PATIENT INFORMATION FORM

Ear Nose and Throat Solutions of NJ, LLC

187 Washington Ave, Suite 2i, Nutley, NJ 07110
Phone: 973-235-0090 • Fax: 973-995-1145

Derrick I. Wallace, MD, FACS

PLEASE PRINT INFORMATION

PATIENT INFORMATION

Patient			❑ Male ❑ Female
Address			
City	State	Zip	
Patient's SSN:	Date of Birth	Age	
Phone # ( )	Cell # ( )	Email Address	Marital Status:
Is this a Worker's Compensation injury or the result of an automobile accident: ❑ Yes ❑ No			
If patient is a minor			
Guardian Name			
Relationship to Patient			
Guardian's SSN:	Date of Birth	Age	
Phone # ( )	Cell # ( )		

EMERGENCY CONTACT

Name	
Relation to Patient	
Phone # ( )	Other # ( )
Address	

EMPLOYER INFORMATION

Employer		
Address		
City	State	Zip
Phone # ( )	Contact Person	

INSURANCE INFORMATION

Primary Insurance	
Policy #	Group #
Insured Name	Relationship
Birth Date	SSN
Secondary Insurance	
Policy #	Group #
Address	
Insured Name	Relationship
Birth Date	SSN

The information I have provided above is true and accurate to the best of my knowledge. Furthermore, I understand that providing false information may result in my being fully responsible for any charges associated with medical services/treatment provided to me while a patient at this clinic.

Signature:_____ **Date:** _____
(Patient / Guardian)

DERRICK I. WALLACE, MD, FACS

EAR NOSE & THROAT SOLUTIONS OF NJ

Patient's Name: _____.

Primary Physician: _____.

Pharmacy Name: _____.

Height: _____. Weight: _____.

Medications

Please list all medications you are currently taking

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Please list any medications that you are allergic to:

_____ _____

_____ _____

Ear Nose and Throat Solutions of NJ, LLC

PATIENT CONSENT, AUTHORIZATIONS, PAYMENT NOTIFICATION & PRIVACY NOTICE ACKNOWLEDGEMENT

Patient's Printed Name: _____

_x_ **Consent For Treatment**: I authorize the clinic, physician, mid-level providers, its contractors, and employees to furnish medical or surgical treatment by those means he/she considers necessary and proper in treatment of the patient identified below while a patient at **Ear Nose and Throat Solutions of NJ, LLC** for this visit and any subsequent visits. This treatment may require medications, anesthesia, or additional diagnostic procedures including but not limited to x-rays, lab tests, and blood drawings for those tests.

_x_ **Authorization to Release Medical Information:** I hereby authorize **Ear Nose and Throat Solutions of NJ, LLC**, at its discretion, to release any medical information related to my health care (or care of the patient) to the hospital or physician's insurance carrier(s) when so requested by the carrier(s). When a patient is transferred or referred to a hospital, home health agency, or physician, or such transfer or referral is under consideration, this clinic is authorized to release such medical or other information as may be useful in the care and treatment of the patient.

_x_ **Authorization to Pay Benefits to Physicians:** I hereby authorize **Ear Nose and Throat Solutions of NJ, LLC**, at its discretion, to disclose any or all information in my medical record to any person, corporation, agency, or person employed by such in order for the clinic to receive payment for the patient's treatment. These may include, but are not limited to, insurance companies, health maintenance organizations, preferred provider organizations, workers' compensation carriers, welfare agencies, Social Security or its carriers, utilization review companies, and/or employers. It is understood that any money received from the insurance company(s) over and above my indebtedness to the clinic will be refunded to the appropriate party (me or insurance carrier) when my bill is paid in full.

_x_ **Financial Responsibility:** I have been provided a copy of the **Ear Nose and Throat Solutions of NJ, LLC's** *Patient Payment Notification Letter (Policy)* for review. I have read and understand the *Letter (Policy)* and agree to the terms. Furthermore, I understand and agree to pay costs and reasonable attorney's fees in connection with any unpaid balance placed with a collection agency or attorney for collection.

_x_ **Patient's Certification:** I certify that the information provided by me in applying for payment under Titles XVIII of the Social Security Act (Medicare) and/or Title XIX of the Social Security Act (Medicaid) and/or Blue Cross and/or Private Insurance policies which I submit to this clinic to be correct. I authorize my holder of medical or other information about me to release to the Social Security Administration, other intermediaries or carriers, or the State of New Jersey or it's fiscal agent, and/or other appropriate third party payers from whom benefits are being claimed, any information needed for this or a related claim. I hereby request that payment of authorized charges be made in my behalf directly to the clinic for its charges and for any charges of physicians or other providers for whom the clinic is authorized to bill in connection with its service.

_x_ **Notification of Medicare/Medicaid Non-Covered Services:** I hereby acknowledge and understand that before services are rendered, I or my guarantor will be responsible for full payment of known non-covered charges, such as medication given by mouth, inhalation, injections, or other supplies. Medicare patients may be asked to sign a waiver for any services not deemed medically necessary by Medicare.

Acknowledgement of Receipt of Privacy Practice Notice

I, _____, acknowledge that I have received a Privacy Practice Notice from Ear Nose and Throat Solutions of NJ, LLC.

Further, by signing below, I provide my permission for this facility to use and disclose my medical information for the purposes discussed in the Notice of Privacy Practices, which includes, among other purposes, uses and disclosures for treatment, payment and healthcare operations.

_____ _____

Patient / Authorized Representative Signature **Date**

_____ _____

Witness To Signature **Date**

PATIENT PAYMENT NOTIFICATION POLICY

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy or your financial responsibility.

PATIENTS MUST FILL OUT PATIENT INFORMATION FORMS PRIOR TO SEEING THE DOCTOR. WE WILL REQUEST TO PHOTOCOPY YOUR INSURANCE CARD(S) FOR YOUR FILE.

- **APPOINTMENTS** – 24 hour notice must be provided in the event you cannot keep an appointment. If you not provide this notice; a cancellation fee of $25 may then be added to your account as a missed appointment fee. 5 day notice must be provided if you cannot keep a surgical/procedure appointment. If you do not provide this notice it will result in a $250 missed surgical/procedure fee.

- **REFERRALS** – If your plan requires a referral from your primary care physician, it is YOUR responsibility to obtain it prior to your appointment and have it with you at the time of your visit. If you do not have your referral, YOU WILL NOT BE SEEN.

- **CO-PAYMENTS** – By law we MUST collect your carrier designated co-pay. This payment is expected at the time of service. Please be prepared to pay the co-pay at each visit. Should you not pay at the time of service and we subsequently send you a statement, an administrative fee of $25 may be added to your account in addition to the co-pay amount.

- **OUT OF NETWORK PLANS** – You will be responsible for any balance your plan indicates as due on their explanation of benefits form. We will adjust the charges to coincide with your plan's UCR (Usual, Customary and Reasonable) charges. ALL PATIENTS WILL BE RESPONSIBLE FOR THEIR CO-INSURANCE AND DEDUCTIBLE. If we do not 'participate' with your plan, we will send a courtesy bill to that carrier on your behalf. However, should they not pay your claim within 45 days; you will be responsible for the full amount due. Should you receive payment from your insurance carrier, please forward it to the physician's office.
  Private Insurance Authorization for Assignment of Benefits/Information Release: I, the undersigned, authorize payment of medical benefits to **Ear Nose and Throat Solutions of NJ, LLC** for any services furnished. I understand that I am financially responsible for any amount not covered by my contract. I also authorize any holder of medical information about me to release to my insurance company (or their agent) information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

- **SELF-PAY PATIENTS** – Payment is expected at the time of service unless other financial arrangements have been made prior to your visit.

- **MEDICARE** – We will submit claims to Medicare. The patient will be responsible for the deductible and the 20% co-insurance, which can be billed to a secondary insurance if you have one.

  Medicare Lifetime Signature on File: I request that payment of authorized Medicare benefits be made on my behalf to Ear Nose and Throat Solutions of NJ, LLC for any services furnished to me. I authorize any holder of medical information about me to release to the CMS (and its agents) any information to determine these benefits payable for related services. This information will be used for the purpose of evaluating and administering claims of benefits.

- **DIVORCED/SEPARATED PARENTS OF MINOR PATIENTS** – The parent who consents to the treatment of a minor child is responsible for payment of services rendered. Ear Nose and Throat Solutions of NJ, LLC will not be involved with separation or divorce disputes.

  You are responsible for the timely payment of your account. Should it become necessary for us to use an outside agency to collect payment from you, Ear Nose and Throat Solutions of NJ LLC may apply a $25 fee to the account and the account will be sent to collections. In the event an account is sent to collections, you will be responsible for full payment of your account and whatever charges we incur as a result of this.

WE ACCEPT CASH, MASTERCARD, OR VISA

THANK YOU for taking the time to review our policies. Please feel free to ask any questions or share with us special concerns.

Patient's Name: _____ DOB: _____

Responsible Party Signature: _____ Date: _____

Print Name: _____ Relationship: _____

EAR NOSE & THROAT
SOLUTIONS OF NJ
Derrick I. Wallace, MD, FACS

Nasal Endoscopy Consent Form

There are times when the Doctor needs to perform an in office procedure to be able to correctly diagnose problems of the nose and throat. This is accomplished through the use of a Nasal Endoscope. A Nasal Endoscope provides direct observation of the nasal passages, larynx, pharynx and other surrounding structures. It is used to help diagnose or detect problems such as nasal polyps, nasal blockage, recurrent sinusitis and any other diseases of the throat or nose. Given the nuances in insurance policies it is your responsibility to contact you insurance company to find out what your financial responsibility is for this procedure. This can be done by calling your insurance provider and requesting information about your coverage on the following CPT codes: 31231, 31575, 31238 or 92511. There are cases that insurance companies look on this procedure as an in office surgery and the payment is applied to the deductible. By signing this form you are committing to satisfy the financial responsibility established by you and your insurance provider through your policy coverage. Please remember that we are a specialist and are able to deliver high quality of care through the use of highly effective and highly specialized diagnostic tools such as the nasal endoscope. If you have any questions please do not hesitate to ask the front desk staff or the doctor for more information.

Signing this consent does not mean that you must or will have this procedure. Endoscopy is only performed as the Doctor deems necessary, on a case by case basis. If you choose not to have this procedure performed, consent may be revoked at any time. This consent is valid for one year as of today's date. Thank you.

Patient Name _____ DOB_____
(please print)

Patient Signature_____ Date_____

Guardian Name_____
(please print)

Guardian Signature_____