EAR, NOSE, & THROAT CLINIC
OF COFFEE COUNTY

312 Westside Drive, Douglas, GA 31533
(912) 384-2200 phone (912) 383-7992 fax
2016 Pineview Avenue, Tifton, GA 31794
(229) 391-3440 phone (229) 386-2082 fax

246 West Benjamin Hill Drive, Fitzgerald, GA 31750
(229) 423-5565 phone (229) 426-7051 fax

Jeffrey L. Silveira, MD

Cell Phone: _____
Pharmacy: _____ Email: _____

Patient Information

Last Name: _____ First Name: _____MI: ___ SSN#:_____

Address: _____ City: _____ State: ___ Zip Code: _____ Home #: _____

Sex: M ___ F ___ Age: ____ Birthday: _____ Single: ___ Married: ___ Widowed: ___ Separated: ___ Divorced: ___

Employer: _____ Occupation: _____ Business Phone#: _____

Whom may we thank for referring you? _____

Personal Primary Care Physicians (s): _____

Primary Insurance

Insurance Company: _____ Address: _____

Insurer's Name: _____ Relation to Pt: _____ Insurer's Sex: _____

Insurer's DOB: _____ SSN/ID Number: _____ Group Number: _____

Policy Holder Address: _____ Phone #: _____ Employer: _____

Secondary Insurance

Insurance Company: _____ Address: _____

Insurer's Name: _____ Relation to Pt: _____ Insurer's Sex: _____

Insurer's DOB: _____ SSN/ID Number: _____Group Number: _____

Emergency Information

Emergency Contact: _____ Relationship: _____Phone#: _____

Assignment of Benefits and Billing Terms

I hereby authorize direct payment of surgical/medical benefits to Jeffrey L. Silveira, MD, for services rendered by him or under his supervision. I realize I am responsible for any deductibles or co-insurance as set forth in the financial agreement. I hereby authorize Jeffrey L. Silveira, MD, to release any medical or incidental information that may be necessary for either medical care or in processing applications for insurance benefits.

Signature of Pt (or Responsible Party): _____ Date: _____

Financial Agreement

We are going to do our very best to provide you the finest health care available. We will do this with little emphasis on payment; but without payment we would be unable to continue to provide health care. It is important to both of us that you have a clear understanding of our financial policy.

By signing below, I understand that the Ear, Nose, and Throat Clinic of Coffee County, PC will file a claim with my insurance carrier (if applicable) on my behalf. I will provide documentation of correct proof of insurance. If insurance benefits are not paid within 60 days of rendered services, I understand that my account is immediately due and payable to me. I agree to pay those unpaid amounts in a timely fashion.

I understand that should my account become delinquent and require the services of a collections agency or attorney, I agree to pay all reasonable collections fees and/or court costs for said collection. A finance charge of 1 ½ % per month (18% annum) on all past due accounts on the unpaid amount will be assessed. The Ear, Nose, and Throat Clinic of Coffee County, PC will not be involved in disputes regarding deductible, co-payments, secondary insurance, etc.

Signature of Patient (or Responsible Party) _____

Relationship: _____ Date: _____

Medigap Assignment Authorization

I request that payment of authorized Medigap benefits to be made on my behalf to Jeffrey L. Silveira, MD. I authorize any holder of medical information to release to _____ any information needed to determine these benefits.

Signature of Patient (or Responsible Party) _____

Relationship: _____Date: _____

Beneficiary Agreement for Non-Covered Services

Medicare requires us to inform you of services that are non-covered. These include:

Hearing Aids

Ear Plugs

I have been notified by Jeffrey L. Silveira, MD. and staff that the above listed services are non-covered services. I agree to be responsible for payment.

Signature of Patient (or Responsible Party) _____

Relationship: _____ Date: _____

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EAR, NOSE, & THROAT CLINIC
OF COFFEE COUNTY

FINANCIAL POLICY

Patient Name: _____ Date: _____

Responsible Party: _____ Relationship: _____

ENT CLINIC OF COFFEE COUNTY is committed to meeting your health care needs. Our goal is to keep your insurance or other financial arrangements as simple as possible. In order to accomplish this we ask that you adhere to the following guidelines. We submit all personal checks electronically.

__PLEASE INITIAL ON EACH LINE__

_____ All co-payments are due at the time of service, before your appointment. We accept check, (we submit all personal checks electronically), cash, debit cards, health flex spending cards, and all major credit cards. We also offer Care Credit, (a patient payment plan). Please inquire at check-in. There will be a $30 returned check charge.

_____ It is your responsibility to provide us with your current address, telephone number and insurance information at each visit. If you do not have proof of your current insurance at your visit you will be considered a self-pay patient for that visit and payment will be due in full that day.

_____ It is your responsibility to contact your insurance carrier to confirm that our physician participates with your plan and you understand your insurance benefits and requirements.

_____ If we do not contract with your insurance provider you will be responsible for the entire bill at the time of service. We can submit a claim to your insurance as a courtesy just so that they will have it on file.

_____If you have a procedure, we bill only for our physician services. You should receive a separate bill from the facility, and/or other providers (Ex: Anesthesia, Pathology, etc...)

_____ Ear, Nose, and Throat Clinic will not become involved with any disputes in regards to co-insurance, deductibles, Primary/Secondary coverage conflict with Insurance Coverage. This is the responsibility of the insured. Ear, Nose, and Throat Clinic will not become involved in responsible guarantor party disputes.

Patient Signature: _____ Date: _____
(Guarantor/Responsible party if patient is a minor)

Ear, Nose, and Throat Clinic of Coffee County, PC

Policy 2.1

Consent for Use of Disclosure of Protected
Health Information for Payment, Treatment
and Health Care Options

By signing below, you hereby consent for this Practice to use or disclose information about yourself (or another person for whom you have the authority to sign) that is protected under federal law, for the sole purposes of treatment, payment, and health care operations. You may refuse to sign this consent form.

You should read the Notice of Privacy Practices for PHI attached to this form before signing the Consent. The terms of the Notice may change from time to time, and you may always get a revised copy by asking the Privacy Officer of the Practice. (I have read the Notice of Privacy Practices.) Please Initial: _____

You have the right to request that the Practice restrict how PHI is used or disclosed to carry out treatment, payment, or health care operations. The Practice is not required to agree to requested restrictions; however, if the Practice agrees to your requested restrictions, the restriction is binding on it.

Information about you is protected under federal law, and you have the right to revoke this Consent, unless we have taken action in reliance on your authorization (as determined by our Privacy Officer). By signing below you recognize that the protected health information used or disclosed pursuant to this Consent may be subject to redisclosure by the recipient and may no longer be protected under federal law.

You may communicate with the following individuals regarding my condition or course of treatment:

Name:	**Relationship to Patient:**

Signature of Patient or Responsible Party: _____ Date _____

As a personal representative, I have authority to act for the individual because I am the individual's

_____

ATTENTION: We can only release any information to persons listed above. If any information is requested by anyone not listed it will not be released. This also means any person that will bring a patient to an appointment

ENT Clinic Assignment of Benefits Form

I _____ (Print Name) with insurance benefits through (Employer Name)_____ (Medicare, Medicaid or Individual Plan), as well as my governing Health and Welfare Plan, hereby authorize all entitled benefits under my governing Plan/Policy to be paid directly to the provider listed above for all services rendered. I understand that I am entitled to all benefits that my Health and Welfare Plan is legally obligated to provide, including any legal claim to benefits under the governing Plan. I understand that my Plan Sponsor and Health Insurance Issuer are both required to accept and honor this agreement for all services rendered, in full compliance of all governing state and federal laws. This authorization includes any and all rights permissible under my governing Health and Welfare Plan; applicable Social Security Act; Federal, City or State Government program; as well as state and federal law related to all services rendered. I understand this authorization also covers any and all other providers of service directly associated with services rendered and requested by the above provider, including but not limited to all providers involved with surgical related services, including surgical assistants, anesthesiology services, diagnostic testing, labs, pathology, radiology, implants, tissues, or any other services as ordered or requested by the provider above and entitled under my governing Plan. I appoint and authorize the above provider and business associate appointed by the provider as my duly authorized and personal representative relating to all services rendered, rights of appeal, rights of disclosure and remedy due me under law.

I hereby certify that all insurance information provided is true and accurate and that I am responsible for keeping it updated. I understand that failure to provide accurate insurance information and coordination of benefit coverage at the time of service or any failure to cooperate with the provider to the fullest extent requested to obtain full entitled reimbursement for all services rendered will result in my full financial responsibility of all services rendered. I hereby authorize the Provider listed above to submit claims, on my behalf, to the insurance company responsible for administering entitled benefits for all services rendered in good faith. I fully agree and understand that the submission of a claim does not absolve me of my responsibility to ensure the claim is paid in full and in full compliance of applicable state and federal laws. I also understand I may be responsible for any and all amounts not payable by my insurance company including any portion paid and not applied to in network benefits for any out of network services, non covered services, services determined by the insurer as not medically necessary, or any failure by my insurer to comply with all governing and applicable laws. I agree to cooperate with all providers listed in this agreement in any attempts by such provider to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with provider against such insurers and /or employee health care plan for failure to pay all entitled benefits or provide all protected rights.
I hereby irrevocably, designate, authorize and appoint Provider listed above as my true and lawful attorney-in-fact. This power of attorney is hereby provided for the limited purpose of receiving all payments, rights and remedies due under my governing Health and Welfare plan or Policy to include all medical services rendered or to be rendered as ordered by the provider listed above. This power of attorney shall automatically terminate, without formal action being taken, as soon as the above listed healthcare provider/s has received payment in full as entitled under my governing Plan and in full compliance of governing federal and state laws. I hereby confirm and ratify all actions taken by my attorney-in-fact pursuant to the authority granted herein. I hereby authorize my Plan and insurer unequivocal assignment and transfer of all entitled plan benefits, all rights under the Plan and federal law of appeal, disclosure, remedies and litigation due me to the Provider listed above and any appointed business associates working with them for the sole purpose of making sure all protected rights and entitled benefits under my specific health and welfare plan of governing law are administered in full compliance and extent of governing law. This authorization includes all protected rights under applicable governing law of entitled benefit administration, submittal of evidence, any request made, to give or receive any notice, receive copies of all relevant documents or data pertaining to my claim or appeal submittals, receive governing plan documents, remedies, request administrative reviews, litigation, or make any statement of fact and law on my behalf to the extent consistent with Federal and state law. This is a direct unequivocal assignment of all rights and benefits under the governing plan/policy/Social Security Act. I understand this payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment where entitled benefits are not paid applicable to governing federal and state laws.
I hereby instruct and direct my Plan or Health Insurance Issuer to pay all entitled plan benefits as required by the governing Plan/Policy directly to any applicable Provider(s) listed above and rendering services following all terms, conditions and requirements of the governing Health and Welfare Plan. I understand under applicable governing law that I have the right and authority to direct where payment for services rendered is sent. If my current policy prohibits direct payment to the provider of service, I under my protected rights pursuant to applicable state, federal or ERSIA law hereby instruct and direct my Insurance Company to provide specific SPD documentation stating such non-assign ability clause to myself and the applicable Provider, along with the regulatory guideline that allows for such non-assignability. Upon proof of specified non-assignability documentation, I then instruct that the insurer make out the check to me and mail it directly to the Provider and address listed on the submitted claim for the professional or medical expense benefits, and otherwise payable to me under my current insurance policy as payment towards the total charges for the professional services rendered. I agree and understand that any funds received by my insurance company due for services rendered by any and all healthcare providers listed in this assignment of benefits will be immediately signed over and sent directly to such provider. Upon receipt of said check, I authorize Provider listed above to receive any such checks, endorse them for deposit only, and to deposit and apply all the proceeds toward payment due on my account. I authorize the release of any information pertinent to my case including any and all medical records required for a full and fair review to any business associate, insurance company, adjuster, Plan Sponsor, governmental agency or attorney involved or responsible for making sure all protected rights and entitled benefits are provided pursuant to the governing Plan, state and federal laws. I authorize all applicable Providers listed providing medical services or appointed business associates to be my personal representative, which allows them as my duly authorized representative to: (1) submit any and all claims and appeals when my insurance company denies me benefits to which I am entitled, (2) submit any and all requests for benefit information, appeals, remedies and protected disclosures from my Plan or insurance company, and (3) initiate formal complaints to any State or Federal agency that has jurisdiction over my insurer and/or plan benefits. Should the account be referred to an attorney or outside agency for collection, the undersigned shall pay reasonable attorney's fees and collection expenses. I understand that all delinquent accounts bear interest or administrative fees at the legal rate. I also agree that any penalties or fines levied against my insurance company will be paid to Provider acting as my personal representative. I understand this assignment will remain in effect until revoked by me in writing except to the extent that the covered entity has already used or disclosed information under the authorization or (b) if the authorization was obtained as a condition of insurance coverage, or other law that provides the insured with the right to contest a claim under the governing Plan/policy. A photocopy of this Assignment shall be considered as effective and valid as the original.

_____ _____

Signature of Patient/Guarantor Date

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY!!

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. The "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. As example of this would include a physical examination.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your insurance company for payment.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest of you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer.

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosure to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with the respect to protected health information.

This notice is effective as of April 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice of the policies and procedures of our office. We will not retaliate again you for filing a complaint.

Please contact us for more information:
For more information about HIPAA
Or to file a complaint:
The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775