Spartanburg & Greer ENT

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

PATIENT INFORMATION RECORD
(Please Print or Write Legibly)

DATE _____

ACCT # _____

PATIENT INFORMATION

NAME _____
First Middle Init. Last

MAILING ADDRESS _____

CITY _____

STATE _____ **ZIP** _____

SEX _____ **RACE** _____

ETHNICITY: ❑ **HISPANIC/LATINO** ❑ **NOT HISPANIC/LATINO** ❑ **DECLINE**

EMPLOYER/SCHOOL _____

PHONE HOME _____

WORK _____ **CELL** _____

MAY WE TEXT YOU? ❑ **YES** ❑ **NO**

DATE OF BIRTH _____

SOCIAL SECURITY # _____

EMAIL ADDRESS _____

MARITAL STATUS: M W S D

HOW DID YOU HEAR ABOUT US? _____

PREFERRED LANGUAGE _____

REFERRING DR. _____

FAMILY DR. _____

IF THE PATIENT IS A MINOR

PARENT INFORMATION:

CHILDS FATHERS NAME _____

CHILDS MOTHERS NAME _____

IF THE PARENTS ARE LEGALLY SEPARATED OR DIVORCED

WHICH PARENT HAS LEGAL CUSTODY? _____

WHICH PARENT IS FINANCIALLY RESPONSIBLE FOR MEDICAL EXPENSES? _____

PLEASE PROVIDE A COPY OF THE LEGAL DOCUMENTATION STATING THE PARENT RESPONSIBLE FOR MEDICAL EXPENSES TO BE INCLUDED IN THE PATIENT'S MEDICAL RECORD.

LEGAL GUARDIAN INFORMATION:

LEGAL GUARDIAN NAME _____

_____
Signature of Parent or Legal Guardian

PLEASE PRESENT LEGAL GUARDIAN DOCUMENTS TO THE RECEPTIONIST

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY _____

ID# _____ GROUP # _____

PRIMARY INSURED'S NAME _____ DOB _____ RELATIONSHIP TO PATIENT _____

SS # _____

INSURED'S EMPLOYER _____ DATE OF EMPLOYMENT _____

DATE OF RETIREMENT _____

SECONDARY INSURANCE COMPANY _____

ID# _____ GROUP # _____

SECONDARY INSURED'S NAME _____ DOB _____ RELATIONSHIP TO PATIENT

SS # _____

INSURED'S EMPLOYER _____ DATE OF EMPLOYMENT _____

DATE OF RETIREMENT _____

ARE YOU SPONSORED BY MEDICAID _____ MEDICAID # _____

ARE YOU BEING SEEN FOR A WORKERS' COMPENSATION CLAIM? _____

CLINICAL SUMMARIES ARE PROVIDED FOR ALL PATIENTS UPON REQUEST.

Spartanburg&Greer**ENT**

Patient Name: _____ DOB: _____

PLEASE INDICATE YOUR PREFERRED METHOD OF CONTACT & HIPAA RELEASE OF INFORMATION

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

❑ Any Method of Contact noted on Patient Information Form

Restricted Contact Preferences

❑ Home Telephone May we leave a message on your home answering machine? ❑ Yes ❑ No

❑ Cell Phone May we leave a message on your cell phone voicemail? ❑ Yes ❑ No

❑ Work Phone ❑ Email (non-encrypted) ❑ Text

HIPAA DELEGATES

❑ OPTION 1:
I authorize the person(s) listed below to receive all health information about appointments, treatments and/or other information pertinent to my healthcare and/or payment for my healthcare provided at Spartanburg and Greer Ear, Nose & Throat. These individuals will be designated as my emergency contacts.

Name:_____ Relationship: _____ Phone: _____

Name:_____ Relationship: _____ Phone: _____

HIPAA DELEGATES

❑ OPTION 2
I do not authorize any information to be disclosed to any other parties except to me as the patient/guardian except in the event of an emergency. Please note the following are emergency only contacts.

Name:_____ Relationship: _____ Phone: _____

Name:_____ Relationship: _____ Phone: _____

PLEASE SIGN AND DATE BELOW

Patient Signature: _____ Date: _____

If a minor, Parent/Guardian/
Legal Representative Signature: _____ Date: _____

Spartanburg&GreerENT

Patient Name _____ Account # _____

FINANCIAL POLICY OF SPARTANBURG & GREER EAR, NOSE & THROAT

PLEASE READ ALL INFORMATION AND ACKNOWLEDGE BY SIGNING BELOW.

1. We ask that you present your insurance card at each visit. It is your responsibility to provide us with correct information to bill your insurance.

2. If you have a change of address, telephone number, or employer, please notify the receptionist.

3. Deductibles, co-payments or charges for non-covered services are due at the time of service. We accept cash, checks, major credit cards and Care Credit.
There will be a $30.00 fee for all returned checks.

4. You are 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, contact our billing department at (864) 699-6981. We reserve the right to refuse service.

5. SELF-PAY PATIENTS: Patients with no insurance are expected to pay at time of service. A discount is offered for payment in full at time of service. If you can't pay in full, contact our billing department prior to seeing the doctor to make payment arrangements.

6. No show or missed appointments – When an appointment is scheduled with the doctor, time is specially allocated for you. Unable to keep an appointment, we ask the courtesy of a phone call to cancel your appointment. We prefer a 24 hour notice of cancellation.
Not keeping an appointment may incur a $50.00 fee.

Remember, whether you do or do not have insurance, you are ultimately responsible for payment of your charges. If you have any questions regarding our financial policy, please contact our billing department at (864) 699-6981.

I have read and have a full understanding of the financial policy of Spartanburg & Greer ENT.

Signature: _____ Date: _____

(required age 18 & older)

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TEMPORARY CONSENT FOR MEDICAL TREATMENT DURING PARENT(S)/LEGAL GUARDIAN(S) ABSENCE

In the event of my absence, I give permission for _____
(name of adult person with child)

to consent to treatment of _____ from the physicians of
(name of child/patient)

Spartanburg and Greet Ear, Nose & Throat.

In the event of an emergency, I may be reached at: (_____) _____-_____.

_____ _____
Signature of Parent of Legal Guardian Date

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GENERAL CONSENT

The following are the 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.

AUTHORIZATION FOR RELEASE OF INFORMATION

The practice and physicians are authorized to release any medical information required in the processing of applications or submission of information for financial coverage, discharge planning and further medical treatment. I/we also agree to the release of medical or other information about me to government federal or state regulatory agencies as required by law.

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.

WORKER'S COMPENSATION PATIENT RECORDS RELEASE AND AUTHORIZATION FORM

I understand that South Carolina and North Carolina Worker's Compensation law provides that written information which pertains directly to a workers' compensations claim must be provided by a healthcare facility/physician to the insurance carrier, the employer, the employee, their attorneys, or the applicable State Workers' Compensation Commission pursuant to the SC Code Ann § 42-15-95 and NC ST § 97-27. I authorize Spartanburg and Greer Ear, Nose and Throat to provide copies of my medical records or to speak to duly authorized representatives of any of the above regarding my medical records, medical treatment, or condition.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I/we have received 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

Patient Signature: _____ Date: _____

If a minor, Parent/Guardian/
Legal Representative Signature: _____ Date: _____

IMPORTANT NOTICE!

Our local hospitals are teaching institutions. On a regular basis, our physicians take part in the training of young physicians and doctors in training. Often times, a resident or medical student will be working with one of our doctors.

In this office, our main priority is the comfort and well-being of our patients. Please inform any of our staff as soon as possible if you do not wish to have a resident or medical student present during your visit today.

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