CUMBERLAND VALLEY ENT CONSULTANTS
HEARING CARE CENTER

HIPAA Compliant Information Form

Date_____ *(Please complete front & back, and sign form)*

For Office Use Only
Chart # _____
Doctor _____
Updated _____
Initials _____

Please PRINT clearly

PATIENT INFORMATION

Name (Last): _____ (First): _____ (MI): _____

Sex:___ M __ F Date of Birth:_____ Age: _____ SS #: _____

Marital Status: S____ M____ Other _____ P.O. Box: _____

Street Address: _____ City:_____ State:_____ Zip: _____

Billing Address: _____ City:_____ State:_____ Zip: _____

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

Please share your email address. Patient/Guardian email address is: _____

Employer: _____ Employer Address: _____

Family Doctor (Full Name): _____ Referring Doctor (Full Name): _____

Pharmacy: _____ Address: _____ Phone: _____

Please list an alternate person to whom we may release medical information if you are unable to be reached. (Example: spouse, parent, etc.)

Name: _____ Relationship:_____

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

INFORMATION REQUIRED BY THE FEDERAL GOVERNMENT

Preferred Language: _____ Place of Birth: _____

Race:

_____ American Indian or Alaska Native _____ Asian _____ Black or African American

_____ More than one race _____ Native Hawaiian _____ Other Pacific Islander

_____ White _____ Refuse to report

Ethnicity:

_____ Hispanic or Latino _____ Not Hispanic or Latino _____ Refuse to Report

PARENT / LEGAL GUARDIAN *(For children under age 18)*

Name (Last): _____ (First): _____ (MI): _____

P.O. Box: _____ Street Address: _____ City:_____ State:_____ Zip:_____

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

Social Security #: _____ Date of Birth: _____

Legal Custodian: _____ Relationship to Patient: _____

Please provide us with a copy of legal documentation

The person(s) listed above are authorized to receive medical information for this patient: YES or NO (Please Circle)

*****Note: The parent who brings a child to the office for medical treatment is responsible AT THE TIME OF SERVICE for co-payment, deductibles, and account balances. If our provider is not a participating provider with your insurance company, payment in full is required at the time of service.**

See Reverse Side →

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Patient Name _____ **Date** _____

POWER OF ATTORNEY *(For Adults) (If Applicable)*

Name (Last): _____ (First): _____ (MI):_____

P.O. Box: _____ Street Address: _____ City:_____ State:_____ Zip:_____ __

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

Relation to patient: _____ ***Please provide us with a copy of legal documentation***

PRIMARY INSURANCE INFORMATION

Insurance Company: _____ Effective Date: _____

Policy Number: _____ Group Number: _____

Subscriber's Name: _____ (First) (MI) (Last) Sex: ___M ___F Subscriber's Date of Birth:_____

Subscriber's SS #: _____ Patient's Relationship to Subscriber: _____

Subscriber's Employer: _____ Employer's Phone #: _____

Employer's Address: _____

SECONDARY INSURANCE INFORMATION

Insurance Company: _____ Effective Date: _____

Policy Number: _____ Group Number: _____

Subscriber's Name: _____ (First) (MI) (Last) Sex: ___M ___F Subscriber's Date of Birth:_____

Subscriber's SS #: _____ Patient's Relationship to Subscriber: _____

Subscriber's Employer: _____ Employer's Phone #: _____

Employer's Address: _____

***Please inform us if you have a third insurance.**

If this is Workers' Comp. or accident related, please inform us and provide us with the proper paperwork.

Date of Injury: _____ Insurance Company: _____

Contact Person: _____ Phone Number:_____

Claim Number: _____

I certify that the information on this form is current and accurate to the best of my knowledge.

(SEAL)_____ _____ _____

Signature of Patient/Parent/Guardian Relationship Date

CUMBERLAND VALLEY ENT CONSULTANTS
HEARING CARE CENTER
11110 Medical Campus Road, Suite 126
Hagerstown, MD 21742
301-714-4375

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FINANCIAL AGREEMENT, AUTHORIZATION FOR TREATMENT AND NOTICE OF PRIVACY PRACTICES' RECEIPT

- Patient is responsible for payment at the time of service when: **1)** patient is a self-pay; **2)** patient has a nonparticipating insurance company; or **3)** patient has an HMO and comes without the referral specified by the insurance company.
- We file all claims to insurance companies in which we participate. You may use the fee ticket to file your insurance claims when we do not participate with your insurance company.
- There is a $5.00 charge for replacement of a lost receipt
- Patient is responsible for any service that is not covered by his/her insurance as well as any co-pays, deductibles, and co-insurance.
- As part of your routine ENT exam, we may perform some common procedures on you. These may include hearing tests and an examination of the nose, sinuses or throat with various telescopes. An important part of your entire ENT exam, these tests and procedures aid your doctor in determining the proper treatment for your condition. Based on the contract you have with your insurance company, the endoscopic procedures may be categorized as surgical procedures even though they are part of your exam. Patient is responsible to contact insurance company with questions regarding benefits and co-payment obligations for office surgical procedures.
- **Copays are due at the time of service.**
- It is the patient's responsibility to provide our office with a written referral when required by his/her insurance plan.
- Patient is responsible to make sure laboratory studies, x-rays, scans, pre and post-operative testing are performed at a facility participating with patient's insurance.
- I agree to pay all charges promptly.
- A $35 returned-check fee will be assessed to the patient's account for each check returned to our office for non-sufficient funds
- If my account is assigned to a collection agency, I agree to pay the collection agency fee, court costs and attorney fees.

I hereby authorize Cumberland Valley ENT Consultants and Hearing Care Center to furnish information, including records from other health care providers, to my insurance company, authorized agency, or health care provider specified concerning my medical care. I agree to pay all charges promptly upon presentation thereof. I hereby assign and transfer any medical benefits due me to Cumberland Valley ENT Consultants for the services provided to me by this medical practice. I permit a copy of this authorization to be used in place of the original. Regulations pertaining to Medicare Assignment of Benefits apply, as applicable. I acknowledge the information I have supplied is correct.

I hereby authorize Cumberland Valley ENT Consultants and Hearing Care Center to treat me as needed. Also, I acknowledge receipt of the Notice of Privacy Practices.

_____ (SEAL) _____
Date Signature

I, parent or legal guardian, do hereby authorize Cumberland Valley ENT Consultants to treat
_____ _____, being _____years of age and a minor. I understand that I am fully responsible for this minor's medical charges and agree to pay all charges for services rendered by the above-named medical practice. Also, I acknowledge receipt of the Notice of Privacy Practices.

_____ (SEAL) _____
Date Signature
(Parent or Legal Guardian)

_____ _____
Printed Name of Parent or Guardian Relationship to Patient