The Mann Ear, Nose & Throat Clinic

Est. 1991

Today's Date _____

WELCOME TO OUR PRACTICE********PLEASE FILL OUT THIS ADULT PATIENT INFORMATION SHEET**

Name:_____
First Middle Initial Last Nick Name

Address_____

City: _____ State:_____ Zip: _____

Home Phone #:_____ Cell Phone #:_____Work Phone #: _____

Preferred Communication for Appointment reminders: Text Message / Phone Call

Date of Birth:_____Circle one: Male / Female ; Circle one: Married / Single / Divorced / Widowed

Race: _____ Language:_____ Religious affiliation : _____

Social Security #:_____ E-mail address: _____

Employer:_____Occupation: _____

Primary Care Physician:_____**AND** Practice Name:_____ NONE

IF Referred: Referring Provider:_____And Practice Name:_____

**********EMERGENCY CONTACTS**********

Emergency Contact Name_____Home Phone:_____

Cell Phone:_____DOB:_____Relationship:_____

**********BILLING INFORMATION **********

Guardian /Person Responsible for Bill: _____

Address_____

Home Phone #:_____ Work Phone #: _____

********** INSURANCE INFORMATION **********

Insurance Company: _____

Policyholder's Name:_____Policyholder's DOB: _____
(This is the person with whom the insurance is purchased through their work)

Policyholder's SS #:_____Policyholder' Employer: _____

****

REASON FOR VISIT: _____

DRUG ALLERGIES: _____

MEDICATION: _____

PHARMACY NAME & NUMBER: _____

****

HOW DID YOU FIND OUT ABOUT MANN ENT?

Primary care physician	Internet	Wellness article	Yellow pages
Insurance book	TV Commercial	Walk-in	Cary News

Patient Referral:_____ Another doctor: _____

Chart # **Patient's Name:**

Disclosure: By signing this document I am stating that I have been given a copy of the Mann ENT HIPAA form. I also have the opportunity to authorize others to access my information according to the HIPAA.

I,_____, give permission to Mann ENT to
(Print)
disclose the following protected health information to the following(this will allow us to discuss information including but not limited to: appointments, payments, insurance coverage). PATIENT'S THAT ARE UNDER ANOTHER FAMILY MEMBERS INSURANCE AND/OR PATIENT'S THAT RELY ON OTHERS FOR TRANSPORTATION NEED TO FILL THIS PORTION OUT.

FAMILY:_____Relationship:_____

Name:_____Relationship:_____

Name:_____Relationship:_____

Legal Representative:_____Papers Presented Date:_____

OTHER_____

Information to be disclosed (check all that apply):

	Medical Records		Billing information
	Treatment Records		Leave Detailed Voice Mail
	Diagnostic Records		Email

Other: _____

_____

This authorization expires_____(OPTIONAL)
This signature is good for the life of the patient's care at Mann ENT unless otherwise stated.
[Specify (1) date or (2) event that relates to the purpose of this use or disclosure]

Finally, you may revoke this authorization in writing at any time by sending written notification to the Medical Records Department at our Cary Office (919-859-4744). Please note that your new notice of revocation will not apply to actions taken prior to the date we receive your written request to revoke authorization.

_____. _____
Signature Date

_____. _____
Mann ENT Rep- Print Mann ENT Rep- signature

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Acknowledgement of Receipt

Of Notice of Privacy Practices

Patient Name: _____

Patient Address: _____

_____

I have received a copy of the Notice of Privacy Practices for the above named practice.

_____ _____
Signature Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- ❑ An emergency existed & a signature was not possible at the time.
- ❑ The individual refused to sign.
- ❑ A copy was mailed with a request for a signature by return mail.
- ❑

Unable to communicate with the patient for the following reason:

_____

Other:_____

Prepared By _____

Signature _____

Date _____

Our Financial Policies

Thank you for choosing Mann ENT Clinic for your ENT needs. We are dedicated to delivering top-notch medical care while upholding transparency and cost-effectiveness in our services. Your understanding and cooperation are essential to ensure a smooth experience, so please feel free to reach out if you have any inquiries about our policies.

Insurance Coverage:
When scheduling your appointments, please provide us with your current insurance information and promptly inform us of any changes. It is crucial to remember that your health insurance policy is a contract between you and your insurance company. As the policy holder or patient, it is your responsibility to comprehend your coverage, including deductibles, copayments, and coinsurance. Make sure your doctor is in-network and that the services are covered under your plan. If you have questions about your insurance benefits, we encourage you to contact your insurance plan directly.

Insurance Claims:
We bill your insurance company as a courtesy, but we do require accurate and up-to-date insurance information, including primary and secondary insurances, for proper billing. Failure to keep us informed may result in personal financial responsibility for your bill. While we can provide estimates, your insurance company makes the final determination of your eligibility and benefits. You agree to cover any charges not covered by your insurance, including those above the usual and customary allowance. If we are out of network with your insurance, and they pay you directly, please forward the payment to us promptly.

Referrals and Authorizations:
Certain insurances require referrals or prior authorizations from your Primary Care Provider before seeing a specialist. Obtaining these is your responsibility. Failing to secure necessary paperwork may result in self-payment for your visit, with payment due when services are rendered.

Address/Phone Number Changes:
To maintain effective communication, please notify the front desk of any changes to your address, phone number, or other contact information.

Medicare Patients:
Please note that Medicare may not fully cover the cost of all recommended services by your doctor.

Payments:
All co-payments and past-due balances are expected at the time of service. If you cannot provide your co-payment or balance at the time of service, you may be asked to reschedule. We bill your insurance for covered services, and once they have paid, you will receive a statement for any remaining deductible or co-insurance amounts. These balances should be settled in full within 30 days of statement receipt. Failure to do so may result in further collection activities, including involvement with an outside collection agency. If you encounter difficulties paying within the 30-day timeframe, please contact our office to explore alternative options.

Self-Pay:
Self-pay patients are required to make payments for medical evaluation and treatment at the time of service. We will provide a good faith estimate, if requested, of these charges prior to evaluation and management, but please

note that the actual required treatment by your physician or PA may generate charges that exceed the estimate provided.

Credit Card on File:
To simplify out-of-pocket expenses, we have implemented a credit card on file system. All patients will be asked to participate, and co-pays, co-insurances, deductibles, and past-due balances are expected to be provided at check-in for your appointment.

After Hours Call:
In the event of after-hours calls, our answering service will contact the physician on call. Please be aware that non-emergent after-hours calls may incur a $50 charge, which is the patient's responsibility.

Additional charges

We kindly wish to inform our valued patients about the various fees associated with our services. These charges have been implemented for specific reasons to maintain the efficiency and quality of care we provide:

1. **No Show Charge – $50**: In the event of a missed appointment without a 24-hour notice, a $50 fee will be applied. This fee serves as a gentle reminder of the importance of timely notification, allowing us to accommodate other patients who may require our care.

2. **Returned Checks/Insufficient Funds – $25**: A $25 fee will be charged in cases of returned checks or insufficient funds. This helps us cover the costs associated with these transactions.

3. **Completion of Disability and FMLA – $25**: To cover administrative expenses related to the completion of disability and FMLA paperwork, a $25 fee may be applied. This ensures we can continue providing this essential service.

4. **Medical Records Requests – Varies**: Patients requesting their medical records may be charged $10 for the first 13 pages and $0.75 for each additional page. These fees help us manage the administrative workload associated with maintaining and providing your medical history.

5. **Missed Office/Hospital Procedure/Surgery – $75**: If a patient does not arrive for an office/hospital procedure or surgery without providing us with one week's notice, a $75 charge may be applied. This fee helps us in managing resources efficiently and rescheduling any affected appointments.

We appreciate your understanding of the necessity of these fees and their role in ensuring the smooth functioning of our medical practice. If you have any questions or concerns regarding these fees, please do not hesitate to contact us. Thank you for entrusting us with your healthcare needs.

Assignment of Benefits: I hereby request that payment of authorized Medicare, Medicaid and all other insurance benefits be made on my behalf to Mann ENT for any services provided to me and or my dependants. I authorize any holder of medical information about me or my dependants to release to the appropriate entity and its agents any information needed to determine these benefits payable for related services.

Note to custodial parent/guardian: Responsibility for payment of services rendered to any dependent children lies with the parent who physically brings minor to the visit, regardless of any court documents assigning responsibility.

Guarantee of Payment: I hereby agree to be responsible for any co-pays, co-insurance, deductibles and /or non covered services deemed by my insurance contract. In the event that I default on payment of my account, I understand that I am responsible for any and all costs incurred on the collection of my account. This may include, but not limited to court costs, reasonable attorney's fees. If the debt is assigned to a third party collection agency, I will be responsible for the **$10.25 collection fee** incurred on the account.

I acknowledge that I have reviewed and had an opportunity to ask questions concerning the practice's financial policy and agree to the terms of payment due.

Print Patient Name	Patient Date of Birth
Patient's Signature	Date
Responsible Party Signature	Relationship to Patient

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HIPAA RELEASE OF INFORMATION AUTHORIZATION

Consent for access to Protected Health Information:

I give consent to the staff at Mann ENT Clinic to communicate with the person(s) listed below regarding my medical treatment. I consent to the use of my protected Health Care Information when communicating with the person(s) below. Mann ENT Clinic may communicate in person, by telephone, mail, e-mail, fax, or other means. I may withdraw this consent at any time by notifying Mann ENT Clinic in writing. Any communication prior to such notice will be considered to have been authorized by me.

Patient Signature_____**Date** _____

PLEASE LIST NAMES OF PERSONS OR FAMILY YOU AUTHORIZE TO RECEIVE INFORMATION ABOUT YOU.

Name:_____Relationship: _____

Name:_____Relationship_____

Name:_____Relationship_____

Patient Rights:

- I have the right to revoke this authorization at any time in person or in writing
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases when the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.
- I understand released information may include a communicable disease diagnosis such as HIV or a diagnosis related to mental health or substance abuse.

REVOKED
How: □ in person on_____(Date) If in person, signature is required.
Signature of Patient or Personal Representative: _____

ϒ in writing