Patient Demographic Form
Please PRINT

PATIENT INFORMATION

Last Name	First Name	Middle Initial	Nickname
Date of Birth	Age/Gender	Social Security Number	
Marital Status	If incorrect: ☐Single ☐Married ☐Life Partner ☐Separated ☐Divorced ☐Widowed ☐Other		Spouse First/Last Name
Primary Language			
Race (Optional)	If incorrect: ☐White-Non Hispanic ☐Black-Non Hispanic ☐Hispanic ☐American Indian/Alaskan ☐Asian/Pacific Islander ☐Other: ___________		
Home Address	City	State IA	Zip Code
Home Phone	Work Phone	Mobile Phone	
Email Address			
Employment Status	☐Active Duty ☐Child ☐Disabled ☐Employed Full-Time ☐Employed Part-Time ☐Homemaker ☐Not Employed ☐Retired ☐Self Employed ☐Student Full-Time ☐Student Part-Time ☐Other__________		
Employer		Employer Phone	

PREFERRED APPOINTMENT REMINDER METHOD

❑ Voice message: ____________________ ❑ Text: ____________________ ❑ Email: ________________________

PREFERRED PHARMACY

Pharmacy	Address

REFERRING PROVIDER INFORMATION

Primary Care Provider	Referring Provider

RESPONSIBLE PARTY (GUARANTOR) INFORMATION

Relationship to Patient	☐Self (if self, skip to Emergency/Next of Kin) ☐Parent (if patient is a minor) ☐Work Comp		
Last Name	First Name	Middle Initial	Nickname
Date of Birth	Gender	Social Security Number	
Home Address	City	State	Zip Code
Home Phone	Work Phone	Mobile Phone	
Email Address			
Employment Status	☐Active Duty Military ☐Child ☐Disabled ☐Employed Full-Time ☐Employed Part-Time ☐Homemaker ☐Not Employed ☐Retired ☐Self Employed ☐Student Full-Time ☐Student Part-Time ☐Other__________		
Employer	Employer Phone		

EMERGENCY/NEXT OF KIN CONTACT INFORMATION

Last Name	First Name	Patient's Relationship to Contact	
Home Address	City	State	Zip Code
Home Phone	Work Phone	Mobile Phone	

Patient Insurance Form

Please PRINT

Patient Name: **Patient DOB:**

PRIMARY INSURANCE		
Plan Name	**ID**	**Group No.**
Subscriber Name	**Subscriber Address**	**Subscriber DOB**
Subscriber Employer	**Subscriber Phone**	**Relationship to patient**
SECONDARY INSURANCE		
Plan Name	**ID**	**Group No.**
Subscriber Name	**Subscriber Address**	**Subscriber DOB**
Subscriber Employer	**Subscriber Phone**	**Relationship to patient**

INSURANCE RELEASE AND HIPPA PRIVACY ACKNOWLEDGEMENT INFORMATION

I HEREBY AUTHORIZE **ENT MEDICAL SERVICES, PC** TO RELEASE TO MY INSURANCE COMPANY ANY NECESSARY INFORMATION NEEDED TO FILE AND EXPEDITE PAYMENT ON MY CLAIM. I FURTHER ASSIGN ANY BENEFITS PAYABLE ON MY BEHALF TO **ENT MEDICAL SERVICES, PC.** I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE NOT COVERED BY MY INSURANCE CARRIER. I HAVE BEEN PRESENTED WITH A COPY OF THE NOTICE OF PRIVACY PRACTICES, DETAILING HOW MY HEALTH INFORMATION MAY BE USED AND DISCLOSED AS PERMITTED UNDER FEDERAL AND STATE LAW AND OUTLINING MY RIGHTS REGARDING MY HEALTH INFORMATION.

PRINTED NAME OF SIGNEE: ___________________________________ **DATE:** ______________________

SIGNATURE: ____

PATIENT, RESPONSIBLE PARTY OR POWER OF ATTORNEY

ADDRESS OF SIGNEE:____

ENT MEDICAL SERVICES, PC
2615 Northgate Drive
Iowa City, IA 52245-9565
Phone (319) 351-5680
Fax (319) 351-8980

ENT PHYSICIANS & SURGEONS
Thomas A. Simpson, MD
Jeremy D. Vos, MD
Daniel R. Olney, MD
Michael J. Reed, MD
Robert D. Thomas, MD
Elyse K. Hanly, MD
Brooke A. Bradley, ARNP

FINANCIAL POLICY

This agreement is between ENT Medical Services, P.C. as **creditor** and the **patient/guarantor** named on this form. By executing this agreement, you are agreeing to pay for all services that are received.

IT IS YOUR RESPONSIBILITY TO KNOW THE REQUIREMENTS OF YOUR INSURANCE COMPANY. THIS INCLUDES PARTICIPATION, IN NETWORK, OUT OF NETWORK, REFERRAL REQUIREMENTS, SECOND OPINION, PRIOR APPROVAL, PRE-CERTIFICATION AND OUTPATIENT AND/OR INPATIENT STATUS. YOU ARE ALSO RESPONSIBLE FOR ALL CO-PAYMENTS, CO-INSURANCE AND DEDUCTIBLES REQUIRED BY YOUR INSURANCE PLAN. YOU MUST BE AWARE OF ANY PRE-EXISTING CONDITIONS, WAIVERS OR WAITING PERIODS, OUTLINED BY YOUR INSURANCE CARRIER.

MONTHLY STATEMENTS: If you have a balance on your account, you will receive a monthly statement. It will show your current balance, insurance adjustments/payments and monthly interest on balances over 60 days. Unless other arrangements are approved by ENT Medical Services, P.C. in writing, **the balance in full on your account is due and payable within 60 days from the date of service.**

INSURANCE CLAIMS: We will gladly submit your claims and will assist you in receiving the maximum benefit from your plan. All plans, however, have limitations and some may not cover 100% of the fees for our services.

SURGICAL PROCEDURES: Twenty five percent (25%) of your insurance deductible is due prior to all surgical procedures.

CO-PAY: Co-payments are due at the time of service. Your contract with your insurance company requires that you pay all applicable co-payments and deductibles. Failure to comply, could lead to loss of insurance coverage.

DIVORCE: In the case of a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for the subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, **it is the authorizing parent's responsibility to collect from the other parent.**

WORKERS COMPENSATION: We require written approval or authorization by your employer and/or Worker's Compensation carrier PRIOR to your initial visit. If your claim is denied, you are responsible for payment in full.

MONTHLY PAYMENT OPTIONS:

- Automatic withdrawal from your checking/savings account ON BALANCES OVER $300 **without** interest. We will include a service fee for all rejected withdrawals due to NSF.
- Cash, check, credit card or money order **with** interest of **1.5% monthly or 18% annually. This excludes all USA government sponsored payers; Ex: Medicare, Title 19 and Tricare.**
- In addition, you may use CareCredit®. Please contact our Insurance Department regarding this product. Literature is available upon request and in our reception area.

UNINSURED PAYMENT OPTIONS: Payment is required in full from the date of service, unless other arrangements have been made, in writing, with ENT Medical Services, P.C. A 20% discount will be taken if balance is paid in full on the date of service.

EXTENSIVE TREATMENT and/or LARGE BALANCES: We understand that medical bills can add up quickly and you may not be able to pay the balance in full within 60 days. We would suggest securing a bank loan for balances over $1000.00 if necessary, as we are unable to extend credit for long periods of time.

PAST DUE ACCOUNTS: If your account becomes past due, we **will** take necessary steps to collect this debt by means of a collection agency or an attorney.

MONTHLY PAYMENT SHEDULE
FOR PATIENT BALANCE

$0-$50	**Payment in full**
$50-$150	**2 monthly payments**
$150-$300	**3 monthly payments**
$300-$500	**4 monthly payments**
$500-$2000	**6 monthly payments**
$2000-$3000	**12 monthly payments**
$3000-$5000	**18 monthly payments**
$5000-Above	**24 monthly payments**

We understand there will be some exceptions to these policies and are willing to work with you whenever possible.

EFFECTIVE DATE: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and this agreement will be in full force and effect.

Patient's Name_______________________________________ **Date:**_________________

Signature____ **Date:**_________________
(Signature of patient, responsible party or power of attorney)

HIPAA Release Form

Who may we speak with?
(e.g., spouse, child(ren), caretaker)

Thomas A. Simpson, MD
Jeremy D. Vos, MD
Daniel R. Olney, MD
Michael J. Reed, MD
Robert D. Thomas, MD
Elyse K. Hanly, MD
Brooke A. Bradley, ARNP

Patient Name: **Date of Birth:**

☐ **I do <u>not</u> authorize ENT Medical Services, PC, to share my medical or financial information with anyone. Please sign and date below.**

☐ **I authorize ENT Medical Services, PC, to share my information with the following individual(s):**

Person #1

Name (Please print):

____

Relationship to patient: ________________________ Phone #: ______________

☐ Both Medical & Financial Information ☐ Medical Information ONLY ☐ Financial information ONLY

Person #2

Name (Please print):

____

Relationship to patient: ________________________ Phone #: ______________

☐ Both Medical & Financial Information ☐ Medical Information ONLY ☐ Financial information ONLY

Person #3

Name (Please print):

____

Relationship to patient: ________________________ Phone #: ______________

☐ Both Medical & Financial Information ☐ Medical Information ONLY ☐ Financial information ONLY

STATEMENT OF CONSENT

I am aware that I may withdraw my consent at any time, except to the extent that action has already been taken in reliance on this statement of consent.

X_______________________________________ ______________________
Signature of Patient or Patient's Guardian/Representative Date

____
If signed by Patient's Guardian/Representative, please print name and relationship to patient

ENT Medical Services, PC
2615 Northgate Drive
Iowa City, IA 52245

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Robert D. Thomas, M.D.
Elyse K. Hanly, M.D.

MEDICARE LIFETIME BENEFICIARY CLAIM AUTHORIZATION

TODAY'S DATE:_________________

NAME OF BENEFICIARY **HIC NUMBER**

I request that payment of authorized Medicare benefits be made either to me on my behalf or to **ENT Medical Services, PC** for any services furnished by **ENT Medical Services, PC.** I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information to pay the claim. If item 9 of the CMS 1500 claim form is completed, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance and non-covered services. Co-insurance and deductible are based upon the charge determination of the Medicare carrier.

Beneficiary Signature **Date**

NAME: ______________________ DATE: ______________

DATE OF BIRTH: ____________ ENT PHYSICIAN: ______________

GENDER: __________ AGE: __________ REFERRING PROVIDER: ______________

MARITAL STATUS: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

OCCUPATION: ______________ Are you here with anyone today? ☐ No ☐ Yes--relationship: __________

If retired, from what?

Staff use ONLY

(Please do not write in this area)

MEDICATIONS *List ALL the medications you are currently taking (include over-the-counter medications)*

Drug Name (Generic/Brand)	*Dosage*	*Frequency*	*Drug Name (Generic/Brand)*	*Dosage*	*Frequency*
1.			9.		
2.			10.		
3.			11.		
4.			12.		
5.			13.		
6.			14.		
7.			15.		
8.			16.		

ALLERGIES TO MEDICATIONS *List ALL your medication allergies*

Medication	*Reaction*	*Medication*	*Reaction*
1.		4.	
2.		5.	
3.		6.	

PAST MEDICAL HISTORY *List ALL your Prior Surgeries, Medical Conditions & Major Injuries*

Medical Conditions/Operations/Illnesses/Injuries	*Year*	*Doctor*	*Town/Hospital*
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Patient Name: **Patient DOB:**

SOCIAL HISTORY

Tobacco use

Have you ever smoked? ☐ Yes ☐ No

If yes, do you still smoke? ☐ Yes ☐ No ☐ Occasionally

If you quit completely, when did you quit completely? _______________

How many packs per day during the time that you smoked? ______________

For patients age 13 and up: Is there exposure to tobacco smoke at work? (Check no if not employed). ☐ Yes ☐ No

For patients age 12 and younger (check at least one): Is there tobacco exposure? ☐ At home ☐ During pregnancy ☐Neither

Alcohol use

Do you drink alcohol?

☐ 6 or more drinks per day ☐ 3-6 drinks per day ☐ 1-2 drinks per day ☐ Occasionally ☐ Never

Recreational drug use

Do you use any street or recreational drugs?

☐ Daily ☐ Occasionally ☐Never If yes, what recreational drugs do you use? ____________________________

FAMILY HISTORY

What runs in your family?	*Who had it?*
1.	
2.	
3.	
4.	
5.	

REVIEW OF SYSTEMS

CHECK ONLY THE ONES YOU NOW HAVE OR HAVE HAD RECENTLY

CONSTITUTIONAL:	☐ Fever	☐ Weight loss	☐ Weight gain	
ALLERGIC:	☐ Sneezing	☐ Hayfever	☐ Nasal allergies	
EYES:	☐ Double vision	☐ Excessive tearing	☐ Itchy/watery eyes	
EARS:	☐ Ear pain ☐ Ringing/tinnitus/ unwanted noise	☐ Ear drainage ☐ Wax problems	☐ Ear infections ☐ Itchy ears	☐ Hearing loss
NOSE:	☐ Post-nasal drip/drainage ☐ Decreased smell ☐ Facial pressure	☐ Congestion ☐ Sneezing	☐ Obstruction ☐ Runny nose	☐ Bloody noses ☐ Sinusitis episodes
MOUTH:	☐ Bad breath ☐ Loss of taste	☐ Mouth sores/spots	☐ Dry Mouth	☐ Bad teeth
THROAT/NECK:	☐ Sore throat ☐ Pain on swallowing ☐ Neck pain	☐ Bad tonsils ☐ Difficulty swallowing ☐ Neck mass or lump	☐Tonsil debris ☐ Choking	☐ Hoarseness ☐ Throat clearing
CARDIOVASCULAR:	☐ Hypertension/High blood pressure		☐ Palpitations/Rapid heart beat	
RESPIRATORY:	☐ Wheezing	☐ Cough		
GASTROINTESTINAL:	☐ Heartburn	☐ Vomiting	☐ Diarrhea	
GENITOURINARY:	☐ Bedwetting			
HEMATOLOGIC:	☐ Easy bruising/bleeding	☐ Taking blood thinners/ Anticoagulants	☐Aspirin use	
ENDOCRINE:	☐ Hypothyroidism	☐ Hyperthyroidism	☐Diabetes	
MUSCULOSKELETAL:	☐ Arthritis	☐ Fibromyalgia		
SKIN:	☐ Rash	☐ Ulcerative lesions	☐ Enlarging lesions	☐ Persistent lesions
NEUROLOGICAL:	☐ Headaches ☐ Memory loss	☐ Migraines	☐ Facial pain	☐ Dizziness
PSYCHIATRIC:	☐ Bipolar disease ☐ Anxiety	☐ Drug use	☐ Alcohol abuse	☐ Depression
SLEEP:	☐ Snoring	☐ Fatigue	☐ Sleep disturbance	