Comprehensive ENT HEAD & NECK SURGERY PC

SurgOne, P.C

Randy Taylor, M.D., Ph.D.
Jeffrey Chain, M.D.
Carol J. Langdoc, M.D.
Laurie Burns, MSN, FNP-C

PATIENT INFORMATION

Requesting/Referring Physician _____**Primary Care Physician**_____

Name (Legal): ***Last***: _____ ***First***:_____ ***M.I.***_____ Nickname:_____

Address: _____***City***:_____ ***State***:_____ ***Zip***:_____

Sex: M / F ***Marital Status***: S / M / W / D ***Date of Birth***: _____ _____ _____ ***Age***:_____
MM DD YYYY

SS#: _____-_____-_____ ***Race:*** _____ ***Ethnicity:*** _____ ***Email:*** _____

Phone: ***Home*** ( ) _____ ***Work*** ( ) _____ ***Cell/Pager*** ( ) _____

Patient's Email Address:_____

Patient's Employer: _____***Patient's Occupation***:_____

Employer's Address:_____Employer's Phone #:_____

Person Responsible for Payment of Services (If different from Patient):_____

Emergency Contact: Relative/Friend, **not living with you** (In case we are unable to contact you or need to contact someone regarding your care in an emergency).

Contact:_____ Phone #:_____ Relationship to Patient:_____

Address:_____ City:_____ State:_____ Zip:_____

INSURANCE INFORMATION

☐ **Legible Copy of Ins. Card** ☐ **Copy of Driver's License**

PRIMARY Insurance:_____***Subscriber ID#***:_____

Group# _____***Mailing Address (for claims)***:_____

Policy Holder Name_____***Relationship***: Self / Spouse / Child / Other_____

Policy Holder DOB: _____***Ins. Phone #:*** ( )_____***Employer carrying insurance***:_____

If Accident:☐ WorkComp or ☐ Auto: Date of Injury _____ Claim No._____

SECONDARY Insurance:_____***Subscriber ID#***:_____

Group# _____***Mailing Address (for claims)***:_____

Policy Holder Name_____***Relationship***: Self / Spouse / Child / Other_____

Policy Holder DOB:_____

I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES. I WILL FURNISH THIS OFFICE WITH ALL INFORMATION NECESSARY TO BILL MY INSURANCE. ANY BALANCE AFTER INSURANCE HAS PAID OR DENIED IS DUE BY ME. I AGREE THAT IF IT BECOMES NECESSARY TO FORWARD MY ACCOUNT TO A COLLECTION AGENCY, I WILL ALSO BE RESPONSIBLE FOR THE REASONABLE COST OF COLLECTION, TO INCLUDE ATTORNEY FEES. I UNDERSTAND THAT MY INSURANCE BENEFITS AND REFERRAL REQUIREMENTS ARE MY RESPONSIBILITY AND THAT ALL COPAYMENTS ARE DUE AT THE TIME OF SERVICE. I HEREBY ASSIGN MY RIGHT AND AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO SURGONE FOR THESE SERVICES AND ALL FUTURE CLAIMS AND I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM AND ALL FUTURE CLAIMS.

X_____(Signed) Date:_____

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PATIENT INFORMATION (2)

Patient's Preferred Pharmacy _____

NAME PHONE LOCATION

REVIEW OF SYSTEMS

Please circle all symptoms present ***WITHIN THE LAST 24 HOURS***:

General
Fever
Chills
Weight Loss
Night Sweats
Appetite Loss
Fatigue

Cardiovascular
Chest Pain
Palpitations
Fainting
Murmur

Respiratory
Shortness of Breath
Cough
Wheezing
Hemoptysis

Gastrointestinal
Abdominal Pain
Constipation
Diarrhea
Nausea
Vomiting
Heartburn
Jaundice

Genitourinary
Blood in urine
Trouble urinating
Frequent urination
Kidney/Bladder infection
Frequent/Heavy Menses (female only)

Neurologic
Decreased memory
Weakness
Tingling
Tremor
Headache
Loss of sensation
Numbness
Convulsions

Musculoskeletal
Joint Pain
Joint Swelling
Joint Redness
Muscle Pain
Back Pain
Arthritis

Endocrine
Appetite changes
Cold intolerance
Heat intolerance
Excessive thirst
Hair Loss

Dermatologic
Hives
Rash

Psychiatric
Anxiety
Depression
Mood Swings
Disorientation
Insomnia
Nervousness

Hematologic
Easy bruising
Excessive/prolonged bleeding
Enlarged lymph nodes

PATIENT: _____
Name Date of Birth

SurgOne, P.C.

Protected Health Information and Communication Consent

Your physician and/or the staff may at times need to contact you and/or discuss your care with those persons whom you give us consent to do so. By completing the information below, we will be better able to serve you.

In an effort to protect your privacy and follow new federal guidelines, we have developed a policy regarding leaving medical care messages and/or discussing your care with others:

- We will ***NOT*** leave messages on voice mail or answering machines ***UNLESS WE HAVE WRITTEN PERMISSION TO DO SO***.
- We will ***NOT*** discuss your care with others ***UNLESS WE HAVE WRITTEN PERMISSION TO DO SO***.

PATIENT NAME: _____ Birth Date:_____

		May we leave a message?		**May we discuss your care?**	
HOME PHONE:	_____	Yes	No	Yes	No
WORK PHONE:	_____	Yes	No	Yes	No
CELL PHONE:	_____	Yes	No	Yes	No
EMAIL*:	_____			Yes	No

(*Please note that most standard email addresses (yahoo, comcast, hotmail, aol, etc)are not secure/HIPAA compliant. By writing in your email above and circling YES, you are giving us permission to contact you via unsecure email).

Please carefully consider with whom we may leave messages and/or whom you wish to have us communicate with in regard to your medical and/or billing information:

Spouse or Partner	Yes	No	If yes, name:_____
Son or Daughter	Yes	No	If yes, name:_____
Mother or Father	Yes	No	If yes, name:_____
Friend/Neighbor	Yes	No	If yes, name:_____
Other	Yes	No	If yes, name:_____

Notes:_____

Voice mail or answering machine messages may include the following information:

Specific information regarding my surgery/treatment	Yes	No
Scheduling for Lab/Test/Surgery	Yes	No
Results for Lab/Test/Surgery	Yes	No

I fully understand that this consent will remain valid until revoked in writing by me.

SIGNATURE:_____ **DATE:**_____

Revised 03/01/2017

SURGONE, P.C. FINANCIAL POLICY

Thank you for choosing SurgOne, P.C. for your healthcare. In order to achieve our goal of providing and maintaining a good physician-patient relationship, we believe it is important to have solid financial policies in place. We also believe that these policies will allow us to provide our patients with high quality, cost-effective care. We ask that you carefully read and sign the following SurgOne, P.C. Financial Policy prior to your treatment.

- Upon arrival, please sign in at the front desk and present your current health insurance card as well as your driver's license or another acceptable form of ID. You may be asked to present both of these items at each visit for proper identification.
- If you do not have health insurance coverage, choose to bill your own insurance, or if our physicians do not participate in your health insurance plan, payment IN FULL is due at the time of service. Acceptable forms of payment are cash, check, VISA and MasterCard.
- You are responsible to make complete insurance information available to SurgOne, P.C. for accurate filing of claims. Complete insurance information includes current benefit cards (primary and secondary), proper identification, and referrals from other providers if applicable.
- You are responsible for checking with your insurance plan regarding any co-payment, deductible or co-insurance that you may owe at the time of service.
- Co-payments are a contractual obligation with your insurance company. You are required to pay your co-payment, and we are required to collect your co-payment at the time of each visit. Co-payments are collected prior to service.
- If the insurance information that you provide at the time of your visit is incorrect, you will be responsible for payment of your visit and to submit the charges to the correct plan.
- For indemnity-type health insurance plans, insurance payments received by SurgOne, P.C. will be applied to your account and you agree to pay the balance.
- If you have a HMO or PPO health insurance plan and our SurgOne, P.C. physicians participate in your plan, we will accept payment from the carrier for services covered by your benefit plan.
- Not all services provided by our office are covered by every health insurance plan. Any service determined NOT to be covered by your plan will be your responsibility.
- SurgOne, P.C. is committed to providing the best treatment for our patients; however, you are responsible for any unpaid balance regardless of your insurance company's arbitrary determination of usual and customary rates.
- For scheduled appointments, prior balances must be paid prior to the visit.

- We require 48-hour notice for canceling any appointments. A cancelation fee may apply.
- A $20 fee will be charged for any checks returned for insufficient funds, plus any bank fees incurred.
- A $35 fee is required for the completion of patient forms regarding disability insurance, life insurance and FMLA.
- If you undergo a surgical procedure, in addition to a bill from your surgeon, you may also receive bills from the hospital or surgical center, the anesthesiologist, pathology/lab and/or radiology, depending on the procedure.

_____ Initial If you have a surgical procedure that requires the use of a surgical assistant, SurgOne, P.C. may not bill for those services. You will receive a separate bill from the surgical assistant. Most insurance companies do not have contracts with surgical assistants, therefore your assistant may be out of network. The surgical assistant may or may not be covered by your health insurance plan. If you have specific questions regarding surgical assistant services or whether an assistant will be required for a specific surgical procedure, please let your provider or the staff know.

- **It is your responsibility to know your healthcare benefits and coverage limitations.**

We will be happy to address any questions you may have after reading our Financial Policy. Please let our staff know if you would like a copy of this policy.

I have read and understand SurgOne, P.C.'s Financial Policy and agree to comply and accept the responsibility for any payment that becomes due as outlined in the above policy. I agree to pay for all services rendered not covered by my insurance and to notify this office should there be any change to my health insurance coverage.

_____
Patient's Printed Name

_____ _____
Patient Signature Date

_____ _____
Legal Guardian Printed Name Relationship to Patient

_____ _____
Legal Guardian Signature Date

SurgOne, P.C.

NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGEMENT

I acknowledge that I am in receipt of the Notice of Privacy Practices for SurgOne, P.C.

_____
Print Name

_____ _____
Signature Date