describe _____
3. Have you ever smoked? Y N Do you smoke now? Y N How many years did you smoke? _____
How much (packs per day)? _____ Use smokeless Tobacco? Y N What year did you quit? _____
4. Do you use alcoholic beverages? Y N How much? _____ Recreational Drug Use? Y N
5. Occupation/Jobs past & present _____
6. In your jobs or hobbies have you been exposed to loud noise levels? Y N Describe _____
7. Do you have trouble understanding people? Y N Do you wear hearing aids? Y N
8. Do you drink caffeine? Y N Do you have any pets? Y N
9. Have you ever suffered a severe head injury? Y N
10. Please list the current prescription and nonprescription medications you take with dosage and frequency: (use back of form if needed or give list to receptionist) _____

11. Please list surgical procedures you have undergone _____

12. Please list current or past medical illnesses or hospitalizations _____

SYSTEMS REVIEW (please circle any of the following which you have had or currently have)

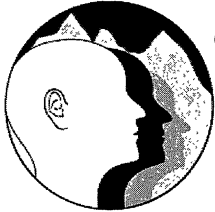
Cancer

Location? _____	Spine Injury	Thyroid Problems	Trouble Breathing	Liver Disease
_____	Nervous Breakdown	Frequent Sore Throat	During Day	Yellow Jaundice
_____	Depression	Trouble Swallowing	During Night	Kidney Stones
Sugar Diabetes	Anxiety	Pneumonia	With Exercise	Prostate Trouble
Recent Weight Loss	Memory Loss	Broken Nose	Chest Pain/Palpitation	Chronic Pain
Recent Weight Gain	Poor Hearing	Cough	Heart Trouble/Murmur	Where? _____
Change in Appetite	Ringing in Ears	Restless Sleep	Heart Attack	Sores Which Don't Heal
Fatigue	Broken Eardrum	Snoring	High Blood Pressure	Reaction to Anesthetic
Poor Vision	Frequent Ear Infection	Nose Bleeds	Rheumatic Fever	Tuberculosis
Epilepsy	Discharge from Ear	Postnasal Drip	Joint Swelling	MRSA
Seizures or Fits	Hoarseness	Stuffy Nose	Joint Pain	Hepatitis
Frequent Headaches	Swollen Glands	Sinus Infections	Back/Neck Pain	Aids
Migraines	Easy Bruising		Heartburn	HIV Positive
Fainting Episodes	Easy Bleeding		Stomach Trouble	
Dizziness	Anemia		Ulcers	
Stroke				

FAMILY HISTORY (please circle any of the following which seem to run in your family or have occurred in any directly related family member - this does not include member by marriage or adoption)

Bleeding Disorders	Heart Disease	T.B	Migraine	Cancer
Diabetes	Asthma	Arthritis	Reaction to General	High Blood Pressure
Hay Fever	Stroke	Hearing Loss	Anesthetic	
Thyroid Problems	Bleeding Problems			

IMMUNIZATIONS Flu? Y N Pneumonia? Y N COVID-19? Y N Brand: _____



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Authorization to Release Information

Patient Name _____

Date of Birth _____

I hereby give permission to Southwestern Colorado Ear, Nose, and Throat Associates of Durango, Colorado to Release/Obtain Patients medical records.

Facility or Physician Name: _____

Phone Number: _____

Fax Number: _____

- CT
- PET
- MRI
- Referral
- Other:

- Ultrasound-guided Biopsy
- Barium esophagram
- Ultrasound
- Last office Note

STAT

Routine

Sincerely,

Patient/Gaurdian Signature _____

Date _____

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Cancellation Policy/No Show Policy For Doctor Appointments and Surgery

1. *Cancellation/ No Show Policy for Doctor Appointment*

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly “full” appointment book.

If an appointment is not canceled at least 24 hours in advance you will be charged a twenty five dollar (\$25) fee; this will not be covered by your insurance company.

2. *Cancellation/ No Show Policy for Surgery*

Due to the large block of time needed for surgery, last minute cancellations can cause problems and added expenses for the office.

If surgery is not canceled at least 10 days in advance you will be charged a seventy five dollar (\$75) fee; this is will not be covered by your insurance company.

3. *Account balances*

We will require that patients with self pay balances do pay their account balances to zero (0) prior to receiving further services by our practice.

Patients who have questions about their bills or who would like to discuss a payment plan option may call and ask to speak to a business manager with whom they can review their account and concerns.

Print Name

Signature Patient/Guardian

____/____/____
Date

Patient Account # _____
(Office Use Only)