

MID-SOUTH EAR, NOSE, AND THROAT, P.C.
PATIENT REGISTRATION

TODAY'S DATE _____

ACCOUNT # _____

WHO IS YOUR APPOINTMENT WITH: (Circle One)

Dean A. Klug, M.D.

Bruce L. Fetterman, M.D.

Anne Moffatt, APN

Lauren Bruff, APN

Sri I. Naidu, M.D.

Scott D. Burge, M.D.

Michelle Pattat, APN

Amanda Person, APN

Mark A. Milburn, M.D.

Brandon A. Shepherd, M.D.

Marsha Dean, APN

Ashley Marsh, APN

John S. Touliatos, M.D.

PATIENT INFORMATION

LAST NAME _____ FIRST NAME _____ M.I. _____

STREET ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE () _____ WORK PHONE () _____ CELL PHONE _____

DATE OF BIRTH _____ AGE _____ SS # _____

MARITAL STATUS: SINGLE MARRIED OTHER SEX: F M

EMPLOYER _____ EMAIL _____

PRIMARY CARE PHYSICIAN NAME _____ PHONE () _____

EMERGENCY CONTACT INFORMATION

NAME _____ PHONE NO. () _____ RELATION _____
(RELATIVE/FRIEND NOT LIVING IN SAME HOUSEHOLD)

REFERRING INFORMATION

HOW DID YOU HEAR ABOUT US? (Circle One) PHYSICIAN YELLOW PAGES FRIEND/RELATIVE

INSURANCE DIRECTORY INTERNET WALK-IN

FULL NAME OF PERSON WHO REFERRED YOU _____

PARENT/GUARDIAN INFORMATION IF PATIENT IS A CHILD

MOTHER'S INFORMATION

MOTHER'S NAME _____ ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE () _____ DATE OF BIRTH _____ S.S. NO. _____

EMPLOYER _____ WORK PHONE () _____ CELL PHONE _____

FATHER'S INFORMATION

FATHER'S NAME _____ ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE () _____ DATE OF BIRTH _____ S.S. NO. _____

EMPLOYER _____ WORK PHONE () _____ CELL PHONE _____

INSURANCE INFORMATION

Your insurance company requires us to keep your current insurance information and a signed authorization of benefits on file.

PRIMARY INSURANCE INFORMATION

SECONDARY INSURANCE INFORMATION

NAME OF INSURANCE CARRIER

ADDRESS

CITY/STATE/ZIP

POLICY HOLDER'S NAME

POLICY HOLDER'S ADDRESS (CITY, STATE, ZIP)

POLICY HOLDER'S DATE OF BIRTH

POLICY HOLDER'S EMPLOYER

POLICY HOLDER'S ID #

GROUP # / NAME

NAME OF INSURANCE CARRIER

ADDRESS

CITY/STATE/ZIP

POLICY HOLDER'S NAME

POLICY HOLDER'S ADDRESS (CITY, STATE, ZIP)

POLICY HOLDER'S DATE OF BIRTH

POLICY HOLDER'S EMPLOYER

POLICY HOLDER'S ID #

GROUP # / NAME

Name of outpatient/hospital facility your prefer to schedule tests/surgery _____

Please list family members or significant others, if any, whom we may inform about your medical condition and your diagnosis (including treatment, payment and health care operations):

Please print the telephone numbers where you want to receive calls about your scheduling, test results, and other health care information if other than your home phone number: _____

I am fully aware that a cell phone is not a secure and private line.

Can we leave a general message requesting a return call to our office on your telephone answering machine or voice-mail? **Work** _____ Yes _____ No **Home** _____ Yes _____ No

I certify the information I provided on this form is correct to the best of my knowledge.

PATIENT / GUARDIAN SIGNATURE

DATE

Patient Location/Room Number: _____

Medicare (please circle): YES NO

AUDIOLOGY PROCEDURE(S)

- _____ TYMPS
- _____ REFLEXES
- _____ BASIC COMP.
- _____ PURE TONE
- _____ SPEECH (SRT + WORD REC.)
- _____ VRA
- _____ PLAY AUDIO
- _____ DOC'S
- _____ SWIMMOLDS
- _____ HEARING AID EVAL
- _____ HEARING AID CHECK

X-RAY(S)

- _____ 3 VIEWS
- _____ WATERS/LATERAL
- _____ WATERS/CALDWELL
- _____ WATERS ONLY
- _____ LATERAL ONLY
- _____ NASAL BONES

AUDIOLOGY PROCEDURE(S) TO BE SCHEDULED

- _____ ECOCHG
- _____ ENG
- _____ ABR (NEURODIAGNOSTIC)
- _____ ABR (THRESHOLD)
- _____ OAEs
- _____ VRA
- _____ PLAY AUDIO
- _____ FLU
- _____ MAMMOGRAM
- _____ PAP SMEAR
- _____ COLONOSCOPY
- _____ PNEUMONIA
PQRS

SURGERY TO BE SCHEDULED:

PAYMENT AGREEMENT

PATIENT NAME _____

ACCOUNT # _____

By signing the space below as patient, guardian or guarantor, or as the patient's guardian, spouse, or guarantor's spouse, I hereby agree that all charges connected with services performed by Mid-South Ear, Nose, and Throat, P.C. not covered by any insurance program, sponsorship, or other third party coverage I may have are due and payable at the time of discharge or discontinuation of treatment.

I hereby acknowledge that Mid-South Ear, Nose, and Throat, P.C. will bill my insurance or third party carrier. I acknowledge that it is my responsibility to know the benefits of my insurance plan including deductible and co-insurance amounts and verifying the provider is in network with my insurance plan. I understand that I shall be responsible for all of my charges except those paid under medical insurance. I will be responsible for non-covered services, the deductible, and co-insurance amounts. Deductibles and co-insurance payments are due prior to the surgery date. Post-op visits after endoscopic sinus surgery that include nasal endoscopies are billable charges and will be filed with your insurance. Remaining balances are due upon receipt of an itemized bill. I authorize Mid-South Ear, Nose, and Throat, P.C. to release medical information necessary to process insurance claims. I further authorize payment of medical benefits directly to the physician or supplier of services rendered.

I agree that if I am more than thirty (30) days delinquent in the payment of my bill connected with these charges my account will be referred for collection. I further agree to pay attorney's fees, court cost, and/or collection fees associated with the collection process.

Patient/Guardian/Guarantor

Date

FOR MEDICARE PATIENTS ONLY

ONE-TIME PAYMENT AUTHORIZATION & ASSIGNMENT

Medicare Policy #: _____

Medigap Insurance Company: _____ Policy #: _____

I request that payment of authorized Medicare benefits and authorized Medigap benefits be made on my behalf to Mid-South Ear, Nose, and Throat, P.C. for any services furnished to me by that provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents and/or any Medigap insurer any information needed to determine these benefits or the benefits payable for related services.

Patient/Guardian

Date

MID-SOUTH EAR, NOSE, AND THROAT, P.C.

7378 Yale Road Bartlett, TN 38133

1458 W. Poplar Ave, Suite 204 Collierville, TN 38017

7600 Wolf River Blvd., Suite 220 Germantown, TN 38138

7600 Wolf River Blvd., Suite 130 Germantown, TN 38138 (Allergy Center)

7600 Wolf River Blvd., Suite 120 Germantown, TN 38138

Authorization For Release Of Information

For information about how your medical information may be used or disclosed, please see the Patient Notice. You have the right to review the Notice before you decide to sign this form. The Notice is subject to change. You may request a copy of the Notice from the Privacy Officer. The Notice is also posted at Mid-South Ear, Nose and Throat, P.C.'s offices.

- YOU HAVE THE RIGHT TO INSPECT, COPY AND/OR AMEND INFORMATION TO BE USED OR DISCLOSED.
- YOU MAY REFUSE TO SIGN THIS FORM, HOWEVER IT MAY PREVENT US FROM COMPLETING A TASK YOU HAVE REQUESTED (such as enrollment in research study or examining you to create a report for your attorney).
- WE WILL NOT CONDITION YOUR TREATMENT ON AN AUTHORIZATION, EXCEPT FOR AN AUTHORIZATION FOR RESEARCH-RELATED TREATMENT.
- WE MUST PROVIDE YOU WITH A COPY OF THIS AUTHORIZATION FORM.

THIS AUTHORIZATION IS VOLUNTARY

I, _____, Date of Birth _____ do hereby authorize Mid-South Ear, Nose, and Throat, P.C. to obtain, use, disclose or receive my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization to whom I authorize disclosure of my personal data and/or individually identifiable health information is not a health plan, health care provider, or clearinghouse the released information may no longer be protected by federal privacy regulations.

I authorize release of information from my medical record (as outlined below and initialed):

_____ Complete medical record that may contain treatment notes regarding radiology, pathology (*including HIV test results and genetic testing information*), immunization, procedure(s), *alcohol and drug abuse records protected by Federal Confidentiality Rules 42 CFR Part 2*, and other common medical record documentation made by the physician, nurse or other ancillary personnel for the entire time I was treated by the practice.

OR

_____ For information collected/services described below and provided during the time period of _____.

Description of records to be released: _____

Release my medical records to the following: _____

For the purpose(s) of: _____

Once Mid-South Ear, Nose, and Throat P.C. gives out the information that I want released, I know that the Mid-South Ear, Nose, and Throat P.C. has no control over the information. The individual or organization that I authorize to receive the information might re-disclose it. Federal and state privacy laws may no longer protect the information.

I understand that I may withdraw my authorization in writing to the Privacy Officer at any time except to the extent that action has been taken in reliance on this statement. I understand that even if I do not withdraw authorization that this statement will expire **one (1) year from this date**. I have carefully read and understand the above, and do herein expressly and voluntarily authorize the disclosure of the above information about, or medical records of, my condition to those persons or agencies listed above.

Signature of patient or patient's representative
(Form MUST be completed before signing.)

Date

Printed name of patient's representative _____

Description of the Representative's authority to act for the patient _____

This form does not have to be completed to release information for treatment payment or healthcare operations except when the information to be released contains confidential details as listed above, privileged categories or certain research information.

Patient Account No. _____

TENNCARE NOTICE

Mid-South Ear, Nose and Throat is not contracted with any TennCare plans. This includes BlueCare, TnCare Select, United Healthcare Community Plan or Amerigroup.

I acknowledge that _____ does not have TennCare,
Patient Name
has not applied for TennCare or does not have an application pending for TennCare.

Patient/Guardian Name (Please Print)

Relationship to Patient

Patient/Guardian Signature

Date