Mountain Regional ENT **Welcome**

Patient Name (Last, First, Middle) _____
Mailing Address: _____
City: _____ **State:** _____ **Zip:** _____
Telephone #: _____ **Cell:** _____
Date of Birth: _____ **Age:** _____
Patient's Social Security #: _____-_____-_____ **MALE/FEMALE**

Person Responsible for Payment: _____
Father's Name: _____
Mailing Address: _____
City: _____ **State:** _____ **Zip:** _____
Telephone #: _____ **Cell:** _____
Social Security #: _____-_____-_____ **Date of Birth:** _____
Mother's Name: _____
Mailing Address: _____
City: _____ **State:** _____ **Zip:** _____
Telephone #: _____ **Cell:** _____
Social Security #: _____-_____-_____ **Date of Birth:** _____

Parent Employment
Father's Company Name: _____
Address: _____
City: _____ **State:** _____ **Zip:** _____
Telephone #: _____
Mother's Company Name: _____
Address: _____
City: _____ **State:** _____ **Zip:** _____
Telephone #: _____

Insurance Information **REFFERING PHYSICIAN** _____
Primary Insurance Company _____
Insured's Name (if other than Patient) _____
ID #: _____ **Group Name/#:** _____
Secondary Insurance Company _____
Insured's Name (if other than Patient) _____
ID #: _____ **Group Name/#:** _____

To whom may we release information about your condition, diagnosis or treatment?
_____Parent _____Insurance _____Caregiver _____Legal Guardian ____No One
____Other _____

Assignment and Release
I, the undersigned, certify that I (or my dependent) have insurance coverage as noted above and assign directly to Mountain Regional Ear, Nose &Throat, P.A. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance as stated in the financial policy. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.
Signature of Responsible Party: _____
Relationship: _____ **Date:** _____

PATIENT MEDICAL HISTORY

Chief Complaint-Child

What is the main reason for today's visit? _____
When did the symptoms begin? _____
What other doctors has your child seen for this problem? _____
What medications has your child taken or is he/she taking for this problem?_____
Did the child's mother have a normal pregnancy and delivery? _____

Past Medical History

Please list any illnesses, hospitalizations or surgeries that your child has had in the past or that he/she currently has: _____
Does your child take any medications on a routine basis? [ ] Yes [ ] No If yes, please list medication and dosage: _____ _____ _____
_____ _____ _____

Is your child allergic to any medications? [ ] Yes [ ] No If yes, please list: _____

Is your child allergic to latex? [ ] Yes [ ] No

Family History

Medical problems of mother: _____
Medical problems of father: _____
Medical problems of immediate blood relatives: _____

Social History

Have you ever smoked or chewed tobacco? [ ] Yes [ ] No If yes, how many cigarettes per day? ____
For how many years? _____ Are you still smoking? _____ If not, how many years since you quit? _____ Are you now or have you ever been a heavy drinker? [ ] Yes [ ] No

Review of Systems

Please check the following symptoms that frequently bother your child:

ALLERGY
_____ Hay Fever
_____ Itchy Eyes or Throat
_____ Postnasal Drip
_____ Asthma
_____ Blocked Nose

EARS
_____ Hearing Loss
_____ Ringing in Ears
_____ Dizziness
_____ Earache
_____Ear Infections

NOSE & SINUS
_____ Sinus Headaches
_____ Sinus Infections
_____ Stuffy Nose
_____ Snoring
_____ Nose Bleeds
_____ Recurrent Head Colds
_____ Facial Pain

THROAT
_____ Recurrent Sore Throats
_____ Enlarged Neck Glands
_____ Difficulty Swallowing
_____ Hoarseness
_____ Bad Breath
_____ Cough

Has your child taken aspirin-containing products in the last two weeks? [ ] Yes [ ] No
When? _____

Has your child had any blood transfusions [ ] Yes [ ] No Year of transfusion? _____
Is your child at risk for AIDS? [ ] Yes [ ] No

Mountain Regional Ear Nose & Throat, P.A.

FACIAL PLASTIC SURGERY

FINANCIAL POLICY

John P. Pickens, M.D.

Otolaryngology – Head & Neck Surgery, Facial Plastic Surgery

Diplomate, American Board of Otolaryngology – Head and Neck Surgery

Member, American Academy of Facial Plastic and Reconstructive Surgery

Mountain Regional ENT is committed to providing the best possible medical care. To help us achieve our goal, it is important that you understand our financial policy.

Your health insurance coverage is an agreement between you and your insurance company. The doctor's bill for services rendered is an agreement between you and your doctor. We participate with most major insurance companies; however, if you are unsure of our participation with your insurance company, please contact them to verify our participation. It is your responsibility to know your individual insurance benefits, coverage amounts, and terms.

Co-Pay: Most insurance plans require a patient to pay a copay at each visit. The practice, as well as the patient, is bound by our contracts with the insurance plans to collect that copay. You will be responsible for paying the copay at the time of check-in.

Claims Filing: We will gladly file your claim with your insurance company. You are responsible for any balances that remain after insurance has processed the claim.

Current Insurance: You are required to verify your current insurance at each visit. In the event that Mountain Regional ENT or your insurance plan fails to receive accurate information to process your claim, you will be held responsible for the full amount due for services rendered.

Self-Pay: Patients without insurance coverage will be required to pay for all services at the time they are rendered. We offer a discounted rate to self-pay patients when payment is made in full at time of service.

(Continued)

7 Walden Ridge
Suite 200
Asheville, NC 28803
Office: (828) 654-9299
Fax: (828) 654-9266

Past Due Payments: Under state law, claims must be paid or denied within 30 days of receipt by your insurance carrier. If your insurance carrier does not pay your claim or denies your claim within 30 days, you will receive a statement from Mountain Regional ENT requiring payment of the remaining balance. Any balance remaining on your account is due 30 days of receiving a statement for services, including all surgical procedures. If your account becomes delinquent (past 90 days) your account will be subject to collections. If you have financial hardship or you are unable to pay your bill in its entirety, please contact our office to discuss payment options.

Returned Checks: A $25.00 fee will be charged on all returned checks.

Transfer of Care: When transferring care to another provider, we will request you to close out any balances due. Payment is due at the time the records request is made.

Form of Payment: We accept Visa, MasterCard, Discover, personal checks, cash, and debit cards. We do not accept postdated checks. We do not accept American Express.

Lab and Imaging Services: We use outside clinics for lab work, CT scans, and MRIs; these services will result in a separate bill from the clinic used for said services. It is your responsibility to know if the services performed are covered by your insurance policy. If there are any questions regarding coverage of lab or imaging services, please contact your insurance carrier.

I have read, understand, and agree to Mountain Regional ENT's Financial Policy. I also understand that I am responsible for any balance on my account, including any "non-covered services" as deemed by my insurance company.

_____
Patient's Name (Please print)

_____ _____
Patient's Signature (Parent or legal guardian must sign if patient is under 18) Witness

_____ _____
Date Date

Mountain Regional Ear Nose & Throat, P.A.

FACIAL PLASTIC SURGERY

PATIENT INFORMATION CONSENT FORM

I have read and fully understand Mountain Regional ENT's Notice of Information Practices. I understand that Mountain Regional ENT may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided, and any administrative operations related to treatment and/or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment, and administrative operations if I notify the practice. I also understand that Mountain Regional ENT will consider requests for restriction on a case-by-case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Mountain Regional ENT's Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

_____

Patient's Name (Please print)

_____

Patient's Signature (Parent or legal guardian must sign if patient is under 18)

_____

Date

After a good faith attempt to obtain receipt of the "PATIENT INFORMATION CONSENT", the patient or representative refused or was unable to sign for the following reason: _____

_____.

_____ _____

Patient/Representative Witness

John P. Pickens, M.D.

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FACIAL PLASTIC SURGERY

HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

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1. Authorization

I authorize **Mountain Regional Ear, Nose and Throat** to use and disclose the protected health information described below to **allow me to be contacted (by phone, mail or email) regarding products or services** , for example, to be contacted about a hearing aid software upgrade available.

2. Effective Period

This authorization for release of information covers the time period:

a. Date: _____ until revoked in writing.

3. Extent of Authorization

a. □ I authorize the release of **only my contact information.**

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to any person or entity that has already acted on my previous authorization.

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____
Patient's Name (Please print)

_____
Patient's Signature (Parent or legal guardian must sign if patient is under 18)

_____
Date

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