Spartanburg | Greer
ENT&Allergy

EAR, NOSE & THROAT | HEAD & NECK SURGERY | SINUS & ALLERGY | SLEEP | COSMETICS

TO COMPLETE YOUR FORM:

- Fill out all applicable sections
- Resave file with a unique name
- Email your resaved form to operator@spartanburgent.com

DATE _____

ACCT# _____

Thank you for choosing Spartanburg and Greer Ear, Nose & Throat!

PATIENT INFORMATION

Name: _____ Date of Birth: _____ Sex: ☐ M ☐ F

Mailing Address: _____ Marital Status: ☐ S ☐ M ☐ LS ☐ D ☐ W

City: _____ State: _____ Zip: _____ Social Security Number: _____

Street Address (if different from mailing): _____ Email: _____

City: _____ State: _____ Zip: _____ Primary Language: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Race: ☐ White/Caucasian ☐ Black/African American ☐ Native Hawaiian ☐ AM Indian/Alaskan Nat
☐ Unavailable/Unknown ☐ Decline to Provide

May choose multiple races

If a minor: Father's Name _____ Mother's Name _____

If the patient is a minor child and the parents are legally separated or divorced, please complete the following:

Which parent has legal custody of the minor child? _____

Which parent is financially responsible for the minor child's medical expenses after insurance? _____

Please provide a copy of the legal documentation stating the parent responsible for medical expenses to be included in the patient's medical record.

RESPONSIBLE PARTY

☐ You may check here if the responsible party is the same as the patient.

Name: _____ Date of Birth: _____ Sex: ☐ M ☐ F

Mailing Address: _____ SSN: _____

City: _____ State: _____ Zip: _____ Relationship to Patient: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____ Preferred Phone: ☐ H ☐ C ☐ W

Employer/School: _____ Email: _____

RIGHTS OF THE PATIENT

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to Spartanburg and Greer Ear, Nose & Throat. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer by protected be federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

_____ _____

Signature of Patient or Personal Representative Date

_____

Description of Personal Representative's Authority (attach necessary documentation)

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DATE _____

ACCT# _____

Patient Name: _____

PLEASE INDICATE YOUR PREFERRED METHOD OF CONTACT INFORMATION

How would you like to be contacted regarding appointments, treatment and/or other information pertinent to your health care and/or payment for your health care provided at Spartanburg and Greer Ear, Nose & Throat?

☐ I may be contacted by any method

If not any method, contact me by: ☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Mail ☐ Email
(check all that apply)

May we leave a message on your answering machine/voicemail? ☐ Yes ☐ No

Of the selected preference or preferences above, what is your preferred method of contact or how you like to be contacted first?

☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Mail ☐ Email

HIPAA RELEASE OF INFORMATION *(please choose an option below)*

☐ **OPTION 1: HIPAA DELEGATES**

I authorize the person(s) listed below to receive all health information about appointments, treatment and/or other information pertinent to my health care and/or payment for my health care provided at the Spartanburg and Greer Ear, Nose & Throat.

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

☐ **OPTION 2: HIPAA DELEGATES**

I do not authorize any information to be disclosed to any other parties except to me as the patient/guardian except in the event of an emergency. In an emergency, you may contact my emergency contacts below.

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

☐ **OPTION 3: MINOR PATIENT RELEASE**

I authorize the following individual(s) to consent to medical treatment in my absence.

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

HIPAA RELEASE OF INFORMATION

_____ _____

Parent Signature: Date:

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ACCT# _____

Thank you for choosing Spartanburg and Greer Ear Nose & Throat!

Patient Name: _____

PRIMARY INSURANCE INFORMATION *(please provide copies of all medical insurance cards)*

Name of Primary Insurance: _____ ID Number: _____

Group Number: _____ Co-Pay Amount: _____ Effective Date: _____

Subscriber information *(Person who carries the insurance)* ☐ Check here if same as patient

Name: _____ DOB: _____

Mailing Address: _____ SSN: _____

City: _____ State: _____ Zip: _____ Relationship to Patient: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Employer/School: _____

SECONDARY INSURANCE INFORMATION *(please provide copies of all medical insurance cards)*

Name of Secondary Insurance: _____ Certificate Number: _____

Group Number: _____ Co-Pay Amount: _____ Effective Date: _____

Subscriber information *(Person who carries the insurance)* ☐ Check here if same as patient

Name: _____ DOB: _____

Mailing Address: _____ SSN: _____

City: _____ State: _____ Zip: _____ Relationship to Patient: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Employer/School: _____

FINANCIAL POLICY

This information is to provide clarification for patients of Spartanburg and Greer Ear, Nose & Throat regarding matters of insurance, co-pay, deductibles and co-insurance amounts due at the time of service. Spartanburg and Greer Ear, Nose & Throat has an obligation to various health care plans to apply any deductible and/or collect any co-payment prior to provision of service. You may be asked to present your insurance card at each visit.

Co-Pays: You will be required to pay your co-payment upon arrival for your appointment.

Deductibles and Co-Insurance: You will be asked at check-in or check-out for any deductible or co-insurance that may be applicable to your office visit.

Previous Balances: You will be expected to provide payment for previous balances or balances sent to collections prior to your office visit. If you are unable to pay your balance in full, you may be asked to set up a payment plan. You may set up this plan with our office or contact Billing Services at 864-699-6981.

I acknowledge that the above information is true and accurate demographic and insurance information for the patient listed on this registration form. I also acknowledge that by signing this form, I authorize payment of medical benefits to the undersigned physician or supplier for services described. I have also read the above Spartanburg and Greer Ear, Nose & Throat financial policy and agree to the terms of the policy.

_____

Patient Signature

_____

Parent or Guardian Signature

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ACCT# _____

GENERAL CONSENT

The following are conditions for services provided by Spartanburg and Greer Ear, Nose & Throat for the patient whose name appears at the bottom of this page.

CONSENT FOR MEDICAL TREATMENT

I/we voluntarily consent to medical treatment and diagnostic procedures provided by Spartanburg and Greer Ear, Nose & Throat.

ACKNOWLEDGEMENT OF PATIENT FOLLOW UP PLAN

Health care is a partnership in which the physician and the patient both have responsibilities. It is the physician's responsibility, in consultation with you, to arrive at a diagnosis, keep you informed of your diagnosis, identify treatment options and explain the importance of any recommended follow-up. Once the diagnosis and course of treatment have been established and agreed upon collaboratively, it is the patient's responsibility to follow the agreed-upon treatment plan and to return as advised for ongoing assessments of health, illness and treatment outcomes.

ASSIGNMENT OF INSURANCE BENEFITS

I/we guarantee payment of all charges made for or on account of the patient, and I/we assign my/our rights in any insurance benefits or other funding to the physician and Spartanburg and Greer Ear, Nose & Throat. I/we understand that I/we am/are responsible for any charges not covered by insurance or other forms of benefits.

Should I be eligible for Medicare coverage, I request that payment of authorized Medicare benefits be made to Spartanburg and Greer Ear, Nose & Throat on my behalf. The information given by me is correct, in applying for payment under Title XVIII of the Social Security Act.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I/we was/were offered a copy of the Notice of Privacy Practices. The notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the Notice may be changed at any time. The Notice of Privacy Practices may be accessed at www.spartanburgent.com

CONTACTING PATIENTS

I hereby authorize Spartanburg and Greer Ear, Nose & Throat to contact me through the information provided at the time of registration.

DISCLOSURE/USE OF HEALTH INFORMATION

I understand that uses and disclosures of my personal and health information are described in Spartanburg and Greer Ear, Nose & Throat's Notice of Privacy Practices. These include providing my information to other providers for my continuing care, to an insurance company or other payor (such as Medicare) to process payment for my care.

PHOTOGRAPHING

I consent to Spartanburg and Greer Ear, Nose & Throat taking photographs for purposes of identification. Photographs that could identify me will only be used for internal medical record identification purposes.

Patient Signature: _____ Date: _____

If a minor, Parent/Guardian/
Legal Representative Signature: _____ Date: _____