PATIENT INFORMATION

Photo I.D. and Insurance card(s) are required at every patient appointment to verify identity – per FTC guidelines.
Thank you for choosing ENT Surgical Associates! In order to serve you properly, please complete both sides of this form. Please print clearly. ALL information is kept confidential. If the information you provide is not correct – we cannot process your claim through your insurance company. **ALL copays are due at the time of service.**

Patient Name: _____ Date of Birth: _____

Home Phone: _____ Cell Phone: _____ SSN: _____

Race: ☐ African American ☐ Caucasian ☐ Hispanic ☐ Asian ☐ American Indian ☐ Alaskan Native

☐ Multi-Racial ☐ Hawaiian ☐ Latino ☐ Other: _____

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

Address: _____ City: _____ State: _____ Zip Code: _____

Email Address: _____

Patient Employer: _____ Work Phone: _____ Ext. _____

Employer Address: _____ City: _____ State: _____ Zip Code: _____

Nearest Relative (not living with patient): _____ Phone: _____

Emergency Contact: _____ Relation to Patient: _____ Phone: _____

Does the patient have an Advance Directive? YES or No

Referring Physician or Primary Physician: _____

RESPONSIBLE PARTY INFORMATION (If it is NOT the patient)

Name of Responsible Party: _____ Relation to Patient: _____

Address: _____ City: _____ State: _____ Zip Code: _____
(write same – if address is the same as the patient)

Home Phone: _____ Work Phone: _____ Cell Phone: _____

SSN: _____ Date of Birth: _____ Employer: _____

Address: _____ City: _____ State: _____ Zip Code: _____

PRIMARY INSURANCE INFORMATION

Name of Insured: _____ Relation to patient: _____

SSN: _____ Date of Birth: _____ Employer: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Insurance Company: _____ Policy #: _____ Group #: _____

Copay Amount: $_____ Effective Date of Policy: _____ Expiration Date of Policy: _____

Does the patient have a Secondary Insurance to be filed? ☐ **YES** ☐ **NO**

If the answer is YES – Please complete the back of this form with the Secondary Insurance Information.

If the answer is NO – Signature is required on the back of completed form.

Photo I.D. and Insurance card(s) are required at every patient appointment to verify identity – per FTC guidelines.

SECONDARY INSURANCE INFORMATION
(ONLY IF APPLICABLE FOR PATIENT)

Name of Insured: _____ Relation to patient: _____

SSN: _____ Date of Birth: _____ Employer: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Insurance Company: _____ Policy #: _____ Group #: _____

Copay Amount: $_____ Effective Date of Policy: _____ Expiration Date of Policy: _____

I authorize release of any information concerning my (or my dependent's) health care, advise and treatment providing for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits payable to the insured party to be directly paid to ENT Surgical Associates of Central Georgia, PC and/or ENT Surgical Center of Central Georgia, Inc. I understand that I am financially responsible for any charges not covered by my insurance, and they are due in full upon receipt of notice. ALL information use for any purpose will be within the guidelines stated in our patient privacy policy according to HIPPA Law.

ENT Surgical Associates and ENT Surgical Center are separate facilities and are billed separately. All Claims are filed to the insurance company as a courtesy to our patient – but if the claim is denied the patient or the responsible party will be held responsible for payment(s). Any out-of-network claims for the ASC that have been paid to the insured party must be remitted immediately or the patient/insured party will be responsible for the account in full upon receipt. Signing below states you verify all information to be complete and accurate and understand our policy for insurance processing and payment(s) to our practices. The Insurance company is responsible for the patient's policy and it is a contract between the Policy holder and the Insurance Company.

_____ _____

Signature of Patient (or Parent/Guardian if patient is a minor) **Date**

PLEASE TAKE AN ADDITIONAL MINUTE TO TELL US HOW YOU HEARD ABOUT OUR OFFICE...
Select from the following list – mark/complete any that apply. Thank you for your time and help!

- FAMILY
- FRIEND _____
- MED-STOP
- EMERGENCY ROOM
- INTERNET – Search Engine _____
- ENT WEBSITE (www.entsurgical.info)
- RFERRAL FROM DR. _____
- EMPLOYEE AT ENT SURGICAL ASSOCIATES/CENTER
- YELLOW-PAGES ADVERTISEMENT
- NEWSPAPER
- OTHER: _____

COMPLETE ALL INFORMATION ON TIIS FORM AND RETURN IT TO THE RECEPTIONST.

INSURANCE CARD AND PICTURE I.D. ALSO REQUIRED –
WE CANNOT FILE A CLAIM TO THE INSURANCE WITHOUT THE INSURANCE CARD.
THANK YOU.

FORM MUST BE COMPLETED AND SIGNED OR INSURANCE CANNOT BE PROCESSED.
PAYMENT(S) REQUIRED IN FULL BEFORE APPOINTMENT WITH PROVIDER.

ENT Surgical Health History Form

First Name:_____ Middle:_____ Last:_____ Date of Birth:___/___/____

Home Phone: (___) ___-_____ Cell Phone: (___) ___-_____ Gender: ☐ Male ☐ Female ☐ Other

Review of Symptoms–Check only the ones you NOW have or have had RECENTLY, if there are no symptoms check NONE.

General	Skin	Head	Eyes	Ears
☐ Weakness	☐ Skin Color Changes	☐ Headaches	☐ Blurred Vision	☐ Hearing Loss
☐ Fatigue	☐ Skin Rashes	☐ Head Injuries	☐ Eye Redness	☐ Ringing
☐ Fever	☐ Itchy Skin	☐ Head Lesions	☐ Itchy Eyes	☐ Ear Discharge
☐ Chills	☐ Skin Sores	☐ Head/Facial Lesions	☐ Burning Eyes	☐ Earache
☐ Night Sweats	☐ None	☐ None	☐ Eye Swelling	☐ Itchy Ears
☐ Fainting			☐ Eye Pain	☐ Loss of Balance
☐ None			☐ Dry Eyes	☐ Dizziness
			☐ Tearing	☐ Room Spins
			☐ None	☐ Ear Blockage/ Obstruction
				☐ Ear Infections
				☐ Ear Lesions/Sores/ Deformity
				☐ None

Nose	Mouth	Throat	Neck	Lungs
☐ Loss of Smell	☐ Bleeding Gums	☐ Sore Throat	☐ Neck Enlargement	☐ Cough
☐ Nose Bleeds	☐ Oral Sores	☐ Bad Tonsils/ Tonsillitis	☐ Neck Stiffness	☐ Phlegm
☐ Nasal Pain	☐ Dental Problems	☐ Hoarseness	☐ Neck Soreness/ Pain	☐ Coughed Blood
☐ Nasal Discharge	☐ Mouth/Jaw Pain	☐ Hard to Swallow	☐ Neck Lumps	☐ Shortness of Breath
☐ Nasal Obstruction	☐ Bad Breath	☐ Recurrent Infections	☐ Neck Masses	☐ Wheezing
☐ Nasal Congestion	☐ Loss of Taste	☐ Oral White Spots	☐ None	☐ Pain in Lungs
☐ Snoring	☐ Dry Mouth	☐ None		☐ Chest Congestion
☐ Post Nasal Drip	☐ Oral Ulcers			☐ Inhalant Exposure
☐ Deviated Septum	☐ Oral Blisters			☐ None
☐ Runny Nose	☐ Bad Taste			
☐ Sinus Congestion	☐ None			
☐ Nasal Sores/Lesions				
☐ None				

Heart	Gastrointestinal	Neurological	Psychiatric	Endocrine
☐ Murmur	☐ Abdominal Pain	☐ Seizures	☐ Hyperventilation	☐ Weight Loss
☐ Palpations	☐ Nausea	☐ Vertigo	☐ Alcohol Abuse	☐ Weight Gain
☐ Rapid Heartbeat	☐ Vomiting	☐ Loss of Facial Expression	☐ Drug Use	☐ Hoarseness/ Voice Changes
☐ Swollen Extremities	☐ Abdominal Bloatedness	☐ Weak Grip	☐ Drug Abuse/ Addiction	☐ Hypoglycemia/ Low Blood Sugar
☐ Cold Extremities	☐ Belching	☐ Paralysis	☐ None	☐ Diabetes/ High Blood Sugar
☐ Tightness/Pressure	☐ Heartburn	☐ Slurred Speech		☐ None
☐ Chest Pains	☐ Indigestion	☐ Tingling/ Burning/ Numbing		
☐ Varicose Veins	☐ None	☐ Disorientation		
☐ Blood Clots		☐ None		
☐ Blue Extremities				
☐ None				

Medications: List all medications you are currently taking. Include ALL medications even over the counter ones.

Drug Name (Generic/Brand)	Dosage	Frequency	Status
			☐ Current ☐ Chronic ☐ Discontinued
			☐ Current ☐ Chronic ☐ Discontinued
			☐ Current ☐ Chronic ☐ Discontinued
			☐ Current ☐ Chronic ☐ Discontinued
			☐ Current ☐ Chronic ☐ Discontinued
			☐ Current ☐ Chronic ☐ Discontinued

List ALL Allergies	Allergic Reaction

Past Medical History – Please provide a complete history including all illnesses, injuries, hospitalizations, and operations.

List ALL Illnesses, Injuries & operations	Date	Hospital	Treatment	Physician	Response

Immunizations:

☐ DPT ☐ Measles
☐ Mumps ☐ Pneumococcal
☐ Smallpox ☐ Influenza
☐ Typhoid ☐ Polio
☐ Tetanus ☐ MMR

Has the patient listed tested **positive** for any of the following:

☐ HIV
☐ Hepatitis, if positive please list type(s): _____
☐ Other communicable diseases: _____

Last Chest X-Ray: _____
☐ Normal ☐ Abnormal
Last TB Skin Test: _____
☐ Normal ☐ Abnormal
Last EKG: _____
Last Eye Exam: _____

Family History – Please list all **Blood Relatives** with their current health status and any illnesses that they have had or have.

List Blood Relatives:	Health Status	Age if Living	Age at Death	Cause of Death	Illnesses
Father					
Mother					
Brother (s)					
Sisters (s)					

Alcohol: ☐ Never ☐ Beer(s) _____ Per week ☐ Liquor _____ Per Week ☐ Wine ____ Per Week How Many Years? _____

Smoking: ☐ Never ☐ Current ☐ Previous Packs Per Day: _____ How Many Years? _____

Caffeine: ☐ None ☐ Current ☐ Previous Cups Per Day: _____ How Many Years? _____ Other: _____

Aspirin: ☐ None ☐ Current ☐ Previous Quantity Per Day: _____ How Many Years? _____ Other: _____

Signature: _____ Date: _____

ALL INFORMATION IS REQUIRED TO BE COMPLETE AND ACCURATE. INSURANCE COMPANIES REQUEST THIS INFORMATION TO VERIFY CLAIMS THAT ARE PROCESSED. THIS FORM WILL BE UPDATED ANNUALLY.

E.N.T. SURGICAL ASSOCIATES OF CENTRAL GEORGIA, P.C.
1719 RUSSELL PARKWAY
McNEAL CENTER - BUILDING 300 - SUITE 301
WARNER ROBINS, GEORGIA 31088
(912) 923-0106

OTOLOGY
RHINOLOGY
LARYNGOLOGY
ALLERGY

FACIAL PLASTIC SURGERY
HEAD AND NECK ONCOLOGY

A. DANIEL TOLAND, D.O. F.A.A.C.S., DIPLOMATE
AMERICAN BOARD OF OTOLARYNGOLOGY, HEAD AND NECK SURGERY

IDENTITY THEFT PREVENTION POLICY

Patient Initials or Guardian

Effective May1, 2009, the staff of E.N.T. Surgical Associates of Central Georgia will be required under the Federal Trade Commission (FTC) to verify your identity. Upon time of patient registration/ check-in for ALL appointments, you will be required to provide either a driver's license or other photo I.D. and current health insurance card(s). If the photo I.D. does not show your current address, please bring a utility bill to show proof of address. The parent or legal guardian of a minor (patient under the age of 18) should bring the above stated information.

E.N.T. Surgical Associates reserves the right to decline services if you fail to provide the necessary information. This is requirement by the FTC to protect your identity. E.N.T. Surgical Associates is bound to protect ALL sensitive patient health information under the HIPPA security standards.

CANCELLATION FEE POLICY EFFECTIVE 01/01/2010

Patient Initials or Guardian

This notice is to inform ALL patients that as of January 01, 2010 if the patient does not cancel their scheduled appointment 24 HOURS before the appointment, there will be a $50.00 fee applied to their patient account.

Please contact our office with any questions. This fee will not be billed to the insurance policy. It is the patient responsibility in full. Fee is required to be paid in full to schedule any future appointments.

This fee has been established due to the amount of patients not keeping their scheduled appointments and appointments are not available for other patients requiring medical treatment.

I hereby acknowledge that I have provided E.N.T. Surgical Associates with the correct proof of identification. By signing below and initialing by each policy, I certify that I have read and fully understand the policies listed above.

Signature _____ **Date** _____

Witness _____ **Date** _____

ACKNOWLEGEMENT OF RECEIPT OF PRIVACY NOTICE:

I have been presented with a copy of ENT Surgical Associates of Central Georgia, P.C. **Notice of Privacy Policies**, detailing how my information may be used and disclosed as permitted under Federal and State law. I understand the Contents of the Notice, and I may request restriction(s) concerning the use of my personal medical information (PMI).

PLEASE LIST ANY INDIVIDUAL(s) THAT MAY ACCESS PATIENT PMI:

_____

_____

_____

_____

Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

Signed: _____ Date: _____

If not signed by the patient, please indicate relationship to the patient (ie spouse, mother)

Relationship to patient: _____ **Witness:** _____

By initialing this each year your medical and demographic information continues to be used and disclosed as directed above and according to the Notice of Privacy Policy.

Initials:_____ Date: _____ Initials: _____ Date: _____

Iniials: _____ Date: _____ Initials: _____ Date: _____

Initials:_____ Date: _____ Initials: _____ Date: _____

INTERNAL USE ONLY: If the patient or patient's representative refused to sign acknowledgement of receipt of notice, please document the date and time the notice was presented to the patient and sign below.

Presented on: _____ By whom: _____
(date and time) (Employee name and title)

FOR OFFICE USE ONLY:

[ ] Consent received by: _____ Date: _____

[ ] Consent refused by patient and treatment refused as permitted.

[ ] Consent added to the patient's medical record on this date: _____

E.N.T. SURGICAL ASSOCIATES OF CENTRAL GEORGIA, P.C.

OTOLOGY
RHINOLOGY
LARYNGOLOGY
ALLERGY

1719 RUSSELL PARKWAY
McNEAL CENTER - BUILDING 300 - SUITE 301
WARNER ROBINS, GEORGIA 31088
(478) 923-0106

FACIAL PLASTIC SURGERY
HEAD AND NECK ONCOLOGY

Authorizations and Financial Policy

Authorization for Treatment: I present myself or child for whom I am guardian for evaluation, and treatment or surgical procedure(s) that may be ordered or required during my treatment by Dr. Toland, his assistants, or his designee and authorize any emergency medical care. I understand that the practice of medicine is not an exact science and that NO GUARANTEE OR ASSURANCES HAVE BEEN MADE TO ME concerning the results of any procedure or treatment as a result of the examination by ENT Surgical Associates, ENT Surgical Center, Dr A. Daniel Toland or Erin Burch, R.N, MSN, FNP-C.

Billing for ENT Surgical Center: I understand that by having services provided by **ENT Surgical Associates and ENT Surgical Center** that I will be billed for the facility. I accept full responsibility for both accounts that I will have with Dr. Toland. I understand that I am responsible for any monies no payable to ENT Surgical Center outside the allowable fee schedule agreed upon by my insurance(s) and ENT Surgical Center. *****Our Center may be out of network with your insurance company, but it will be treated as an in network facility. In most instances, your insurance company will be mailing the payment for services rendered by Dr. Toland and/or the ENT Surgical Center to the insured party. Remember that these monies are for the surgical services already performed and we are obligated and will ask for prompt payment once you receive payment. ***** I fully understand that any payments mailed to the insured party are my responsibility and I will remit the payment to the ENT Surgical Center upon receipt of the payment.

Medicare/Medicaid Patient's Certification: I certify that the information given by me in applying for payment under Title XVII and XIX of the Social Security Act is correct. I request payment be made directly to the provider of services on my behalf and I authorize said provider to release any and all information necessary regarding the treatment and services provided as stated below.

Assignment of Benefits: I hereby authorize payment directly to ENT Surgical Associates or ENT Surgical Center by my insurance company(s). In the event an overpayment is made from more than one insurance company, I understand the overpayment will be sent to the appropriate payer.

Surgery Services Provided: I hereby understand that all ENT Surgical Associates and ENT Surgical Center surgery procedures are to be paid in full before services are rendered. In the case that the patient is self-pay, payment can be made with credit card, money order, or cash. **In order to pay for surgery by check, payment must be presented at least 10 days in advance to the office.**

Insurance: ENT Surgical Associates and ENT Surgical Center will file your insurance as a courtesy to you. If our office does not hear from your insurance company within 30 days, we request your help in contacting your Insurance Company to resolve the payment delay. The Insurance plan is a contract between you and your Insurance Company. We must hold you responsible for any balance due.

(Over)

Referrals: I understand that my insurance may require an authorization before services can be rendered. I hereby agree to obtain any referrals and authorizations for any visits necessary. I hereby understand that any services rendered without a referral authorization will in turn be my financial responsibility.

Payment of Services: I understand I am financially responsible for all charges and fees related to the services rendered to me by ENT Surgical Associates and ENT Surgical Center. I understand that all co-pays and deductibles are due at the time of service. I further understand that payment in full is expected upon receipt of the first statement and/or prior to additional office visits; this may include co-payments, additional deductibles and any services not covered by Insurance. I further understand that all post-dated checks will not be accepted. I also understand that if I am self-pay that payment is due on the date of service.

Fees: I understand the ENT Surgical Associates and ENT Surgical Center may charge $ 30.00 or 5% of the face amount of the instrument; whichever is greater, in addition to any institutional fees for a returned check. I further understand that if payments are not made as stated I agree to pay all reasonable legal fees and costs of collection to the extent permitted by law. I also agree that this contract cannot be substituted by and Debt Management Program proposals.

_____

Patient/Guardian Name (please print): _____

Signature_____ Date_____

Witness_____ Date_____