***PATIENT REGISTRATION* DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date of Birth**: \_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_ **SSN**:\_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_

**Sex**: ****Male ****Female

**Marital Status**: ****Single ****Married ****Divorced ****Widowed

**Ethnicity**: ****White ****Black ****Hispanic ****Asian ****Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Preferred Language**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Mailing Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street City Zip

**Home Phone:** (\_\_\_\_\_\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Cell Phone:** (\_\_\_\_\_\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Employment Status:**  ****Employed ****Not Employed ****Retired

**Employer:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Occupation:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Work Phone:** (\_\_\_\_\_\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Can we leave messages at your home/work/cell numbers? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact/Responsible Party Information**

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­\_\_\_\_\_\_\_\_

Name Date of Birth Relationship

Home Phone: (\_\_\_\_\_\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: (\_\_\_\_\_\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­\_\_\_\_\_\_\_\_

Name Date of Birth Relationship

Home Phone: (\_\_\_\_\_\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: (\_\_\_\_\_\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Email:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_@\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**LOCAL PHARMACY OF CHOICE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **LOCATION:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PRIMARY CARE PHYSICIAN**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Consent to Receive Information**

Please include family members, doctors and specialists involved in your care.

**\*\*\*NOTE: If the patient is under the age of 18 – parents *must be included* in this list as well\*\*\***

|  |  |
| --- | --- |
| **NAME** | **RELATIONSHIP TO PATIENT** |
|  |  |
|  |  |
|  |  |
|  |  |

**Augusta ENT and Facial Plastic Surgery (herein referred to as AENT) appreciates the confidence you have shown in choosing us to provide your healthcare needs.**

***The following are our general policies. Please review this information and sign where indicated. Thank You!***

**Patient Financial Policies**

* I understand that it is my responsibility to provide AENT with current, accurate billing information at the time of check in and to notify AENT of any changes in this information.
* I understand that it is my responsibility to pay my co-pay at the time services are rendered. I understand that this is a contractual agreement that I have with my health plan and that AENT also has a contractual agreement with my health plan to collect co-pays at the time of service.
* I understand that I will be billed for any amounts due by me including co-insurance amounts, co-pays and deductibles and that I have a financial responsibility to pay these amounts.
* I understand that due to increased usage of cash reward programs, all credit card transactions will have a 3% surcharge applied to the payment.
* I understand that insurance claims pending which exceed the agreed upon time limit for payment with respect to the terms of my insurance company’s contract with my provider are my responsibility.
* I understand that if any charges billed to me are still outstanding after 90 days from the date services were rendered, my account may be referred to a collection agency or an attorney for collections, unless other acceptable payment arrangements can be made. I agree to pay all costs of collection, including but not limited to, **thirty three percent collection** agency fees plus attorney fees and court costs. In the event that my account is in default, I agree to pay interest at the rate of 18% per annum from and after the date of treatment. I hereby waive the benefit of my homestead exemption as to this debt.
* I understand it is my responsibility to obtain a referral (if required by your insurance). If this referral is not obtained, then all charges will be the responsibility of the guarantor.
* I understand there is a $35.00 fee for any check returned from my bank.
* I understand that if I do not cancel my appointment 24 hours prior to my scheduled appointment time, or if I do not show for my appointment, there may be a $25.00 fee. If I cancel/no show three (3) appointments, I may be released from care. If I am released, I will be notified in writing by AENT.

**I have read the above policy regarding my financial responsibility to AENT for providing services to me or the above named patient. I authorize my insurer to pay any benefits directly to AENT, the full and entire amount of the bill incurred by me or the above named patient.**

**Signature** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Relationship to Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_\_\_ /\_\_\_\_\_\_\_\_\_\_**

**Consent for Treatment & Authorization for Release of Information**

* I hereby authorize AENT through its appropriate personnel, to perform or have performed upon me, or the above named patient appropriate assessment and treatment procedures.
* I understand that in the course of treatment, there is a possibility that AENT healthcare workers may become exposed to my blood or bodily fluids. State laws require a sample of my blood be tested for the presence of infectious diseases. The result of the test will be released to me and the healthcare worker who was exposed.
* I further authorized AENT to release any and all medical information on myself or the above named patient to my insurance company to process my claim and hereby authorize a copy of my medical information be sent to my primary care physician as well as any attending or consulting physicians.

**Signature** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Relationship to Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_\_\_ /\_\_\_\_\_\_\_\_\_\_**

**Acknowledgment of Receipt of Privacy Notice**

I understand that this provider’s office may release information from my medical record and billing records in accordance with the provisions of the Health Insurance Portability and Accountability Act (HIPPA) and statutory regulations of the Commonwealth of Virginia. My signature below acknowledges that I have received a copy of the Federal Notice of Privacy Practices either on the practice website at [www.drkeefeENT.com](http://www.drkeefeENT.com) or in person at my appointment.

**Signature** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Relationship to Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_\_\_ /\_\_\_\_\_\_\_\_\_\_**