SurgOne, P.C.

PATIENT INFORMATION

Requesting/Referring Provider _____**Primary Care Provider** _____

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

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

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

MM DD YYYY

SS#: _____-_____-_____ ***Email:*** _____

Phone: □ ***Home*** ( )_____ □ ***Cell*** ( ) _____ □ ***Work*** ( ) _____

PLEASE CHECK PREFERRED PHONE NUMBER

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

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

Emergency Contact: (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 #:*** ( )_____***Policy Holder Employer***:_____

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

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

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

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

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:_____

(Revised 10-11-2019)

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

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

Preferred Pharmacy: _____

NAME PHONE LOCATION

PATIENT: _____

Name (Please Print) Date of Birth (DOB)

Protected Health Information and Communication Consent

Your provider 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, gmail, 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:

	PLEASE CIRCLE		**NAME AND PHONE NUMBER**
Spouse or Partner	Yes	No	If yes, name/number:_____
Son or Daughter	Yes	No	If yes, name/number:_____
Mother or Father	Yes	No	If yes, name/number:_____
Friend/Neighbor	Yes	No	If yes, name/number:_____
Other _____	Yes	No	If yes, name/number:_____

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 03/26/2019

In-Office Procedures Notice of Financial Liability and Consent

Comprehensive ENT SurgOne physicians are pleased you have chosen us to assist in your care. Our physicians feel that a patient presenting to our office requires a thorough examination. In some cases, this can only be accomplished using diagnostic tests or procedures. Our providers only perform these procedures when deemed medically necessary to best diagnose and treat our patients. These tests and/or procedures are separate from the physician's office consultation and thus have a separate charge. At times, your insurance company may apply these charges towards your deductible. In such cases, payment for the procedure will be due from the patient. Please note that insurance companies will list this as “surgery” on the Explanation of Benefits that you receive. Be assured that we are following accepted billing and coding guidelines.

If you are presenting with a sinus, throat/voice, or ear complaint, there is a chance the provider will need to perform one of these procedures. While most of these are relatively minor in scope, it is nonetheless mandatory that patients understand the risks, benefits, and potential financial liability of these interventions

Examples of in-office procedures include, but are not limited to:

Flexible Laryngoscopy CPT-31575 -- This procedure involves passing a long thin flexible fiber-optic scope through the nose, after applying a topical anesthetic, into the throat. The fiber-optic scope enables the physician to visualize areas of the throat not readily seen on routine exam. Risk is limited to bleeding from inadvertent trauma induced by the scope, or reaction to anesthetic.

Nasal Endoscopy CPT-31231 -- This procedure uses a flexible or rigid scope to view areas of the nasal cavities, after application of topical anesthetic, that cannot be viewed by the physician using the standard nasal speculum. The risks of this intervention are negligible, and primarily include inadvertent trauma to the nasal membranes and/or mild nasal bleeding, reaction to anesthetic.

Nasal Endoscopy with Debridement or Biopsy CPT-31237 -- This is the same procedure as above with removal of crusting or tissue present in the sinus cavities. After sinus surgery this will need to be performed intermittently to allow for optimal healing after surgery. Risks are as above.

Flexible Nasopharyngoscopy CPT-92511 -- This involves examining both the tissues of the nasal passages and the pharynx and larynx. Risks are as above.

Control of nosebleed CPT 30901 or 31238 (depending on severity)—This involves cauterizing the nose to stop or prevent nosebleeds. A small scope may be used to reach areas deeper in the nasal cavity. Risks are as above, as well as possible need for future treatment.

Removal of foreign body CPT 69200 (ear) or 30300 (nose) —This involves using specialized instruments to remove a foreign body from the ear or nose. For the nose this may require using a rigid scope. Risks are as above.

Ear wax removal CPT-69210 —removal of ear wax or debris from the ear canal using special instruments and a microscope. The risks are minimal. Rarely patients experience pain. If earwax is adherent to the delicate skin of the ear canals minor bruising or bleeding can occur. It is extremely unlikely that the eardrum can be punctured and typically only occurs with sudden patient movement.

Hearing tests—A number of different hearing tests can be performed depending on the nature of your problem. The specific code depends on the type and extent of testing that has been performed.

Please discuss with our front desk or medical assistants if you have any questions. As a courtesy to all our patients and to minimize waiting times, we are not able to talk with your insurance and perform the procedure on the same day. It is ultimately the patient's responsibility to know how their insurance benefits are applied. Once these charges are billed, they cannot be reversed.

I authorize Randall Taylor M.D, PhD/Jeffrey Chain MD/Carol Langdoc MD/Laurie Burns FNP-C. to perform any or all indicated minimally invasive office interventions (on myself or on my dependent/child) during today's or subsequent office visits. I understand that such interventions will only be performed as deemed necessary by my provider and that these interventions are customarily billed to myself or my insurance plan separately from a general office visit and that I am responsible for any balance my insurance company applies to my deductible/copay/coinsurance. I understand that risks and complications as noted above could occur, and that listed risks or complications are in no way indicative of all potential complications which could occur. I also acknowledge that I have the right to refuse any intervention offered, and I accept the risks of any such refusal. My informed consent for recommended or needed interventions is thus obtained. Patients

_____

Patient Name (please print)

_____

Patient/Guardian Signature Date

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. Cancellation Policy

At SurgOne, P.C. ("SurgOne"), we strive to render care in a timely and prompt manner. When a patient misses a scheduled appointment, or cancels an appointment with minimal notice, not only is that time lost, but it negatively impacts our ability to schedule other patients that require medical care. SurgOne has thus adopted the following Cancellation Policy. By signing below, you hereby acknowledge and agree to the following:

- Any patient that fails to show up for a scheduled appointment or cancels a scheduled appointment with less than 48 business hours' notice, will be charged a Cancellation Fee.

- Cancellation Fees can range from $25.00 up to $200.00 depending on the length of the appointment and the specialty of the provider with whom it was scheduled. SurgOne can provide the exact amount of a Cancellation Fee at the time an appointment is scheduled.

- All outstanding Cancellation Fees must be paid in full prior to the scheduling of a patient's next appointment with SurgOne.

- Patients are solely responsible for the payment of Cancellation Fees, not insurance companies, Medicare, or other third-party payers.

- If a patient is more than 15 minutes late for a scheduled appointment, SurgOne reserves the right to reschedule the appointment.

- Any patient who, in a given 12-month period, misses three or more scheduled appointments, or cancels three or more scheduled appointments with less than 48 business hours' notice, may be dismissed as a patient from SurgOne.

I have read and understand the above SurgOne Cancellation Policy and I agree to be bound by its terms.

_____

Patient Signature

_____

Patient Name

_____

Date

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