Midwest Ear Nose & Throat, Ltd

PATIENT REGISTRATION FORM

PATIENT'S NAME _____
Last **First** **M.I.**

HOME ADDRESS_____

CITY_____ **STATE**_____ **ZIP** _____

HOME PHONE: (_____)_____ **CELL PHONE:** (_____)_____ **WORK PHONE:** (_____)_____

BIRTH DATE:_____ **SOCIAL SEC.#** _____ **GENDER:** ☐ **MALE** ☐ **FEMALE**

MARITAL STATUS: ☐ **SINGLE** ☐ **MARRIED** ☐ **PARTNERED** ☐ **DIVORCED** ☐ **WIDOWED** ☐ **OTHER**

EMPLOYER NAME_____ **OCCUPATION** _____

ADDRESS_____ **CITY**_____**STATE**_____**ZIP**_____

EMAIL ADDRESS:_____

☐ **Yes** ☐ **No I give consent to be web-enabled to access the patient portal and the messenger portion to communicate with our office.**

PRIMARY CARE DOCTOR:_____ **PHONE**_____

REFERRED BY: _____ **IS THIS A DOCTOR: _____YES _____NO NO REFERRAL: _____**

PHARMACY NAME:_____ **PHONE :** _____

ADDRESS: _____

I attest that all the above information is correct to the best of my knowledge. I authorize the release of any medical information necessary to process this bill to my insurance company, and request payment of benefits to Midwest Ear, Nose, & Throat. I acknowledge that I am financially responsible for the payment whether or not covered by my insurance.

Signature:_____ **Date**:_____

MEDICATIONS:
(PLEASE PRINT CLEARLY)

Medication/Vitamin/Supplement Name	Dosage (if known)

ALLERGIES: _____

_____

_____

HEIGHT: _____

WEIGHT: _____

SURGICAL HISTORY: Please indicate past surgeries or check below if you have not had surgical procedures

OPERATION	DATE

Caffeine: None Coffee Tea # of Cups Per Day: _____

Do you drink alcohol and if so, how many drinks in a week? _____

Do you use Tobacco?

Cigarettes per day: ____ # of Years: _____

Family History:

Father: Alive Deceased Unknown Medical Conditions: _____

Mother: Alive Deceased Unknown Medical Conditions: _____

Siblings: Brother_____ Sister:_____

Children: Son _____ Daughter _____

Yes No Do you have an Advanced Directive or Power of Attorney over your healthcare in the event that you are unable to make medical decisions for yourself?

Midwest Ear, Nose & Throat, Ltd.
Northwestern Institute of Cosmetic Surgery
PRACTICE GUIDELINES AND POLICIES

_____ 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 for the purposes of:

- 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 for my healthcare bills.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

My protected health information means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, peer review, or my employer. This protected health information relates to my past, present or future physical or mental health or condition and identifies me.

_____ I have been informed by you of your *Notice of Privacy Practices* and I have been given the opportunity to review that notice prior to signing this consent. The *Notice of Privacy Practices* describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, quality assurance, peer review, or in the performance of health care operations of Dr. Siegel's office. This *Notice of Privacy Practices* also describes my rights and Midwest Ear Nose and Throat duties with respect to my protected health information.

_____ The patient acknowledges that this practice is using an electronic health record information system (the "EHR System"), in coordination with Northwestern Memorial Hospital. The collection and use of all information through the EHR System is primarily for the purpose of treatment of patients by NMH, this medical practice and other medical practices in a clinically integrated care setting.

All information collected through the EHR System may also be shared with, and used by, NMH and certain other hospitals, academic institutions, and health care providers that perform medical or research activities on NMH's campus or otherwise in conjunction with NMH (including, but not limited to, Northwestern University, the Feinberg School of Medicine, Children's Memorial Hospital, and the Rehabilitation Institute of Chicago) for the following related activities, including without limitation: (a) conducting peer review; (b) promoting quality assurance; (c) mortality and morbidity analysis; (d) conducting utilization review; (e) evaluating and improving the quality of care; (f) promoting and maintaining professional standards; (g) examining costs and maintaining cost control; (h) conducting medical audits; (i) assisting the medical staff membership and credentialing process; (j) performing data quality management; (k) improving the efficiency and effectiveness of healthcare; (l) conducting research; (m) extracting data from the EHR System and any related database and incorporating it into a data warehouse maintained by NMH. The EHR System is not equipped to segregate such data as mental health, HIV, drug and alcohol abuse and genetic testing information.

_____ I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Signature: _____ Date: _____

Midwest Ear, Nose & Throat, Ltd.
Northwestern Institute of Cosmetic Surgery
PRACTICE GUIDELINES AND POLICIES

_____ **Payment:** Payment and/or co-payments, (determined by your insurance company), are due in full at the time services are rendered. Your insurance company requires that we collect these fees, as they are terms of your healthcare contract. Methods of payment accepted are cash, Visa, MasterCard, or check. In the event your services are not covered or denied by your insurance company you are ultimately responsible for payment in full. Please contact our billing department promptly for assistance in the management of your account should you not be able to make a timely payment. If your account should go unpaid and/or without a payment arrangement, you will be subject to referral to a collection agency and/or legal action, as well as additional administrative filing fee. Payment is due for any cosmetic procedures done in the office at the time of service. Payment for scheduled procedures is due two weeks prior to the procedure.

_____ **Return Check and Interest Charge:** Returned checks will be subject to a $39.00 service charge. Please note that an interest charge will be applied at a rate of 1.5% per month for any returned check.

_____ **Demographics Face Sheet:** The demographic sheet provided must be completed in full in order for our computer system to process your claim. We follow the Health Insurance Portability & Accountability Act of 1996 (HIPAA), guidelines. This information will not be given out to anyone without your authorization.

_____ **Insurance Forms Filing:** Most insurance companies require that forms be filed within 60 days of the time of service. If you, the patient provide us with the wrong insurance information or do not complete forms sometimes required by the insurance company, you will be responsible for the payment in full. In such case, we will not file an appeal on your behalf.

_____ **Missed Appointments:** We ask that if you need to change or cancel an appointment time that you kindly give 24 hours notice by phone, as others may be able to utilize that time slot. You will be subject to a $50.00 fee for any cancelled or missed appointments with less than 24 hours notice. We have 24-hour phone service with voicemail available for your convenience if you need to cancel or reschedule an appointment. It is important to note that your health insurance will not reimburse for missed appointments. If you will be late for your appointment, please let us know as soon as you are aware.

_____ **Insurance Authorization and Financial Obligation:** We encourage you to verify your health benefits with your insurance provider. *Note that most insurance plans require prior authorization for surgery*. Our office will call your insurance company but you must also report it. It is your responsibility to obtain authorization for these services. Services rendered without proper authorization will be billed in full to you at a "self-pay" status. Insurance companies do not cover cosmetic procedures. We will not bill for any cosmetic surgery. You must pay up front and call the facility where the procedure will be performed to make payment arrangements.

_____ **Billing:** We can provide you with a monthly statement of your account if requested. In most cases we are able to bill your insurance company directly. In other cases, which we can discuss, it will be your responsibility to submit this information to your insurance provider for reimbursement of payment for which you may be authorized. If you need to submit information directly to your insurance company, your statement will include all necessary information to assist with filing your claim.

_____ **Referrals:** If you have POS / HMO / Workers Comp plan that require you to have a referral prior to seeing us, you are responsible for obtaining it and required to provide it to us. If you do not bring in your referral or your primary care physician does not send it to us, you will be responsible for the payments incurred.

If you have questions regarding this information, please do not hesitate to question us.
We will be happy to explain it to you.

I, **(Print Patient Name)** _____have read, understand and agree with the policies enforced by Midwest Ear, Nose, & Throat, Ltd. / Northwestern Institute of Cosmetic Surgery. 3 East Huron, 1st Fl. Chicago, IL 60611

Patient Signature_____ **Date:** _____

Midwest Ear, Nose & Throat, Ltd.
Northwestern Institute of Cosmetic Surgery
PRACTICE GUIDELINES AND POLICIES

_____ Authorization for Treatment: I agree to any examination, treatment, and procedure including without limitation, Laryngoscopy or Nasopharyngoscopy, Nasal Endoscopy and other with endoscope procedures that Gordon J. Siegel, M.D. performs during office visits. In the event emergency medical treatment is required to preserve my life and health. I give my consent to Gordon J. Siegel, M.D. and other personnel on his medical staff to administer such care, procedures, testing, and treatment that is deemed necessary and in my best interest.

_____ Please note that a Nasal Endoscopy, Nasal/ Sinus Endoscopy, Laryngoscopy or Nasapharyngoscopy are considered surgical procedures by the insurance companies and may be applied towards your deductible with a cost ranging between $275.00 - $675.00. This charge is not generally included in your co-pay. This information is based off of your insurance plan.

_____ I am aware that my insurance may not cover 100% of my charges due to my deductible / coinsurance/ out of pocket costs. I understand that I am responsible for any charges that are not covered or denied by insurance.

Signature: _____ Date: _____

Midwest Ear Nose & Throat, LTD

Payment Policy

Thank you for choosing us as your healthcare provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. Insurance. We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit. **There will be a $10 fee charge per co-pay that we have to bill for.**

3. Non-covered services. Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services upon denial from your insurance.

4. Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you are responsible for the full balance. Some insurance have a 30 day filing limitation.

5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

7. Nonpayment. If your account is over 90 days past due, you will receive a letter stating that you have 10 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

8. Missed appointments. ***Our policy is to charge $50 for missed appointments not canceled within 24 hours ahead of time.*** These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

I authorize Midwest Ear Nose & Throat, LTD to keep my signature on file and to charge my credit card (held in our secure system) for:

1. Charges associated with appointments that are not cancelled within the timeframes listed above.

2. Charges associated with payment arrangements. Contact billing office to make payment arrangements.

Attestation Statement:
I have read, understand, and agree to the above Midwest Ear Nose & Throat, LTD, Payment Policy. I understand that charges not covered by my insurance company, as well as applicable copayments and deductibles, are my responsibility. I acknowledge that these policies do not obligate Midwest Ear Nose & Throat, LTD to extend credit.

I authorize my insurance benefits be paid directly to Midwest Ear Nose & Throat, LTD
I authorize Midwest Ear Nose & Throat, LTD to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Signature of patient or responsible party **Date**

Physicians are bound by the Office of Inspector General Laws and regulations as well as private contractual obligations to collect co-pays. Failure to collect co-pays is a violation of the False Claims Act. Providers who do not collect patient co-pays are subject to prosecution for fraudulent billing under federal law. Penalties for physicians who are found guilty of not collecting co-pays include a maximum fine of $25,000, five years in prison, or both.