



A caring approach to treatment of the ears, nose, throat, head, and neck for children and adults

PATIENT INFORMATION

PAIGE POWERS, M.D.

Today's Date

PATIENT INFORMATION

Patient's Name			Sex	Date of Birth	Age
Social Security Number				Marital Status (Circle) Single / Married / Divorced / Widowed	
Patient's Address	City	State	Zip Code	Home Phone	Work / Cell Phone
For Appointment reminders or call-back requests: OK to leave messages on answering machine / voice mail? <input type="checkbox"/> Yes <input type="checkbox"/> No				OK to leave messages with family member? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Employer	Responsible Party / Parent's Name			Responsible Party's Social Security Number	
Responsible Party / Parent's Address	City	State	Zip Code	Home Phone	Work / Cell Phone
How did you hear about us?			Primary Care Physician		

INSURANCE INFORMATION

Primary Insurance	Address / Location		Phone		
Subscriber's Name			Sex	Date of Birth	Social Security Number
Relationship to Patient (Circle) Self / Spouse / Child / Other (specify)		Policy / ID Number		Group Number	Effective Dates From To
					Employer
Secondary Insurance	Address / Location		Phone		
Subscriber's Name			Sex	Date of Birth	Social Security Number
Relationship to Patient (Circle) Self / Spouse / Child / Other (specify)		Policy / ID Number		Group Number	Effective Dates From To
					Employer

EMERGENCY INFORMATION

Emergency Contact	Relationship	Phone / Address
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PLEASE CONTINUE TO THE REVERSE SIDE

FINANCIAL POLICIES

Copayment and deductible payments as determined by your agreement with your insurance carrier are **due at the time of service**. We will file your insurance claim if you agree to have your insurance company pay the doctor directly for services provided. Not all insurance plans cover all services; in the event your insurance plan determines a service to be “not covered”, you will be responsible for payment. Payment is due upon receipt of a statement from our office.

If you have no health insurance, payment is due at the time of service. There will be a \$25 fee for returned checks.

In fairness to other patients and the physician, we request 24 hours notice to cancel an appointment. You may be charged \$25 for a missed appointment. Missing more than two appointments without providing notice is grounds for discharge from the practice.

I agree to the above financial policy. In the event of default, I agree to pay all costs of collection, and reasonable attorney’s fees. I hereby authorize this healthcare provider to release information necessary to secure the payment of benefits from my insurance company.

REFERRAL REQUIREMENTS

I am seeking treatment from Piedmont Otolaryngology / Dr. Powers and understand that **if** my medical insurance company requires a referral to see a specialist, I am responsible for ensuring that the referral has taken place. If I have not obtained a required referral at the time of my appointment, I understand that I am financially responsible for any charges incurred during that office visit, if not covered by my insurance company.

NOTICE OF PRIVACY PRACTICES

I understand that, under the **Health Insurance Portability & Accountability Act of 1996 (“HIPPA”)**, I have certain rights to privacy regarding my protected health information. I further understand that this information can and may be used for any of the following:

1. To conduct, plan and direct my care and follow-up with the multiple healthcare providers who may be directly or indirectly involved in the treatment(s).
2. To obtain payment from third party payers (insurance, etc.)
3. To conduct normal and required healthcare operations such as quality assessments and physician certifications.

I have been informed by Piedmont Otolaryngology of their **Notice of Privacy Practices** containing a more complete description of the uses and disclosures of my health information. I have had the opportunity to review the entire **Notice of Privacy Practices** prior to signing this consent.

SIGNATURE

I have read and agree to the above policies:

Patient Name

Signature

Date