

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

REFERRING 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

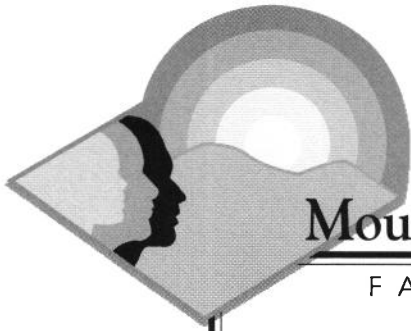
\_\_\_\_\_ Sinus Headaches  
\_\_\_\_\_ Sinus Infections  
\_\_\_\_\_ Stuffy Nose  
\_\_\_\_\_ Snoring  
\_\_\_\_\_ Nose Bleeds  
\_\_\_\_\_ Recurrent Head Colds  
\_\_\_\_\_ Facial Pain

### 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.

F A C I A L   P L A S T I C   S U R G E R Y

## FINANCIAL POLICY

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)

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*

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.**

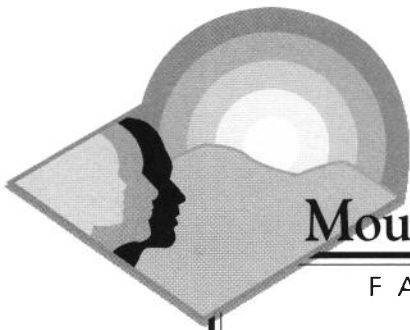
\_\_\_\_\_  
Patient's Name (Please print)

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

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date



# Mountain Regional Ear Nose & Throat, P.A.

F A C I A L   P L A S T I C   S U R G E R Y

## 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.

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\_\_\_\_\_  
Patient's Name (Please print)

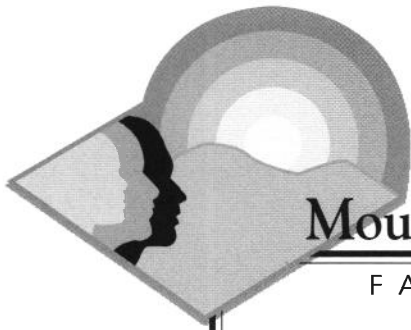
\_\_\_\_\_  
Patient's Signature (Parent or legal  
guardian must sign if patient is under 18)

\_\_\_\_\_  
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



# Mountain Regional Ear Nose & Throat, P.A.

F A C I A L   P L A S T I C   S U R G E R Y

## 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