

DAYTON EAR, NOSE AND THROAT SURGEONS, INC.

Patient #

Financial Information

Please help us serve you better. Complete all sections of this form.

DATE _____ DOCTOR _____ COMPLAINT / SYMPTOMS _____

Patient last name _____ First _____ M.I. _____ Date of birth _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ SS# _____ Age ____ Sex F M Marital Status: S M W D SEP CHILD

Home Fax # _____ Work Phone _____ Cell Phone _____ Occupation _____

In case of emergency notify _____ Phone Number _____

Referring physician _____ Address _____

Family physician _____ Address _____

How were you referred to our practice? Family Doctor Other Specialist Friend Other _____

Billing/Insurance information—all patients please complete. (If patient is a minor, include information regarding both parents.)

1. Name of Insurance _____

Cardholder name _____ Relationship to patient _____

Address _____ SS# _____ DOB _____

City _____ State _____ Zip _____ Home Phone _____

Employer _____ Work Phone _____

Insurance address _____ Policy or ID # _____ Group # _____

City _____ State _____ Zip _____ Effective date _____

2. Name of Insurance _____

Cardholder name _____ Relationship to patient _____

Address _____ SS# _____ DOB _____

City _____ State _____ Zip _____ Home Phone _____

Employer _____ Work Phone _____

Insurance address _____ Policy or ID # _____ Group # _____

City _____ State _____ Zip _____ Effective date _____

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize Dayton Ear, Nose & Throat Surgeons, Inc. to furnish information to my insurance carriers concerning my illness and treatments. I hereby assign to the physicians all payments for medical services to myself or my dependents. I understand that I am responsible for any amount not covered by the insurance.

Date _____ Signature _____

Date _____ Signature _____

Date _____ Signature _____

Date _____ Signature _____

Dayton Ear, Nose & Throat Surgeons, Inc.

Medical History Form – Please complete all sections of this form.

Patient # _____

Name: _____ Today's date: _____ Date of birth: _____

Referring physician: _____

What are you in for today? _____

Past surgeries: _____

Past medical problems: _____

Yes No Have you regularly smoked? Packs per day _____ How many years? _____

Yes No Do you drink alcohol? (Circle one) occasionally socially regularly past abuse

Yes No Are you currently pregnant? Expected delivery date: _____

Father's medical history: Circle any known illness that has occurred in your immediate family.

stroke	cardiovascular disease	ear disease	arthritis
hypertension	kidney disease	stomach problems	cancer
diabetes	neurologic problem	chronic headaches	asthma
heart attack	kidney stones	leukemia	Alzheimer's
COPD	high blood pressure	seizures	thyroid disease
inner ear problems	fainting spells	back pain	jaw problems

Other: _____

Mother's medical history: Circle any known illness that has occurred in your immediate family.

stroke	cardiovascular disease	ear disease	arthritis
hypertension	kidney disease	stomach problems	cancer
diabetes	neurologic problem	chronic headaches	asthma
heart attack	kidney stones	leukemia	Alzheimer's
COPD	high blood pressure	seizures	thyroid disease
inner ear problems	fainting spells	back pain	jaw problems

Other: _____

Drug allergies: _____

Current medications: _____

OVER 

Review of Systems (Circle problems with any of the following.)

- Yes No Cardiovascular:** Do you have a history of an abnormal EKG, angina, angioplasty, arrhythmia, cardiac surgery, congestive heart failure, coronary artery disease, heart attack or MI, high blood pressure, mitral valve prolapse, significant heart murmurs, valve disease, or valve surgery?
- Yes No Endocrine:** Do you have a thyroid disorder, diabetes-past or present, osteoporosis or any other endocrine problems?
- Yes No Gastrointestinal:** Do you have blood in stool, cirrhosis, Crohn's disease, hepatitis (A, B, or C), hiatal hernia, liver disease, ulcerative colitis, ulcer disease, or ASA/NSAID intolerance?
- Yes No Genitourinary:** Do you have acute renal failure, chronic renal failure, dialysis, kidney transplant, nephrectomy or loss of one kidney?
- Yes No Hematologic/Lymphatic:** Do you suffer from easy bruising, anemia, hemophilia or thalassemia?
- Yes No Immune System:** Do you have HIV/AIDS, illegal IV drug use, AIDS exposure, history of cancer, current infection, past blood transfusions, hepatitis or any other immune system problems?
- Yes No Neurologic:** Do you suffer from fainting, head injury, LOC, weakness, tremors, headaches, seizures, brain surgery, memory loss, speech disorder, paralysis, loss of balance or any other neurologic problems?
- Yes No Psychiatric:** Do you suffer from any untreated anxiety, stress or depression at the present time?
- Yes No Respiratory:** Do you have asthma requiring frequent treatment, bronchitis, COPD, emphysema, TB or symptoms of acute respiratory distress?
- Yes No Vascular:** Do you suffer from phlebitis, DVT, PE, blood clots, bleeding problems, aneurysms, hemophilia or any other vascular problems?
- Yes No Skin:** Do you suffer from itching, skin color changes, rashes, bruising, prolonged bleeding when cut, psoriasis or skin infections?
- Yes No Musculoskeletal:** Do you have any current untreated musculoskeletal problems?
- Yes No Gynecological:** Do you suffer from any gynecological problems?
- Yes No Breast:** Do you have any pain, discomfort, discharge or abnormal mass in your breasts?

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

Signature

Date

PATIENT AUTHORIZATION OF DISCLOSURES

In general, the HIPPA privacy rule gives the right to request a restriction on uses and disclosures of personal health information (PHI). The individual is also provided the right to request confidential communication of PHI be made by alternative means.

I wish to be contacted in the following manner. (Check all that apply.)

Home Telephone:

- O.K. to leave a message with detailed information.
- Leave a message with a call-back number.

Work Telephone:

- O.K. to leave a message with detailed information.
- Leave a message with a call-back number only.
- Do not attempt to reach me at work.

Written Communication:

- O.K. to send mail and communication to my home address.
- O.K. to send mail and communication to my work address.
- O.K. to send a fax to my home.
- O.K. to send a fax to my work.

Third Party Authorization:

- There are no restrictions regarding discussing my personal health information or medical billing with my spouse or other family member or friend involved in my care.
- The following persons are allowed to speak with any employee to discuss my medical or financial information. _____
- Do not speak with anyone other than me regarding my medical information.

Patient Signature

Patient Name

Medical Center Representative

Date

The privacy rule requires healthcare providers to take reasonable steps to limit the use or disclosure of a patient's PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to the use and intent made pursuant to an authorization requested by the individual.

Note: Uses and disclosures of PHI may be permitted without prior consent in an emergency and for the purpose of daily processes as needed to treat and care for the patient.

Dayton Ear, Nose & Throat Surgeons, Inc.

**CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR
TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS**

I consent to Dayton Ear, Nose & Throat Surgeons, Inc. (D.E.N.T.) using and disclosing my protected health information to carry out treatment, payment or health care operations.

I understand and have been provided with a Notice of Privacy Practices, which provides a more complete description of how my protected health information may be used or disclosed. I understand that I have the right to review the notice prior to signing this consent.

I understand that D.E.N.T. reserves the right to change their notice and information practices and that I may obtain a copy of the revised notice by requesting a copy from the office manager.

I have the right to revoke this consent by notifying D.E.N.T. in writing, except to the extent that D.E.N.T. has taken action in reliance on my consent.

I understand that this consent supersedes any and all consents signed including the Authorization for Release of Information contained in the D.E.N.T. registration form.

Signature of patient or patient's representative

Date

Printed name of patient or patient's representative

**Relationship to patient or
representative's authority to act
for the patient.**

DENT FINANCIAL & PAYMENT POLICY

INSURANCE

If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.

You will be asked to update your demographic and insurance information periodically, including providing our office with copies of your insurance card(s). We are required to annually obtain your signature for permission to release information to your insurance carrier. Please assist us in complying with your insurance requirements.

We will gladly submit fees for your covered medical services to your insurance company. We expect payment of all services within 30 days. It may be necessary for you to pay your account in full if your insurance company fails to pay for services within 30 days. It is your responsibility to understand your coverage and benefits, including pre-certifications, referral and authorization requirements. We will assist you to insure all plan requirements are met.

PAYMENT FOR SERVICES

Payment for service, including co-payment and deductible amounts, is due at the time of service. Failure to make co-payment at the time of service will result in an additional fee of \$15. Your failure to pay the required co-pay amounts is a violation of your financial responsibility for coverage and we may report your refusal to pay these amounts to your employer and/or insurance company representative.

We accept cash, checks, Mastercard, VISA, and Discover. Returned checks will have a fee of \$35. Balances older than 60 days, and failure to pay account balances as promised may be subject to external collection and additional collection fees, including attorney and other court fees. We may investigate your credit record to determine your ability to pay your debt.

OUTSTANDING BALANCE POLICY

It is our office policy that all past due accounts be sent two statements. If payment is not made on this account, a single phone call will be made to try to make payment arrangements. If no resolution can be made, the account will be sent to the collection agency, or attorney, and possible discharge from the practice.

In the event an account is turned over for collections, the person financially responsible for the account will be responsible for all collections costs including attorney fees and court costs.

Regardless of any personal arrangements that a patient might have outside of our office, if you are over 18 years of age and receiving treatment, you are ultimately responsible for payment of the service. Our office will not bill any other personal party.

CANCELLED APPOINTMENTS

Fees will be charged for broken, confirmed appointments and appointments canceled without 24 hours advance notice. Your cooperation in canceling your scheduled appointment well in advance of the appointment allows us the opportunity to offer your appointment to another person who needs medical care. Failure to show for a scheduled confirmed appointment may result in the following fees:

Physician office visit - \$25.00
Allergy shot - \$15.00
Allergy testing - \$25.00
IV appointment - \$35.00
LDA shot - \$250.00
Audiology - \$25.00

GENERAL

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. It is important to understand that:

As a result, we take great care to insure that our fees are consistent with the charges in this geographic region. Your insurance company may not use "reasonable charge information" specific to this region and specialty of Otolaryngology. In fact, many carriers purchase nonspecific data and/or do not update their information on an annual basis. Most reputable insurance companies consider our fees usual, customary, and reasonable. Not all services are a covered benefit in all contracts. Some insurance companies select certain services they will not cover. We must emphasize that, as medical care providers, our relationship is with you, not your insurance company.

While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

Signed:

Patient or guarantor

Date _____

Dayton Ear, Nose and Throat Surgeons, Inc.

Dayton Ear, Nose and Throat Surgeons, Inc. **may not be** contracted with your insurance company, or a network that your insurance company may be affiliated with. **You** will need to contact your insurance company to determine if we are part of your network.

Please read the following financial policy based upon the type of coverage you have and write your initials beside the paragraph that applies to your coverage.

_____ **Contracted Commercial Insurance:** Per our contract with your insurance carrier, we agree to submit your medical claims on your behalf. We will accept assignment, and ask the insurance company to reimburse our office for the services you receive. Per your agreement with your insurance company, you agree to pay all deductibles, co-pays, non-covered services or co-insurances at the time the service is provided to you by our office.

_____ **Self Pay: PAYMENT IS REQUIRED AT THE TIME THE SERVICE IS RENDERED IN OUR OFFICE.**

_____ **Non-Contracted Insurance:** (with out-of-network benefits): We do not have a contract with your insurance company that requires us to submit your medical claims. However, as a courtesy, we will submit your claim. **We require that you pay for your services at the time of your appointment**, and we will submit the claim “not” accepting assignment, which means your insurance company will send the reimbursement to you, directly.

_____ **Medicare:** We have an agreement with Medicare to file your medical claims on your behalf. We will accept assignment, and payment will be sent to our office. We will file all claims on your behalf, and send you a statement for any balance due. However, if you are receiving a service that is not covered by Medicare, we may ask for you to sign a Medicare “Advance Beneficiary Notice.”

_____ **ODJFS/BCMH:** We are contracted and will file claims on your behalf. However, if you do not have your card with you at each appointment, you will be considered a self-pay and must pay for services when they are rendered.

- We may release your personal health information for any purpose required by law.
- We may release your personal health information for public health activities, such as required for reporting a disease, injury, and birth and death, and for public investigations.
- We may release your personal health information as required by law if we suspect child abuse or neglect; we may also release your personal health information as required by law if we believe you to be a victim of abuse, neglect or domestic violence.
- We may release your personal health information to the Food and Drug Administration if necessary to report adverse events, product defects or to participate in product recalls.
- We may release your personal health information to your employer when we have provided health care to you at the request of your employer; in most cases you will receive a notice that the information has been disclosed to your employer.
- We may release your health information if required by law to a government oversight agency conducting audits, investigations, or civil or criminal proceedings.
- We may release your personal health information if required to do so by a court or administrative ordered subpoena or discovery request; in most cases you will have a notice of such release.
- We may release your personal information to law enforcement officials as required by law to report wounds and injuries and crimes.
- We may release your personal health information if necessary to arrange an organ or tissue donation from you or a transplant for you.
- We may release your personal health information if you are a member of the military as required by the armed forces services; we may also release your personal health information if necessary for national security or intelligence activities.
- We may release your personal health information to worker's compensation agencies if necessary for your workers' compensation benefit determination.

RIGHTS THAT YOU HAVE

ACCESS TO YOUR PERSONAL HEALTH INFORMATION: You have the right to copy and/or inspect much of the personal health information that we retain on your behalf. All requests for access must be made in writing and signed by you or your representative. We will charge an initial processing fee and additional amount per page if you request a copy of your information. We will also charge for postage if you request a mailed copy and will charge for preparing a summary of the requested information if you request such summary. You can obtain an access request from the Administrator of this practice.

AMENDMENTS TO YOUR PERSONAL HEALTH INFORMATION: You have the right to request in writing that personal health information that we maintain about you be amended or corrected. We are not obligated to make all requests or amendments but will give each request careful consideration. All amendment requests, in order to be considered by us, must be in writing, signed by you or your representative. Accounting request forms are available from the Office Manager of this practice. The first accounting in any 12 month period is free; you will be charged a fee for each subsequent accounting you request within the same 12 month period.

RESTRICTION ON USE AND DISCLOSURE OF YOUR PERSONAL HEALTH INFORMATION: You have the right to request restrictions on certain disclosures made by us of your personal health information for treatment, payment or health care operations on the consent form you signed when you became a patient. We are not required to agree to your restriction request, but will attempt to accommodate reasonable requests when appropriate, and we retain the right to terminate an agreed to restriction if we believe such termination is appropriate. In the event of a termination by us, we will notify you of such termination. You also have the right to terminate in writing or orally any agreed to restriction by sending such termination notice to the Office Manager of this practice.

COMPLAINTS: If you believe your privacy rights have been violated, you can file a complaint in writing with the Privacy Officer, Dayton Ear, Nose & Throat Surgeons, Inc., 7076 Corporate Way, Centerville, OH 45459. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Service in Washington, D.C. in writing within 180 calendar days of a violation of your rights. There will be no retaliation for filing a complaint.

FOR FURTHER INFORMATION:

If you have questions or need further assistance regarding this Notice, you may contact the Office Manager of Dayton Ear, Nose & Throat Surgeons, Inc., 7076 Corporate Way, Centerville, OH 45459. As a patient, you retain the right to obtain a paper copy of this Notice of Privacy Practices.

EFFECTIVE DATE:

This Notice of Privacy Practices is effective March 30, 2011.

ATTENTION

New Patients

PLEASE BE CONSIDERATE OF OTHER DAYTON EAR,
NOSE AND THROAT PATIENTS.

MANY OF OUR PATIENTS HAVE ALLERGIES AND
MANY ARE SENSITIVE TO CHEMICALS.

PLEASE DO NOT WEAR PERFUME, COLOGNE OR
AFTERSHAVE WHEN YOU COME IN FOR AN
APPOINTMENT.

THANK YOU, IN ADVANCE, FOR YOUR
COOPERATION. WE LOOK FORWARD TO SEEING
YOU SOON.

DAYTON EAR, NOSE & THROAT SURGEONS, INC.

7076 CORPORATE WAY
CENTERVILLE, OHIO 45459
937-434-0555
FAX 937-434-7413

JOHN H. BOYLES, JR., M.D.
JAMES J. HOWARD, M.D.
WILLIAM E. ROGERS, M.D.

**DIRECTIONS TO THE OFFICE OF
DAYTON EAR, NOSE AND THROAT SURGEONS, INC.**

Our office located at 7076 Corporate Way

From the North:

From the North Dayton area, take I-75 South, to I-675 North (Columbus).
Follow I-675 to Exit 4A (Centerville).
Turn right on Alex-Bell Road, and then almost immediately,
Turn right on Corporate Way.
Follow Corporate Way to 7076, on the left side of the street.

From the South:

From the Springboro/Franklin area, South of Dayton,
Follow I-75 North to the I-675 North Exit (Columbus).
Follow I-675 to Exit 4A (Centerville).
Turn right on Alex-Bell Road, and then almost immediately,
Turn right on Corporate Way
Follow Corporate Way to 7076, on the left side of the street.

From Downtown/Kettering/Oakwood:

Follow Far Hills Avenue South.
Turn Right on West Alex-Bell Road.
Corporate Way is the first street to the left, almost immediately.

From the Northeast - Xenia/Springfield/Beavercreek/Huber Heights:

Take I-675 South to Exit 4 (Centerville/State Route 48).
Turn left on State Route 48.
At the intersection, turn right on West Alex-Bell Road.
Corporate Way is the first street to the left, almost immediately.