Atlanta ENT
breathe, sleep, look & feel better

Otolaryngology, Nasal & Sinus Surgery, Allergy & Asthma, Snoring & Sleep Apnea, Head & Neck Surgery, Pediatric Otolaryngology, Facial Plastics

No Show/Short Notice Cancellation Acknowledgement

We at Atlanta ENT strive to provide our patients with the best care and quickest appointment times possible. Unfortunately there are patients who make appointments but do not keep them or cancel their appointments with less than 24 hours' notice. This is very disruptive from a business perspective; therefore, Atlanta ENT has now instituted a policy of charging patients $25.00 if a patient NO SHOWS or cancels an appointment with less than 24 hours' notice. The charge will be placed on the patient's account and a future appointment will only be made if there is a credit card on file. Atlanta ENT hopes you understand this policy was instituted with much thought. This in no way takes away from the respect Atlanta ENT has for all of our patients who give appropriate notice if they are unable to appear at the office for a scheduled appointment

By signing this form, you are acknowledging that you will be billed $25.00 every time you NO SHOW for an appointment or if you fail to give us less than 24 hour notice that your are CANCELING your appointment.

Patient or Legal Guardian signature (sign after printing)

Date

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PATIENT'S INSURANCE OBLIGATION

In order to accommodate the needs and requests of our patients, we have contracted with numerous managed care companies. By doing so, we agree to file your insurance claim in a timely manner and to accept a discounted fee for service, in addition to fulfilling other contractual obligations.

IT IS YOUR RESPONSIBILITY TO CONTACT YOUR INSURANCE COMPANY TO VERIFY THAT WE ARE ON YOUR PARTICULAR PLAN.

We rely on you to gives us the correct insurance information needed to file your claim properly. For this reason, we will ask you to present your insurance card at every visit. We can assure you that we file the claim within days of your visit.

In addition, it is impossible for us to know all the individual requirements unique to the specific contract your employer has made with your insurance company. Some contracts exclude a particular lab test, require you to use specific lab for blood work, deny screening test or allergy skin test, allergy shots or require pre-certification for particular x-rays. You can only help yourself by becoming familiar as possible with your benefits. You need to know your particular insurance plan. By becoming an informed consumer and assuming an active role in your helathcare, you can prevent unexpected personal expenses.

We do collect all monies up front that are subject to your deductible and coinsurance at the time of service.

In the event that a non-covered services is performed, we will expect you personally to assume responsibility for payment of your medical care.

If you wish please ask the Front Desk Representative for the Fees.

I have read this insurance statement and agree to accept responsibility as described above

_____ _____

Patient (or Parent/Guardian if patient is minor) (sign after printing)

Date

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Patient Information

Patient Name: Last _____ First _____ MI _____

Social Security No.: _____ _____ _____ **Patient Age:** _____

Street Address: _____

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

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

Date of Birth: ____ ____ ____ **Male:** __ **Female:** __ **Marital Status:** __ **S** __ **M** __ **D** __ **W** __ **Child**

Email Address: _____ **Can we add you to our email list?** **Y** ___ **N** ___

Which Doctor Are You Seeing Today? _____

Primary Care Physician: _____ **Phone Number:** _____

Emergency Contact and how you are related: _____ **Phone Number:** _____

Responsible Party Name: Last _____ First _____ MI _____

Date of Birth: ____ ____ ____ **Male:** __ **Female:** __ **Social Security No.:** _____ _____ _____

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

Street Address: _____

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

Primary Insurance Co: _____ **Policy Holder:** _____

Policy ID# : _____ **Group No. :** _____

Secondary Insurance Co: _____ **Policy Holder:** _____

Policy ID# : _____ **Group No. :** _____

ATTENTION! If Policy Holder is not the Patient, We MUST HAVE the Following Information to File Your Claim

Patient Name: Last _____ First _____ MI _____

Date of Birth: ____ ____ ____ **Male:** __ **Female:** __ **Social Security No.:** _____ _____ _____

Policy Holder: __ **Spouse** __ **Child** **Other:** _____

Patient's Employer: _____ **Employer's Phone:** _____

PAYMENT OF ALL CO-PAYMENTS, DEDUCTIBLES, AND ANY OTHER PATIENT RESPONSIBILITY FEES ARE DUE WHEN SERVICES ARE RENDERED. IF YOU HAVE A QUESTION ABOUT FEES, PLEASE CHECK WITH US, THANK YOU!

I hereby authorize Atlanta ENT Sinus & Allergy Associates PC to diagnose and treat me. I also authorize Atlanta ENT Sinus & Allergy Associates PC to release medical and/or any other information to my insurance carrier, Medicare, and/or the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for payment on Medicare/Insurance Company Claims for services rendered by Atlanta ENT Sinus & Allergy Associates PC and/or it's physicians. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to Atlanta ENT Sinus & Allergy Associates PC and/or its physicians. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for treatment. (Section 1128B of the SS Act and 31 U.S.C. 3801-3812 provides penalties for witholding this informaiton). I have also been informed of my rights to privacy via posters and handouts contained within this office as mandated under the current federal HIPAA laws.

Patients who NO SHOW for their appointments or cancel their appointment within 24 hours of the appointment will be required to provide their credit card information before another appointment is made. Patients who NO SHOW for their 2nd appointment or cancel within 24 hours of the 2nd appointment will be charged $25.00 on their credit card

_____ _____

Patient (or Parent/Guardian if patient is minor) (sign after printing)

Date

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Authorization for Use / Disclosure of Protected Health Information

I authorize the Use/Disclosure of Health Information About Me As Described Below

Patient's Name: _____

Patient's Birth Date: _____

Patient's SSN: _____

A. Person(s) or Organization(s) authorized to provide the information

Atlanta ENT Sinus & Allergy Associate, P.C.
5555 Peachtree Dunwoody Road. Ste 125 Atlanta, GA 30342
Phone (404) 255-2918 Fax: (404) 255-5837

B. Person(s) or Organization(s) authorized to receive the information

_____

_____

_____

C. Specific descriptions of the info that may be used or disclosed (including date(s)):

_____

_____

_____

_____ _____

Patients Signature or Patient's Representative **Date**

_____ _____

Printed Name of Patient's Representative **Relationship to Patient**

NOTE: You have the right to know specifically what information you are authorizing for release (e.g. "results of a lab test performed on 1/4/03" or if your entire medical record is included "all health information"). You have a right to know the name(s) or other identification of the person(s) or organization(s) authorized to release the information (e.g. the names of your health care provider(s)). You have the right to know who is going to use it and what is going to be used for (e.g. John Smith, PhD/Research)

You Have the Right to Receive a Copy of This Form
HIPAA Authorization for Use / Disclosure of Protected Health Information. This form does not constitute legal advice and covers only Federal and not State laws.

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ACKNOWLEDGEMENT OF PRIVACY PRACTICE NOTICE RECEIPT

Notice to Patient:
We are required to provide you with a copy of our Notice of Pivacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of the office's Notice of Privacy Practices.

_____ _____

Please print your name here **Date**

_____

Signature

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- The patient refused to sign.
- Due to an emergency situation it was not possible to obtain an acknowledgement.
- We weren't able to communicate with the patient
- Other (Please provide specific details)

_____

_____

_____

_____

_____ _____

Employee Signature **Date**

HIPAA Acknowledgement of Privacy Practice Notice Receipt. This form does not constitute legal advice and covers only federa, not state law.