Central Tennessee Ear, Nose & Throat PLC

Patient Demographics

Patient Information

Last Name:_____ **First Name:**_____ **MI:**_____

Date of Birth:_____ **Sex: M**____ **F**____ **Other**____ **Social Security**: _____

Street Address:_____ **Apt#**_____

City:_____ **State:**_____ **Zip:**_____

Home#_____ **Cell#**_____ **Email:**_____

Employer:_____ **Work#**_____

Primary Care Doctor_____ **Referring Doctor**_____

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

Race: ☐ White/Caucasian ☐ Am. Indian/Alaska Native ☐ Asian ☐ Black/African ☐ Hawaiian/Other Islander ☐ Other race

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino **Preferred Language**: ☐ English ☐ Spanish ☐ Other_____

Person Responsible for Patient Account ☐ Check if Self

Last Name:_____ **First Name:**_____ **DOB:**_____

Address:_____ **City**_____ **State:**_____ **Zip:**_____

SSN:_____ **Phone#**_____ **Relationship to Patient:**_____

Employer:_____ **Work#**_____

In Case of Emergency Contact

Name:_____ **Phone:**_____ **Relationship to patient:**_____

Insurance Information

1. Insurance:_____ **Policy#**_____ **Group#**_____

Policy Holder Name:_____ **DOB:**_____ **Relationship to Patient:**_____

Address:_____ **City/State/Zip:**_____ **Phone#**_____

2. Insurance:_____ **Policy#**_____ **Group#**_____

Policy Holder Name:_____ **DOB:**_____ **Relationship to Patient:**_____

Address:_____ **City/State/Zip:**_____ **Phone#**_____

Pharmacy Information

Pharmacy:_____ **Location:**_____ **Phone:**_____

Signature of Patient/Representative:_____ **Date:**_____

Patient Name/DOB:_____ Today's Date:_____

Reason for today's visit:_____ Date symptoms began:_____

Past Medical History (check all that apply):

☐ADHD	☐Chronic Fatigue	☐Ear Infection	☐High Cholesterol	☐Sinusitis
☐Allergy/Hayfever	☐Congestive Heart Failure	☐Fibromyalgia	☐HIV	☐Sleep Apnea
☐Anemia	☐COPD	☐GERD/Heartburn	☐Hoarseness	☐Snoring
☐Anxiety	☐Croup	☐Headaches/Migraine	☐Kidney Disease	☐Sore Throat
☐Arthritis	☐Depression	☐Heart Attack	☐Nosebleeds	☐Strep
☐Asthma	☐Diabetes	☐Hearing Loss	☐Pneumonia	☐Stroke
☐Auto Immune Disorders	☐Difficulty Swallowing	☐Hepatitis	☐Ringing in Ears	☐Thyroid Disease
☐Bleeding Disorder	☐Dizziness	☐High Blood Pressure	☐RSV	☐Tuberculosis

☐Cancer: Type(s)_____ Females: Are you currently pregnant? ☐Yes ☐No How many weeks?_____

Have you been diagnosed with Covid 19? ☐Yes ☐No, If yes, list date_____

Past Surgeries (Provide date if known) ☐None.

_____ _____ _____

_____ _____ _____

_____ _____ _____

List ALL Current Medication (use back if more space is needed) ☐None

Medication	Dosage	Times per day	Medication	Dosage	Times per day

Drug Allergies: ☐Unknown Drug Allergy ☐None

☐Latex ☐Statins ☐Erythromycin ☐Penicillin ☐ACE Inhibitors ☐NSAIDs ☐Tetracycline ☐Sulfas ☐IV Contrast Dye/Iodine

☐Other Drug_____ ☐Non-Drug Allergy_____

Social History:

Tobacco Use: ☐No ☐Yes; Type_____ Per day _____ # years_____ ☐Quit: Date_____

Alcohol: ☐Never ☐Daily: Quantity_____ ☐Occasionally ☐Seldom ☐Quit: Date_____

Do you use illicit drugs? ☐Yes ☐No

Family History: ☐Unknown ☐N/A

☐Cancer: Breast	☐Father	☐Mother	☐Sister(s)	☐Brother(s)	☐Son(s)	☐Daughter(s)
☐Cancer: Lung	☐Father	☐Mother	☐Sister(s)	☐Brother(s)	☐Son(s)	☐Daughter(s)
☐Cancer: Other	☐Father	☐Mother	☐Sister(s)	☐Brother(s)	☐Son(s)	☐Daughter(s)
☐Diabetes	☐Father	☐Mother	☐Sister(s)	☐Brother(s)	☐Son(s)	☐Daughter(s)
☐Heart Disease	☐Father	☐Mother	☐Sister(s)	☐Brother(s)	☐Son(s)	☐Daughter(s)
☐High Cholesterol	☐Father	☐Mother	☐Sister(s)	☐Brother(s)	☐Son(s)	☐Daughter(s)
☐Hypertension	☐Father	☐Mother	☐Sister(s)	☐Brother(s)	☐Son(s)	☐Daughter(s)
☐Stroke	☐Father	☐Mother	☐Sister(s)	☐Brother(s)	☐Son(s)	☐Daughter(s)
☐Thyroid Disease	☐Father	☐Mother	☐Sister(s)	☐Brother(s)	☐Son(s)	☐Daughter(s)

Patient Financial Policy

This is an agreement between AdvancedHEALTH, as creditor, and the Patient/Debtor named on this form and indicated by patient/debtor signature below.

In this agreement the words "you", "your" and "yours" mean the Patient/Debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we", "us" and "our" refer to AdvancedHEALTH. By executing this agreement, you are agreeing to pay for all services that are rendered.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect. A copy of your signed financial agreement will be provided to you.

HEALTH INSURANCE - It is YOUR responsibility to:

- Ensure we have been provided with the most current insurance information relative to filing your claim including insurance card, ID number, employer, birth date and patient address. This information will be located on our patient registration form.
- Ensure we are contracted with your insurance carrier to receive maximum benefits.
- Pay your co-payment or patient portion at the time of service.
- Inform us of any insurance changes made after this signed agreement/date of service. Insurance carriers have specific timely filing guidelines and pre-authorization requirements for certain services. If revised insurance information is not provided to us within your insurances' timely filing limits, you will be required to pay for services in full. If prior authorization was required for services already received and your claim is denied for lack of authorization, you will be required to pay for services in full.
- Contact your insurance company if no correspondence is received by you within 45 days of the date of service.

It is OUR responsibility to:

- Submit a claim to your health insurance carrier based on the information provided by the patient/debtor at the time of service or as updated information is provided.
- Provide your health insurance carrier with information necessary to determine benefits. This may include medical records and/or a copy of your insurance card.
- Provide MVA patients a courtesy health insurance claim form for their records upon request.

PAYMENT OPTIONS: Per our contracted agreement with your insurance carrier, we are required to collect your co-payment on the day of service. If you do not have insurance, you are required to pay for treatment at the time of service unless other arrangements have been formally made. A separate self-pay financial agreement will be provided to you.

We accept the following: Cash Check Credit Card *(Visa, MasterCard, Discover, American Express)*

A twenty-five dollar ($25.00) returned check fee will be assessed to the patient account per incident.

For convenience, payments may be made online at **www.ePayItOnline.com.** To utilize this service you will need your account number, access code, and Code ID. This information can be found on the patient statement you will receive reflecting your balance. ***Patients who no-show may be subject to a no-show fee.***

PENDING APPROVALS FOR SERVICES: In the event we are unable to obtain approval for services and you wish to proceed, we will not bill your insurance. Services will be reduced to the in-network insurance allowable amount and will apply to the patient's responsibility.

_____ Initials

Patient and/or Debtor Signature: _____ Date _____/_____/_____

Additional financial explanations are continued on the back side of this page

AdvancedHEALTH

BILLING INFORMATION

STATEMENTS:

A statement of account will be provided to you if insurance has paid leaving a patient portion, denied or no response is received. Due to the type of service we provide, you may receive billing from more than one practice, otherwise known as split billing. The balance on your statement is due and payable within 30 days of receipt unless other arrangements are made with our billing department. The statement will be sent to the address provided at the time of service. In the event your mailing address changes after your service date and your account has not been paid in full, you are required to notify our billing office of this change by calling 615.851.6033 ext. 2067. In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child at time of service will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, court documentation is required for any guarantor address changes, otherwise, it is the authorizing/custodial parent's responsibility to collect from the other parent. Any account with a credit balance of less than $5.00 will not be refunded without specific request from the patient/debtor.

DELINQUENT ACCOUNTS:

We review past due accounts frequently and at every statement cycle. Your communication and involvement to ensure your balance is paid timely is important to us. It is imperative that you maintain communications and fulfill your financial agreement and arrangements to keep your account active and in good standing.

If your account becomes sixty(60) days past due, further steps to collect this debt may be taken. If you fail to pay on time and we refer your account(s) to a third party for collection, a collection fee will be assessed and will be due at the time of the referral to the third party. The fee will be calculated at the maximum percentage permitted by applicable law, not to exceed 18 percent. In addition, we reserve the right to deny any future non-emergency treatment for any and all debtor-related unpaid account balances.

CONSENT TO CONTACT:

I grant permission and consent to AdvancedHEALTH and its agents, assignees, and contractors (which may include third party debt collectors for past due obligations): (1) to contact me by phone at any number associated with me, if provided by me or another person on my behalf; (2) to leave messages for me and include in any such messages amounts owed to me; (3) to send me text message or emails using any email address I provided or any telephone number associated with me, if provided by me or another person on my behalf; and (4) to use prerecorded/artificial voice messages and/or an automated telephone dialing system (an auto dialer) as defined by the Telephone Consumer Protection Act in connection with any communications made to me as provided herein or any related scheduled services and my account. I understand that my refusal to provide the consumer described in this paragraph will not affect, directly or indirectly, my right to receive healthcare services.

WAIVER OF CONFIDENTIALITY:

You understand if your account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

MEDICAL RECORDS:

You will be required to request in writing or sign a medical authorization form for the release of your medical records to any organization or physician. If the request is for a party other than the originally billed insurance and/or party, a **$20.00 medical records fee** will be required on each occasion.

Name of Patient: _____

Patient and/or Debtor Signature: _____ Date: _____

AdvancedHEALTH

General Consent For Treatment

As the patient, you have the right to be informed about your conditions 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 appropriate treatment and/or procedure for any identified condition(s).

I request and authorize medical care as my provider, his assistant or designees (collectively called "the providers") may deem necessary or advisable. This care may include, but is not limited to, routine diagnostics, radiology and laboratory procedures, administration of routine drugs, biological and other therapeutics, and routine medical and nursing care. I authorize my provider(s) to perform other additional or extended services in emergency situations if it may be necessary or advisable in order to preserve my life or health. I understand that my (the patient) care is directed by my provider(s) and that other personnel render care and services to me (the patient) according to the provider(s) instructions.

I understand that I have the right and the opportunity to discuss alternative plans of treatment with my provider and to ask and have answered to my satisfaction any questions or concerns.

In the event that a healthcare worker is exposed to my blood or bodily fluid in a way which may transmit HIV (human immunodeficiency virus), hepatitis B virus or hepatitis C, I consent to the testing of my blood and/or bodily fluids for these infections and the reporting of my test results to the healthcare worker who has been exposed. _____ **(initial)**

I HAVE READ OR HAD READ TO ME AND FULLY UNDERSTAND THIS CONSENT; I HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS AND HAD THESE QUESTIONS ADDRESSED.

Name of Patient: _____

Signature of Patient: _____ Date: _____

☐ Consent of Legal Guardian, Patient Advocate or Nearest Relative **if patient is unable to sign**

☐ Consent Caregiver **if patient is unable to sign**

Name of Legal Guardian, Patient Advocate, Nearest Relative or Other: _____

Relationship: _____ Telephone: _____

Address: _____

Signature of the above: _____ Date: _____ Time: _____

Signature of Witness: _____ Date: _____

AdvancedHEALTH

Notice Of Privacy Practices Acknowledgement

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my PHI. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices.*

Patient Name or Legal Guardian: _____

Signature: _____

Date: _____

PRACTICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of the Notice of Privacy Practices Acknowledgement but was unable to do so as documented below:

Date: _____ Initials:_____

Reason: _____

_____

AdvancedHEALTH

Release Of Medical Information

NAME *(Please print)*: _____

By Signing Below, I Authorize Central Tennessee Ear Nose & Throat To Release My Medical And Billing Information To:

RELATIONSHIP			**NAME OF DESIGNATED PERSON**
SPOUSE	☐ YES	☐ NO	_____
CHILDREN	☐ YES	☐ NO	_____
IN-LAWS	☐ YES	☐ NO	_____
CAREGIVERS	☐ YES	☐ NO	_____
PARENTS	☐ YES	☐ NO	_____

OTHERS _____

PATIENT SIGNATURE _____ DATE _____

PARENT SIGNATURE _____ DATE _____

We ask that if you have any change in this request, that you please inform the receptionist.

CENTRAL TENNESSEE EAR NOSE & THROAT MAY LEAVE APPOINTMENT INFORMATION ON MY VOICEMAIL:

HOME	☐ YES	☐ NO
WORK	☐ YES	☐ NO
RELATIVE	☐ YES	☐ NO

PATIENT SIGNATURE _____ DATE _____

I AUTHORIZE THE FOLLOWING TO PICK UP PRESCRIPTIONS, X-RAYS, ETC.

RELATIONSHIP

SPOUSE	☐ YES	☐ NO	_____
RELATIVE	☐ YES	☐ NO	_____
CAREGIVER	☐ YES	☐ NO	_____

PATIENT SIGNATURE _____ DATE _____

I UNDERSTAND THAT CENTRAL TENNESSEE EAR NOSE & THROAT WILL ASK FOR IDENTIFICATION OF THE PERSON PICKING UP PATIENT MEDICAL INFORMATION OR PRODUCTS.

AdvancedHEALTH

CENTRAL TENNESSEE
EAR, NOSE & THROAT
Advanced Diagnostic Imaging/PhyData Group
787 Weatherly Dr. Suite 200
Clarksville, TN 37043
(931)647-1255 Fax: (931)647-2399

Medical Records Release Authorization

I hereby authorize_____

Address:_____

Phone:_____ Fax:_____

And its physician, employees or agents to disclose the below Provider or Organization all medical records including specially protected health information relating to psychiatric and/or mental conditions, drug and/or alcohol abuse, sickle cell anemia or HIV infections.

Release Records to: **Central Tennessee, Nose & Throat, PLC**
Randolph Richards MD
Jason Mattern PA-C

Patient's name:_____

Date of Birth:_____ SSN:_____

Purpose of disclosure:_____

☐ **All Medical Records at this Facility** ☐ **Treatment Records Only** ☐ **Operative Reports Only**
☐ **Diagnostic Imaging Reports Only** ☐ **CT/MRI Disc** ☐ **Lab Reports Only**

If you DO NOT WANT specific types of your medical records released, please check the box beside the condition you want restricted from release.

☐ **Substance/Alcohol Abuse** ☐ **Behavioral/Mental Health** ☐ **AIDS/HIV/STD**

This authorization will expire on the following date:_____

I understand that I may revoke this authorization at any time prior to the date of expiration. Should I desire to revoke this authorization, I must send written notice to the above-named health care provider. I understand that my protected health information may be subject to disclosure by the recipient and may no longer be protected by federal privacy regulations. I understand that this authorization does not limit above-named health care provider ability to use or disclose my health information for treatment, payment or healthcare operations, or otherwise permitted by law.

Patient or Authorized Representative's Signature Date

Witness Date