Spartanburg | Greer
ENT&Allergy

EAR, NOSE & THROAT | HEAD & NECK SURGERY | SINUS & ALLERGY | SLEEP | COSMETICS

TO COMPLETE YOUR FORM:
- Fill out all applicable sections
- Resave file with a unique name
- Email your resaved form to operator@spartanburgent.com

DATE _____

ACCT #_____

Thank you for choosing Spartanburg Ear, Nose & Throat!

PATIENT INFORMATION

Name: _____ **Date of Birth:** _____ Sex: M F

Mailing Address:_____ **Marital Status:** S M LS D W

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

Street Address (if different from mailing): _____ **Email:** _____

City: _____ **State:**_____ **Zip:**_____ **Primary Language:** _____

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

Race: ☐ White/Caucasian ☐ Black/African American ☐ Native Hawaiian ☐ AM Indian/Alaskan Nat ☐ Unavailable/Unknown ☐ Decline to Provide
May choose multiple races

Ethnicity: ☐ Hispanic/Latino ☐ Non Hispanic/Latino ☐ Decline to Provide

If a minor: Father's Name _____ Mother's Name _____

If the patient is a minor child and the parents are legally separated or divorced, please complete the following:

Which parent has legal custody of the minor child? _____

Which parent is financially responsible for the minor child's medical expenses after insurance? _____
Please provide a copy of the legal documentation stating the parent responsible for medical expenses to be included in the patient's medical record.

RESPONSIBLE PARTY

☐ ***YOU** may check here if the responsible party is the same as patient.*

Name: _____ **Date of Birth:** _____ Sex: M F

Mailing Address:_____ **SSN:** _____

City: _____ **State:**_____ **Zip:**_____ **Relationship to Patient:**_____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____ **Preferred Phone:** H C W

Employer/School:_____ **Email :**_____

EMERGENCY CONTACTS

THE PERSON OR PERSONS BELOW WILL BE CONTACTED IN THE EVENT OF AN EMERGENCY.

Emergency Contact 1 _____ _____ _____
First Name Last Name Telephone

Emergency Contact 2 _____ _____ _____
First Name Last Name Telephone

_____ _____
Patient Signature Date

_____ _____
Parent or Guardian Signature Date

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DATE _____

ACCT #_____

Thank you for choosing Spartanburg Ear, Nose & Throat!

Patient Name: _____

PRIMARY INSURANCE INFORMATION *(please provide copies of all medical insurance card)*

Name of Primary Insurance:_____ **ID Number:** _____

Group Number:_____ **Co-Pay Amount:**_____ **Effective Date:** _____

Subscriber information ***(Person who carries the insurance)*** ☐ **Check here** ***if same as patient***

Name: _____ **DOB:** _____

Mailing Address:_____ **SSN:** _____

City: _____ **State:**_____ **Zip:**_____ **Relationship to Patient:**_____

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

Employer/School:_____

SECONDARY INSURANCE INFORMATION *(please provide copies of all medical insurance card)*

Name of Secondary Insurance:_____ **ID Number:** _____

Group Number:_____ **Co-Pay Amount:**_____ **Effective Date:** _____

Subscriber information ***(Person who carries the insurance)*** ☐ **Check here** ***if same as patient***

Name: _____ **DOB:** _____

Mailing Address:_____ **SSN:** _____

City: _____ **State:**_____ **Zip:**_____ **Relationship to Patient:**_____

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

Employer/School:_____

FINANCIAL POLICY

This information is to provide clarification for patients of Spartanburg and Greer Ear, Nose and Throat regarding matters of insurance, co-pay, deductibles and co-insurance amounts due at the time of service. Spartanburg and Greer Ear, Nose and Throat has an obligation to various Healthcare plans to apply any deductible an/or collect any co-payment prior to provision of service. You may be asked to present your insurance card at each visit.

Co-Pays: You will be required to pay your co-payment upon arrival for your appointment.

Deductibles and Co-Insurance: You will be asked at check in or check out for any deductible or co-insurance that may be applicable to your office visit.

Previous Balances: You will be expected to provide payment for previous balances or balances sent to collections prior to your office visit. If you are unable to pay your balance in full, you may be asked to set up a payment plan. You may set up this plan with our office or contact Billing Services at 864-699-6981.

I acknowledge that the above information is true and accurate demographic and insurance information for the patient listed on this registration form. I also acknowledge that by signing this form, I authorize payment of medical benefits to the undersigned physician or supplier for services described. I have also read the above Spartanburg and Greer Ear, Nose and Throat financial policy and agree to the terms of the policy.

_____

Patient Signature

_____

Parent or Guardian Signature

Spartanburg | Greer
ENT&Allergy

EAR, NOSE & THROAT | HEAD & NECK SURGERY | SINUS & ALLERGY | SLEEP | COSMETICS

ACCT #_____

DATE _____

Authorization expires two years from this date

Patient Name: _____

PLEASE INDICATE YOUR PREFERRED METHOD OF CONTACT INFORMATION

How would you like to be contacted regarding appointments, treatment and/or other information pertinent to your healthcare and/or payment for your healthcare provided at Spartanburg and Greer Ear, Nose and Throat?

☐ **I may be contacted by any method**

If not any method, contact me by: ☐ Home Telephone ☐ Cell Phone ☐ Work Phone ☐ Mail ☐ Email
(check all that apply)

May we leave a message on your answering machine/voicemail? ☐ Yes ☐ No

Of the selected preference or preferences above what is your <u>preferred</u> method of contact or how you like to be contacted <u>first</u>?
☐ Home Telephone ☐ Cell Phone ☐ Work Phone ☐ Mail ☐ Email

HIPAA RELEASE OF INFORMATION (please choose an option below)

<u>HIPAA DELEGATES</u>
I authorize the person(s) listed below to receive all health information about appointments, treatment and/or other information pertinent to my healthcare and/or payment for my healthcare provided at the Spartanburg and Greer Ear, Nose and Throat.

Name: _____ Relationship:_____ Phone: _____

Name: _____ Relationship:_____ Phone: _____

<u>MINOR PATIENT RELEASE</u>
I authorize the following individual(s) to consent to medical treatment in my absence.

Name: _____ Relationship:_____ Phone: _____

Name: _____ Relationship:_____ Phone: _____

RIGHTS OF THE PATIENT

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to Spartanburg & Greer Ear, Nose and Throat at the address above. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer by protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall by in effect until revoked by the patient.

Patient/Parent or Guardian Signature:_____ Date: _____

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GENERAL CONSENT

The following are conditions for services provided by Spartanburg and Greer Ear, Nose & Throat for the patient whose name appears at the bottom of this page.

CONSENT FOR MEDICAL TREATMENT

I/we voluntarily consent to medical treatment and diagnostic procedures provided by Spartanburg and Greer Ear, Nose & Throat.

ACKNOWLEDGEMENT OF PATIENT FOLLOW UP PLAN

Health care is a partnership in which the physician and the patient both have responsibilities. It is the physician's responsibility, in consultation with you, to arrive at a diagnosis, keep you informed of your diagnosis, to identify treatment options and to explain the importance of any recommended follow-up. Once the diagnosis and course of treatment have been established and agreed upon collaboratively, it is the patient's responsibility to follow the agreed upon treatment plan and to return as advised for ongoing assessments of health, illness and treatment outcomes.

ASSIGNMENT OF INSURANCE BENEFITS

I/we guarantee payment of all charges made for or on account of the patient an I/we assign our rights in any insurance benefits or other funding to the physician and Spartanburg and Greer Ear, Nose & Throat. I/we understand that I/we am/are responsible for any charges not covered by insurance or other forms of benefits.

Should I be eligible for Medicare coverage, I request that payment of authorized Medicare benefits be made to Spartanburg and Greer Ear, Nose & Throat on my behalf. The information given by me is correct, in applying for payment under Title XVIII of the Social Security Act.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I/we were provided a copy of the Notice of Privacy Practices. The notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the Notice may be changed at any time. The Notice of Privacy Practices may be accessed at www.spartanburgent.com

DISCLOSURE/USE OF HEALTH INFORMATION

I understand that uses and disclosures of my personal and health information are described in Spartanburg and Greer Ear, Nose & Throat's Notice of Privacy Practices. These include providing my information to other providers for my continuing care, to an insurance company or other payor (such as Medicare) to process payment for my care.

PHOTOGRAPHING

I consent to Spartanburg and Greer Ear, Nose & Throat taking photographs for purposes of identification. Photographs that could identify me will only be used for internal medical record identification purposes.

Patient/Parent or Guardian Signature: _____ Date: _____