Barrow Gwinnet
ENT & Sinus
426 Exchange Blvd, Ste 200, Bethlehem GA
Phone: (678) 392-3913 Fax: (678) 815-15
www.DrChungENT.com

# PATIENT INFORMATION

| | |
|---|---|
| Patient Name:<br>Patient Age: | Gender: Male / Female<br>Date of Birth (month/day/year): ____ / ____ / _________ |
| Home Phone:<br>Work Phone:<br>Cell Phone:<br>Email address: | Home Address: |
| SSN#: | Occupation: |
| Employer: | Referring Physician (if any): |
| | Primary Care Physician Name: |
| Insurer: | Emergency Contact Name:<br>Relationship:<br>Phone #: |
| Insurance member/subscriber ID #: | Which pharmacy do you use? |
| Are you the policy holder? Y / N<br>If no, what is the Policy Holder's Name?<br>What is the Policy Holder's relationship to you? | Are you covered by a secondary insurance? Y / N<br>If yes, what is your secondary insurer? |
| Policy Holder's DOB: ______/______/__________<br>Policy Holder's SSN#:<br>Policy Holder's Phone #: | Secondary Policy Holder's DOB: ______/______/__________<br>Secondary Policy Holder's SSN#:<br>Secondary Policy Holder's Phone #: |

****** PLEASE COMPLETE THE SECOND PAGE OF THIS FORM (OVER) ******

# PATIENT HEALTH HISTORY

**Reason for Today's Visit:**

**Are you allergic to any medications?** ☐ Yes ☐ No

**If yes, what are the medications?**

**Have you had dental anesthesia?** ☐ Yes ☐ No

**Any bad reactions?** ☐ Yes ☐ No

**Do you use tobacco?** ☐ Yes ☐ Used to ☐ Never

**If yes or used to, how many packs per day?**

**Do you drink alcohol?** ☐ Yes ☐ Used to ☐ Never

**If yes or used to, how much?**

**Do you use illegal drugs?** ☐ Yes ☐ Used to ☐ Never

**If yes or used to, what kind?**

**List all prescription, over-the-counter, vitamins, and herbal medications you currently take:**

**Which of the following do you have (circle below)?**

- Allergies, seasonal
- Blood disorders
- Arthritis
- Asthma
- Breathing Problems
- High Blood Pressure
- Cancer / Chemo
- Circulatory Problems
- Cough
- Diabetes
- Difficulty Swallowing
- Difficulty Tasting
- Dizziness or Vertigo
- Ear Problems
- Emphysema
- Epilepsy
- Eye Problems
- Facial Pain
- Fatigue
- Fever
- GERD
- Headaches
- Hearing Loss
- Heart Disease
- Hepatitis Type _____
- Hoarseness or Voice Changes
- Kidney Disease

**Is your mother still alive?** ☐ Yes ☐ No **If no, what did she die of?**

**Is your father still alive?** ☐ Yes ☐ No **If no, what did he die of?**

**List all Surgeries and when they happened:**

**Signature:** ________________________________________

**Print Name:** ________________________________________

**Are you taking birth control pills?** ☐ Yes ☐ No

**Are you breast feeding?** ☐ Yes ☐ No

**Are you pregnant?** ☐ Yes ☐ No

| Today's Date (month/day/year): ______/______/_________ | If yes, what is the due date? |
|---|---|

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# FINANCIAL POLICY

*(revised July 10, 2012)*

Dear Patient: The following financial policy is provided to help you understand your responsibility regarding charges incurred in our office.

<u>IF YOU HAVE HEALTH INSURANCE, AND …</u>

- … if we <u>do</u> participate with your health insurance plan
  a. We will bill your health insurance company for services rendered (both primary and secondary insurance plans, if applicable).
  b. You will be responsible for the payment of co-payments and any charges not covered by your insurer (such as services subject to your deductible). Co-payments will NOT be billed and are due at the time of service.
  c. You will be asked to sign a Waiver of Liability Release Form or Advance Beneficiary Notice if a service being provided to you is not covered and/or is likely to be denied payment by your insurer.
  d. If your insurer denies payment or determines a service to be "not covered," you will be responsible for charges relating to services provided to you. Your bill is due within 30 days of the date of invoice. <u>Patients are encouraged to contact their insurer for clarification of benefits and deductibles prior to services rendered</u>. We will not become involved in a dispute between you and your insurer regarding deductibles, co-payments, secondary insurances, usual and customary charges or medical necessity.
- … if we <u>do not</u> participate with your health insurance plan, payment in full is required at the time of service

<u>IF YOU ARE SELF INSURED</u>: If you do not have health insurance, payment in full is required at the time of service.
<u>DEDUCTIBLES</u>: Depending on your insurance plan, your insurer may make some procedures performed by Dr. Chung in the office visit setting (such as laryngoscopies, nasopharyngoscopies, nasal endoscopies) subject to your deductible. If your deductible has <u>not</u> been met for the year, your insurer may not pay for these diagnostic procedures and you will be responsible for their cost. Your insurer also may not pay for your office consultation if your deductible has not been met.
<u>CANCELLATIONS:</u> Please give us 24-hours advance notice if you are unable to keep your appointment. If you do not provide us with 24-hours advance notice, a missed appointment fee of $25.00 may be charged to your account.
<u>PAYMENTS</u>

1. Payment is required at the time of service. We accept cash, checks, debit and credit cards.
2. If your check is returned for insufficient funds or if there is a chargeback on your debit card, a $45.00 fee will be charged to your account in addition to your unpaid balance and payment is due upon receipt of your statement.
3. **Your account will be sent to a collection agency for management if your balance remains unpaid <u>60 days</u> or more after the date of your first bill, unless you have agreed to a payment plan with us in writing.** If your account enters collections due to non-payment, you will be responsible for all collection and attorney fees.
4. We reserve the right to refuse service if you have an overdue balance on your account.

***My signature below signifies that I have read, fully understand and agree to my financial responsibilities under this policy.***

______________________________________ _____/_____/_______

Patient/Guarantor/Parent/Responsible Party Signature Today's Date (month/day/year)

_________________________________________ _______________________________________

Print Name Patient Name (if different)

## NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- **Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly**
- **Obtain payment from third-party payers.**
- **Conduct normal healthcare operations such as quality assessments and physician certifications.**

I acknowledge that I have reviewed the Notice of Privacy Practices from Barrow Gwinnett ENT & Sinus containing a more complete description of the uses and disclosures of my health information. I understand that Barrow

Gwinnett ENT & Sinus has the right to change its Notice of Privacy from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy practices.

I understand that I may request in writing that you restrict how my information is used or disclosed to carry out treatment, payment or health care operations. I also understand that you are not required to agree to my request if it would interfere with your ability to carry out treatment, payment or health care operations, but if you do agree then you are bound by such restrictions.

Patient Name: ____________________________________________________________

Signature: ____________________________________________________________

Relationship to Patient: ____________________________________________________________

Today's Date (month/day/year): ____/____/______