

SURGEONS

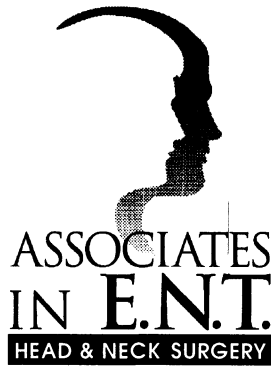
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TELEPHONE: (423) 267-6738

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Welcome to Associates in ENT/Head and Neck Surgery

Please take a moment and read over our patient instructions. You may also visit us on our website @ myentonline.com for directions, patient information and more info on our physicians.

INSURANCE:

Please be sure to bring your insurance cards with you. If you don't have your insurance cards please make sure to get a copy of them from your primary care physician, employer, or insurance company. Please note: We must have a copy of the front and back of each card including where to mail the claims. It is the responsibility of the patient to provide our office with insurance information at the time of his/her office visit. Make sure you notify our office of any insurance changes as they occur.

CO-PAYS:

Co-pays must be paid, as you check in for your office visit. We accept cash, check, Visa, MasterCard and Discover for your convenience at all locations. You may also pay any past due balances at the time of your visit however; they must be made in two separate payments so that your account may be correctly credited.

REFERRALS:

If your insurance requires a referral from your primary care physician to see a specialist, make sure you obtain the referral prior to your appointment. It is the patient's responsibility to make sure the referral is obtained. You may do this by contacting your primary care physician's office referral department at least one week before your appointment with Associates in ENT. Please note: If you have an insurance that is replacing your Medicare it will need a referral and please check with us to make sure that our physicians are in net work. Most insurance companies require a 48-hour turn around on referrals.

SELF PAY:

Patients without insurance are welcome. However, they will be asked to pay at the time of service. If any special tests or procedures are required, you are welcome to talk with the billing manager to set up a payment plan. However, we do accept checks, cash, Visa, MasterCard, and Discover.

CHILDREN UNDER 18:

Please make sure that a parent or legal guardian is with any child under the age of 18. Our physicians can't treat a child without the parent or legal guardian being present. Remember we are a specialty group and in some cases the physician may need to discuss surgery or other treatment that would need the parent's signature.

*Thank you,
Debbie Rockholt
Director of Support Services*

PATIENT TELEPHONE INFORMATION

Commonly Used Telephone Numbers:

Main Operator 423-267-6738
Insurance & Billing 423-209-9110
Insurance Precertification 423-209-9110
Surgical Scheduling 423-209-9103
Audiology Services 423-209-9111

PRESCRIPTION REFILLS:

Call between the hours of 8:30 AM and 4:00 PM

ROUTINE NON-PAIN MEDICATIONS:

If you have not been seen by one of our doctors within the past 12 months, we cannot refill medications. Allow 48 hours for the medication to be refilled and call your pharmacy to see if completed. We will not return your call unless there is a problem. Leave patient's full name with the spelling of the last name, date of birth, phone number where you can be reached, drug allergies, physician's name, medication including strength and dosage, pharmacy phone number and pharmacy name.

PAIN MEDICATIONS:

Pain medications are not refilled after 4PM or on weekends. Leave the patient's full name with the spelling of the last name, date of birth, phone number where you can be reached, drug allergies, physician's name, medication including strength and dosage, pharmacy phone number and pharmacy name. Allow 48 hours for this medication to be refilled and call your pharmacy to see if completed. We will not return this call to you unless there is a problem.

TEST RESULTS:

We will contact you by phone or mail with test results within 14 days or sooner upon receipt of your test report. If you were told by your physician to make a return appointment to discuss your results, please do so. If 14 days have elapsed and you have not received a report of your test results, leave patient's full name with spelling of the last name, date of birth, phone number where you can be reached, doctor's name, test in question, and facility where the test was performed. In addition, leave drug allergies, pharmacy name and pharmacy phone number in the event your doctor prescribes medication after reviewing test results. Indicate if it is permissible to leave a message on your answering machine or voice mail. If test results are available, we will call you within 24 hours.

IF YOU HAVE CALLED OUR OFFICE AND LEFT A MESSAGE, WE WILL RETURN YOUR CALL AFTER CONSULTATION WITH YOUR PHYSICIAN AS SOON AS POSSIBLE. IT IS NOT NECESSARY TO CALL A SECOND TIME.

THANK YOU

WELCOME TO ASSOCIATES IN ENT/HEAD AND NECK SURGERY

The following information will allow us to serve you better

Referred By: _____ Your Primary Care Dr: _____ Doctor's Phone: (____) _____

Have we seen you or a family member before? Name _____ Patient's Home Phone: (____) _____

Patient's Name: _____ Cell Phone: (____) _____
LAST FIRST MIDDLE PREFERRED NAME

Age: _____ Birthdate: _____ Male Female Social Security #: _____

Address: _____
STREET OR P.O. BOX CITY STATE ZIP

Occupation: _____ School (if student): _____

Employer: _____ Business Phone: (____) _____

Employer's Address: _____
STREET OR P.O. BOX CITY STATE ZIP

Marital Status of Patient Or Guardian (if minor): Married Single Separated Divorced Widowed

Spouse/Father/Guardian's Name: _____ Birthdate: _____ Social Security #: _____

Employer: _____ Business Phone: (____) _____

Employer's Address: _____
STREET OR P.O. BOX CITY STATE ZIP

Mother/Guardian's Name: _____ Birthdate: _____ Social Security #: _____

Employer: _____ Business Phone: (____) _____

Employer's Address: _____
STREET OR P.O. BOX CITY STATE ZIP

Emergency Contact: _____ Phone: (____) _____
NAME RELATIONSHIP

INSURANCE INFORMATION

Primary Insurance: _____
INS. COMPANY NAME GROUP NUMBER POLICY OR I.D. INSURED'S NAME

Secondary Insurance: _____
INS. COMPANY NAME GROUP NUMBER POLICY OR I.D. INSURED'S NAME

Payment for services is due when services are rendered. We accept cash, checks, Visa, and MasterCard.

AUTHORIZATIONS AND RELEASES

Please list any family members/significant others that can receive your medical information:

Name of Family Members/Significant Others	Initials	Date
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I, _____, have received/been offered a copy of the Company's Notice of Privacy Practices.
Signature of Patient or Legal Guardian

I hereby authorize Associates in Ear, Nose, Throat/Head & Neck Surgery PLLC to release any medical and social information acquired during the course of my examination and/or treatment, for the purpose of filing for insurance and other financial coverage, and to provide required information to other medical professionals and facilities for my continuing diagnosis and treatment.

I hereby authorize payment of medical benefits directly to Associates in Ear, Nose, Throat/Head & Neck Surgery PLLC. I understand that I am financially responsible for charges not covered by this assignment of benefits; and, should the account be referred for collection, I agree to pay reasonable collection and/or attorney's fees.

Date: _____ Signature of Patient, or Legal Guardian (if minor): _____

PATIENT HEALTH HISTORY

In order for us to obtain a complete medical history, it is important for you to fill out this form as completely as possible. This is very important information. **Please fill out every item.** It is important for your doctor to know you have carefully reviewed every area of this form. This information will be entered into the computer and you are welcome to a copy of the report if you wish.

Patient's Last Name _____ First _____ MI _____

Sex Male Female Date of Birth: _____

Name of Primary Care Physician: _____

Pharmacy Preference (include location): _____

REASON FOR TODAY'S VISIT: _____

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING:

Name of Medication	Dosage	How Often Taken

ARE YOU ALLERGIC TO ANY MEDICATIONS? ___ Yes ___ No. If yes, please list below:

Name of Medication	Type of Reaction

SURGERIES AND HOSPITALIZATIONS:

Have you ever had any problems with anesthesia (being numbed or put to sleep)? ___ Yes ___ No

If yes, please list type of problems: _____

List any surgeries you have had (including dates):

Have you ever been hospitalized for non-surgical reasons? ___ Yes ___ No

If yes, list reasons for hospitalizations _____

CURRENT OR MOST RECENT OCCUPATION: _____

IMPORTANT NOTICE

- If you have had any test related to the problem in which you are being seen, it is imperative you bring a copy of the reports and all films.
- If you can't bring reports and films with you we will need to re-schedule your appointment.