Name:
DOB:
Chart:
Age:
Date:

Ō·tō·laryn·gol·ō·gy Associates
ENT & Face, Head & Neck Plastic Surgery
www.otolaryn.com

M/R RELEASE, MESSAGES, FINANCIAL POLICY

I AUTHORIZE THE RELEASE OF THE ABOVE PATIENT'S MEDICAL RECORDS TO THE INSURANCE CARRIER(S) VIA FAX OR MAIL. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS DIRECTLY TO THE PHYSICIAN FOR SERVICES PROVIDED. **I AUTHORIZE THE RELEASE** OF THE ABOVE PATIENT'S MEDICAL RECORDS TO THE PHYSICIANS INVOLVED IN THE CARE VIA FAX OR MAIL. **I FURTHER AUTHORIZE** OTOLARYNOLOGY ASSOCIATES TO LEAVE THE RESULTS OF THE ABOVE PATIENT'S EXAMINATIONS AND TESTS, INCLUDING MESSAGES, APPOINTMENT REMINDERS, LABORATORY TESTS AND X-RAYS ON THE ANSWERING MACHINE/VOICEMAIL AT THE PHONE NUMBER PROVIDED. **I AM RESPONSIBLE FOR ALL FINANCIAL OBLIGATIONS** OF THE HEALTH SERVICES FOR THE ABOVE PATIENT, AND FOR REIMBURSEMENT AND PAYMENT OF CLAIMS FROM THE INSURANCE COMPANY. I UNDERSTAND THE DOCTOR'S CHARGE MAY EXCEED THE INSURANCE CARRIER'S PAYMENT AND IF THE CHARGE IS MORE THAN SUCH PAYMENT, I WILL BE RESPONSIBLE FOR THE DIFFERENCE IF FOR ANY REASON THE ABOVE PATIENT'S ACCOUNT SHOULD BECOME DELINQUENT, I AGREE TO PAY FOR ALL COLLECTION, ATTORNEY FEES, AND COURT COSTS.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

_____ By signing below, I acknowledge that I have received Otolaryngology Associates, LLC* Notice of Privacy Practices ("Notice").

* This includes Whisper Hearing Centers, Biggerstaff & Associates and Balance Point

PRESCRIPTION MEDICATION HISTORY CONSENT

_____ I agree that Otolaryngology Associates, LLC may request and use my prescription medication history from other healthcare providers or third-party pharmacy benefit payors for treatment purposes.

_____ Date _____
Signature (Patient or Authorized Representative)

_____
Printed (Patient or Authorized Representative)

_____
Printed Patient Name

Name:
DOB:
Chart:
Age:
Date:

OTOLARYNGOLOGY ASSOCIATES PHYSICIAN _____
(FOR OFFICE USE ONLY)

PATIENT NAME _____ _____ INITIAL
(LAST) (FIRST) (MIDDLE)

PATIENT ADDRESS _____ **Last 4 SS#**

CITY _____ STATE _____ ZIP _____

PRIMARY ( ) _____ Home Cell SECONDARY ( ) _____ Home Cell OTHER ( ) _____

SOCIAL SECURITY NUMBER _____ - _____ - _____ SINGLE MARRIED SEPARATED DIVORCED WIDOWEI

DATE OF BIRTH _____ / _____ / _____ AGE _____ SEX: M / F (CIRCLE ONE)

EMAIL ADDRESS (FOR PATIENT PORTAL ACCESS) _____

RACE: Asian Native Hawaiian Other Pacific Islander Black/African American American Indian/Alaska Native White
More than one race Unreported/Refused to report

ETHNICITY: Hispanic/Latino Not Hispanic/Not Latino Unreported/Refused to report LANGUAGE: _____

SPOUSE _____ / /
(LAST) (FIRST) (M.I.) (S.S.#) (DATE OF BIRTH)

CHILD'S MOTHER/GUARDIAN _____ / /
(LAST) (FIRST) (M.I.) (S.S.#) (DATE OF BIRTH)

CHILD'S FATHER/GUARDIAN _____ / /
(LAST) (FIRST) (M.I.) (S.S.#) (DATE OF BIRTH)

ADDRESS IF DIFFERENT THAN PATIENT'S _____

REFERRING M.D. _____ /
(ADDRESS)

FAMILY M.D. _____ /
(ADDRESS)

NOTIFY IN CASE OF EMERGENCY _____ / _____ PHONE ( ) _____
(RELATIONSHIP)

PHARMACY _____ LOCATION _____ PHONE ( ) _____

REASON FOR BEING SEEN TODAY _____

ANY HEARING CONCERNS: YES NO DO YOU HAVE ANY DIZZINESS: YES NO

ANY PROBLEMS WITH ALLERGIES: YES NO

****THIS SECTION MUST BE COMPLETED IN FULL, EVEN IF CARD IS COPIED****

PRIMARY INSURANCE CO. _____ Employer: _____

ID# _____ GROUP # _____ POLICY HOLDER'S DATE OF BIRTH ____/____/____

POLICY HOLDER'S NAME _____ PATIENT SPOUSE FATHER MOTHER STEPPAREN

SECONDARY INSURANCE CO. _____ Employer: _____

ID# _____ GROUP # _____ POLICY HOLDER'S DATE OF BIRTH ____/____/____

POLICY HOLDER'S NAME _____ ☐ PATIENT ☐ SPOUSE ☐ FATHER ☐ MOTHER ☐ STEPPAREN

Name:
DOB:
Chart:
Age:
Date:

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OA Physician: _____

Contact Information for Protected Health Information

I, _____ (patient's name) DOB: _____

request that the following methods be adhered to for the disclosure of my Protected Health Information (Protected Health Information would include your name, diagnoses, test results, dates of service as described in the Notice of Privacy Practices).

Please check any or all of the three options that apply:

Option A:

☐ OA may disclose information by telephone to people designated below. **This document does not allow the people listed below to receive medical records. For OA to allow non patients to receive medical records, a release of information form must be signed by the patient or their power of attorney.**

Name	Phone Number	Relationship

Option B:

☐ You may leave Protected Health Information on my answering machine/voicemail at this phone number: (_____) _____

Option C:

☐ Other _____

Document is good for one year from date signed.

_____ _____
Patient's Printed Name Social Security Number

_____ _____
Patient's Signature (or Guardian if a minor) Date

_____ _____
Witness (optional) Date