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: _____

EMERGENCY CONTACT

Name:_____ Relationship :_____ Phone #_____

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

Primary Insurance Company_____

Secondary Insurance Company _____

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)

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?_____
_____
_____
Sugar Diabetes
Recent Weight Loss
Recent Weight Gain
Change in Appetite
Fatigue
Poor Vision
Epilepsy
Seizures or Fits
Frequent Headaches
Migraines
Fainting Episodes
Dizziness
Stroke

Spine Injury
Nervous Breakdown
Depression
Anxiety
Memory Loss
Poor Hearing
Ringing in Ears
Broken Eardrum
Frequent Ear Infection
Discharge from Ear
Hoarseness
Swollen Glands
Easy Bruising
Easy Bleeding
Anemia

Thyroid Problems
Frequent Sore Throat
Trouble Swallowing
Pneumonia
Broken Nose
Cough
Restless Sleep
Snoring
Nose Bleeds
Postnasal Drip
Stuffy Nose
Sinus Infections

Trouble Breathing
During Day
During Night
With Exercise
Chest Pain/Palpitation
Heart Trouble/Murmur
Heart Attack
High Blood Pressure
Rheumatic Fever
Joint Swelling
Joint Pain
Back/Neck Pain
Heartburn
Stomach Trouble
Ulcers

Liver Disease
Yellow Jaundice
Kidney Stones
Prostate Trouble
Chronic Pain
Where?_____
Sores Which Don't Heal
Reaction to Anesthetic
Tuberculosis
MRSA
Hepatitis
Aids
HIV Positive

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
Diabetes
Hay Fever
Thyroid Problems

Heart Disease
Asthma
Stroke
Bleeding Problems

T.B
Arthritis
Hearing Loss

Migraine
Reaction to General Anesthetic

Cancer
High Blood Pressure

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**

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

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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 <u>not</u> 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 <u>not</u> 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)