Comprehensive ENT
HEAD & NECK SURGERY PC

Randall Taylor, MD PhD
Jeffrey Chain, MD
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Today's Date:_____

PATIENT REGISTRATION FORM

Patient's Name:_____ **Date of Birth:** __/__/____
Last First Middle

Physical Address:_____ **City and State:**_____ **Zip Code:** _____

Alternate Mailing Address:_____ **City and State:**_____ **Zip Code:**_____

Patient's/Guardian's email address:_____ ***Needed for patient portal access.***

Home Telephone #: (____)_____ **Cell Telephone #:** (___)_____

Sex: Male ☐ Female☐ **Marital Status:** ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Other:**_____

Social Security#:_____

Employer:_____**Work Telephone#:** (___)_____

Employment Status: ☐ **Full Time** ☐ **Part Time** ☐ **Unemployed** ☐ **Student** ☐ **Retired**

Race: (Optional Request-please circle): Asian, American Indian or Alaska Native, Black or African American, Native Hawaiian, Other Pacific Islander, White, More than one race

Primary Language: _____

Primary Care Physician:_____

Referring Physician (if other than Primary Care Physician):_____

PERSON TO CONTACT IN CASE OF EMERGENCY:

Name:_____Relationship to Patient:_____

Primary Telephone#: (___)_____Other Telephone#: (___)_____

Patient's Preferred pharmacy:_____ _____ _____
Name Phone Location

Note: Prescriptions will be sent electronically to your pharmacy within 4 hours of leaving our office.

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FINANCIAL INFORMATION:

Guarantor's Name:_____ Relationship to the Patient:_____

Guarantor's Signature:_____ Today's Date:_____

Guarantor's Email address:_____ Required for patient portal.

Primary Insurance:

Insurance Name:_____ ID#:_____

Subscriber's Full Name:_____ Subscriber's Date of Birth:_____

Insurance Mailing Address:_____

Secondary Insurance:

Insurance Name:_____ ID#:_____

Subscriber's Full Name:_____ Subscriber's Date of Birth:_____

Insurance Mailing Address:_____

ASSIGNMENT FOR DIRECT PAYMENT/RELEASE OF INFORMATION:

I authorize and direct that payment of any insurance or healthcare benefits otherwise payable to me for health care services or goods be made directly to the practice and my physicians. I understand that I am financially responsible to the practice or my physicians for charges not covered or paid pursuant to this authorization. I authorize the release of medical information necessary to process my claim.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES: I acknowledge that Comprehensive ENT Head and Neck Surgery, PC has offered me a copy of its Notice of Privacy Practices. I understand that the Notice of Privacy Practices is also electronically available on our website. I understand this acknowledgement in no way affects the care I shall receive at Comprehensive ENT Head and Neck Surgery, PC.

You can electronically access a copy of your health information from your visit by going to: FollowMyHealth.com

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE:

_____ **DATE:**_____

SIGNATURE OF PATIENT, PARENT OR LEGAL GUARDIAN

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FINANCIAL POLICY AND PREAUTHORIZATION REQUIREMENTS:

Welcome to Comprehensive ENT Head and Neck Surgery, PC. We are committed to giving you the best care possible. We would like to take this opportunity to inform you of our office policy.

Physician practices are bound by a strict set of billing guidelines. The amount an insurance company pays for an office visit depends on the complexity of the visit. Any additional test or procedure must be billed separately per insurance company requirements. Examples of these include hearing or allergy tests; using the microscope to look in the ear; using an endoscope to look in the nose; or using a laryngoscope to look into the throat. We cannot know the terms of your individual policy due to the limitless number of carriers and policies that exist. **You need to be aware these charges may be subject to benefits other than the office co-pay and may be applied to a deductible or co-insurance that you will be financially responsible for.** The amount you as a patient pay is strictly between you and your insurance company based upon your policy. We have no ability to change this and attempting to charge you more or less would be a violation our contract with your insurance carrier. Please review your plan booklet or check with your insurance company if you are unsure whether services at Comprehensive ENT are covered under your policy. **It is your responsibility to know if the services you are having needs to be pre-authorized and how much of the cost will be paid by your insurance.**

As a courtesy to our office and other patients, we require **24 hour notice** of cancellation. Failure to notify our office 24 hours in advance of cancellation will result in a $30.00 fee. Failure to give **72 hour notice** for allergy testing, dizziness evaluations (VNG) and office procedures will be charged a $100.00 fee. Thank you for your consideration.

YOU WILL BE EXPECTED TO PAY YOUR COPAY, DEDUCTIBLE AND COPAYMENT AMOUNTS AT THE TIME SERVICES ARE RENDERED. It's your responsibility to know if the services you are having needs to be pre-authorized or not, or if a referral is required.

We accept payment in the form of Cash, Check, Visa, Mastercard or Discover.
HOW DO YOU INTEND TO PAY FOR TODAY'S VISIT:_____

A returned check fee of $40.00, or maximum allowable by law, will be charged to you. Any balances not paid within 30 days will accrue interest in the amount of 1.5% per month. If after 90 days there has been no payment on your account you will be turned over to a creditor for payment and will pay any and all fees associated with this creditor which is usually an additional 40%.

Patients who are self-pay will receive a 20% discount when full payment is made the same day of service. Our office reserves the right to collect a $75.00 pre-payment payable by cash or credit card.

I acknowledge I have read this form and understand its contents and have received a copy hereof. I further acknowledge that I am the patient, or person duly authorized either by the patient or otherwise, to sign this agreement, consent to, and accept its terms.

_____ _____ _____
Signature of Patient or Legally Responsible Person Name (Print) **Date** **Time**

_____
Relationship/ Reason why Patient is Unable to Sign

Address of Person Signing on Patients Behalf:_____

7851 S. Elati Street, Suite 102, Littleton, CO 80120 **6179 South Balsam Way, #120, Littleton, CO 80123**
Phone: 303-798-1309 Fax: 303-798-2319
www.ComprehensiveENT.com compent@yahoo.com

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CONSENT FOR PATIENT CONTACT

From time to time, it may be necessary for Comprehensive ENT to contact you concerning a variety of issues that pertain to your medical care. While the list is not all-inclusive, we might need to contact you to:

- Make an appointment
- Cancel and appointment
- Discuss your medical care and treatment
- Discuss your bill
- Etc.

To assist you with your needs and to address the patient privacy issues described in the Health Insurance Portability and Accountability Act of 1996, we need you to specify the alternative ways we may contact you in the event we cannot reach you personally.

You may contact me by: (please check any box(s) that apply)

☐ Primary Phone: _____
☐ OK to leave a message on the machine
☐ OK to leave a message with who answers

☐ Secondary Phone: _____
☐ OK to leave a message on the machine
☐ OK to leave a message with who answers

☐ **Email:** _____ **Needed to join patient portal.**
☐ US Mail: _____
☐ Other: _____

In the event you cannot contact me personally, you may discuss my care with any of the following individuals.

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

☐ NO ONE

I give my consent for any representative of Comprehensive ENT Head & Neck Surgery, PC to contact me regarding my care using the means I have indicated by the checked boxes above. Further, I give my permission to discuss my care with the individuals whose names are listed. I fully understand that this consent will remain until revoked in writing.

_____ _____
Patient's Name DOB

_____ _____
Patient/Legal Representative's Signature Date

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PLEASE COMPLETE IF PATIENT IS A MINOR:

ANY patient under 18 MUST be accompanied by a parent or adult with LEGAL custody, or LEGAL guardian (this includes step parents) unless there is a NOTARIZED letter from the parent stating someone else may bring the child to the appointment.

With respect to divorced Parents, consent should be obtained from the Parent having decision-making responsibility for medical decisions under the parenting plan or custody decree, if any.

Patient Name:_____ Age:_____ Date of Birth:_____

Who has legal guardianship of the minor patient:_____

If parents are separated or divorced with whom does the patient primarily live:_____

Mother's Name:_____ Date of Birth:_____ SS#_____

Address:_____ Phone#_____

Employer:_____ Phone#:_____

*Email Address:*_____ *Reaquired for patient portal.*

Father's Name:_____ Date of Birth:_____ SS#_____

Address:_____ Phone#:_____

Employer:_____ Phone#_____

*Email Address:*_____ *Reaquired for patient portal.*

Other Legal Guardian Name:_____ Date of Birth:_____ SS#_____

Address:_____ Phone#:_____

Employer:_____ Phone#_____

I understand that I am the Legal parent or Legal guardian for the above child. I consent that I have full decision making responsibility for medical decisions under the parenting plan or custody decree, if any.

Signature of Legal Parent or Guardian:_____ **Date:**_____

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NAME:_____ DOB:_____

REVIEW OF SYSTEMS CHECKLIST

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
Swelling of extremities

Respiratory
Cough
Shortness of breath
Wheezing

Gastrointestinal
Abdominal Pain
Constipation
Diarrhea
Nausea
Vomiting
Heartburn
Rectal bleeding

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

Neurologic
Decreased memory
Muscle weakness
Tingling
Tremor
Headache
Loss of sensation
Numbness

Musculoskeletal
Joint pain
Joint swelling
Joint redness
Muscle pain

Endocrine
Appetite changes
Cold intolerance
Heat intolerance
Excessive Thirst

Dermatologic
Hair Loss
Hives
Rash

Psychiatric
Anxiety
Disorientation
Insomnia
Nervousness
Depression

Hematologic
Easy Bruising
Excessive/prolonged bleeding
Enlarged lymph nodes