Alaska Ear Nose & Throat

3841 Piper Street | Suite T311 | Anchorage, Alaska 99508 | telephone 907-563-3096| fax 907-563-3094

Patient Registration Form

PATIENT: *Please print all information clearly.*

Name: _____ DOB: _____/_____/_____
First M.I Last

Nickname: _____ SS# _____/_____/_____ Sex: ☐ Male ☐ Female

Mailing Address: _____
City State Zip

Home Phone: _____ Work Phone: _____ Cell: _____

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

Race: ☐American India/Alaska Native ☐ Asian ☐African American ☐Hawaiian/Pacific Islander ☐ Caucasian ☐ other

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino

(Please choose one of the following)

☐ OK to call, leaving detailed message if no answer

□ OK to call, but leave no message

Employer Name & Address: _____

Preferred Language: _____ E-Mail: _____

May we discuss your condition with a member of your household or friend? ☐ YES ☐ NO

If so, whom? _____ Relationship to patient: _____

EMERGENCY CONTACT:

_____Phone#:_____Relationship:_____

Were you referred to us by another doctor? ☐ YES ☐ NO If so, by whom?

_____

INSURANCE: (Please present insurance card(s) and a photo ID to receptionist for scanning.)

Primary Insurance Name: _____ Policy Holder's Name: _____

Policy # _____ Group #: _____

Policy Holders DOB: _____ Relationship to Patient: _____

Secondary Insurance Name: _____Policy Holder's Name: _____

Policy # _____ Group #: _____

Policy Holders DOB: _____ Relationship to Patient: _____

Please complete the following ***if the patient is a minor or is disabled.***
(The person accompanying the patient today will be considered the "responsible party.")

Responsible Party Name: _____ DOB: _____/_____/_____ SS# _____/_____/_____

Mailing Address: _____
City State Zip

Assignment and Release

I authorize the release of any information to my referring physician. I hereby authorize Alaska Ear Nose & Throat to furnish my information to insurance carriers upon their written request and hereby assign to Alaska Ear Nose & Throat all payments for medical services rendered to the above patient.

Patient Signature (or responsible party) **Date**

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PAYMENT FOR SERVICES

Please read, initial where indicated, and sign below.

PATIENT RESPONSIBILITY

- Insurance coverage is not a guarantee of payment. (_____*initial*)
- We will bill your insurance if you present your insurance card(s) at the time of your appointment. It is important for you to know that **we are not contracted with your insurance carrier.** This means that you are responsible for monitoring the processes of your insurance company to make certain your claim is processed in a timely manner, for contacting them if you have questions as to how your claim was processed, and that you are ultimately responsible for the payment of services rendered. (_____*initial.*)
- Any copayments or "patient responsibility" percentages must be paid at the time of service. (_____*initial*)
- **If we do not receive a response from your insurance company within forty-five days from the date we bill them, the balance will become your responsibility.** (_____*initial*)
- You will receive a statement for any remaining balance after all applicable insurances have been applied. That balance is due in full at that time. (_____*initial*)
- If we do not receive your payment in full within 90 days from the date of the first statement, your account may be turned over to a third-party collection agency. (_____*initial*)
-

We also recommend that you research your insurance benefits prior to your office visit, if possible, as there could be reasons why your insurance may not pay for your visit. These reasons might include the following:

- Your deductible has not been met. May policies have separate, higher deductibles for surgical procedures. All of the procedures performed in this office, including certain types of injections, are considered to be surgical procedures.
- You have not received the proper referral or preauthorization for the visit or procedure. If your insurance company requires preauthorization, it is your responsibility to obtain it before the procedure is performed. Remember, preauthorization is not a guarantee of payment.
- The serviced or procedures are not covered by your insurance. We will inform you when we know a treatment/procedure will not be covered, but many times it is not possible for us to know with certainty, as this varies greatly among insurance companies, and because they will not make a final determination until they have received the claim. If there is any uncertainty about coverage, we will be happy to provide you with an estimate of your fees before treatment is given. You are responsible to pay for the non-covered services at the time of the visit.

We accept cash, checks, and Visa or MasterCard. If a payment in check for is returned because of insufficient funds, you will be charged a $25.00 fee. Payment **IN FUL**L at the time of service is required in the following circumstances:

- You do not have insurance coverage.
- You have not brought your insurance card(s) with you.
- You have not met your deductible.
- A contract is required by your policy and we are not contracted with your insurance carrier.
- A referral or preauthorization is required by your policy and you have not obtained one.
- Any procedure or treatments we believe are not covered by insurance.

LABORATORY AND PATHOLOGY SERVICES

We use a laboratory of our choice for laboratory services unless you request otherwise. The lab will bill separately for these services. We will share your insurance information with the lab so that they may file a claim with your carrier. The lab will them bill you for any remaining balance. You will need to contact them directly for any questions regarding their bill.

By my signature below, I acknowledge that I have read and that I understand the above statements and am willing to accept responsibility to pay for services rendered if my insurance does not cover them. I also understand that I am responsible for laboratory and pathology charged as well. This authorization is not limited in time.

Patient Signature (or responsible party) **Date**

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HIPAA

In order to comply with federal regulation, we are required to have a document available to you that explains our privacy information policy. There is a copy of this policy at the reception desk. Please advise the from office administrative assistant if you would like a copy.

Read the following carefully. Initial the line below to acknowledge that you have been informed, then sign and date at the bottom.

_____ I have the option to accept or decline that advice and treatment offered by Dr. Jerome List or allied health professionals associated with Alaska Ear Nose and Throat, for myself, or my minor child. Should I decide not to follow a suggested treatment plan, I will accept responsibility for the outcome; this will apply to advice offered in the clinic setting, hospital or by telephone.

CONSENT TO USE OR DISCLOSE HEALTH INFORMATION FOR TREATMENT, PAYMENT OR COORDINATION OF CARE WITH OTHER PROVIDERS.

I hereby consent to the use or disclosure of my individually identifiable health information by Alaska Ear Nose & Throat, in order to carry out treatment, payment or coordination of care with other providers.

At the time, I retain the right to revoke this consent. Such revocation must be submitted to Alaska Ear Nose & throat in writing. The revocation shall be effective except in those instanced that occur prior to the revocations.

I have read and understand the information. I am the patient, or the individual authorized to act on behalf of the patient.

If you are signing this form for the patient, please explain your relationship and authority to perform this act.

Patient Signature (or responsible party) **Date**

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NAME: _____ DOB: _____ AGE: _____

Do you have any **allergies** to medications? ☐ YES ☐ NO

If so, please list the medication allergy and reaction to medication:

Please list all medications you are currently taking: (prescription and non-prescription)

Please list ALL surgeries you have had in your LIFETIME:

Have you had any hospitalizations in the last 5 years?..... ☐ YES ☐ NO
Are you pregnant and/or currently nursing?..... ☐ YES ☐ NO
Have you been exposed to tuberculosis?..... ☐ YES ☐ NO
Have you ever had hepatitis?..... ☐ YES ☐ NO
Do you or any family members have bleeding tendencies?..... ☐ YES ☐ NO
Have you ever sustained a head injury?..... ☐ YES ☐ NO
Do you use tobacco products?..... ☐ YES ☐ NO
Do you drink alcoholic beverages?..... ☐ YES ☐ NO

FAMILY HISTORY	Age	State of Health	If Deceased, Age & Cause of Death
Mother			
Father			
Siblings			
Children			

Please provide the name of your pharmacy: _____

Please provide any additional comments about your health that will assist with your care: _____

Patient Signature (or responsible party) **Date**