Alamogordo Ear, Nose and Throat

Facial Plastic Surgery

PATIENT DEMOGRAPHIC FORM

PATIENT NAME:____**TODAY'S DATE:**______________
Last First MI

PATIENT SSN: __________________________DATE OF BIRTH:____________________SEX: M______F______

MAILING ADDRESS: ____

CITY: ____ STATE:__________ZIP:________________________

HOME PHONE:(_______)_______________WORK PHONE:(______)________________CELL PHONE:(______)___________

EMAIL ADDRESS: ____

I WOULD LIKE TO BE REMINDED OF MY FUTURE APPOINTMENTS BY [ ] CALL [ ] TEXT [ ] EMAIL [ ] ALL

PARENT/ GUARDIAN INFORMATION (IF UNDER 18)

NAME______________________________________RELATIONSHIP_____________________________

HOME PHONE_________________WORK PHONE___________________CELL PHONE_______________

CAREGIVER INFORMATION

CAREGIVER'S NAME _________________________FACILITY NAME______________________

CONTACT PHONE NUMBER____________________

SUPERVISOR NAME__________________________OFFICE NUMBER______________________

DO YOU HAVE POWER OF ATTORNEY FOR PATIENT YES ( ) NO ( )

PHYSICIAN INFORMATION

****REFERRING PHYSICIAN**: ____ PHONE: (_______)___________________

ADDRESS:____________________________________CITY:________________________STATE:_______ZIP:____________

****PRIMARY CARE PHYSICIAN**:____PHONE: (_______)__________________

ADDRESS:_____________________________________CITY:_______________________STATE:_______ZIP:____________

PRIMARY INSURANCE INFORMATION

(PLEASE COMPLETE THIS SECTION COMPLETELY; WE WILL COPY FRONT & BACK OF INSURANCE CARD)

****INSURANCE COMPANY:** ____________________

ID#: ____________________ GROUP #: ____________________

****PRIMARY POLICY HOLDERS NAME:** ____________________

DOB: ____________ SSN: ____________ EMPLOYER: ____________________

CLAIMS ADDRESS: ____________________

CITY: ____________________ STATE: ____________ ZIP: ____________

SECONDARY INSURANCE INFORMATION

(PLEASE COMPLETE THIS SECTION COMPLETELY; WE WILL COPY FRONT & BACK OF INSURANCE CARD)

****INSURANCE COMPANY**: ____________________

ID#: ____________________ GROUP #: ____________________

****SECONDARY POLICY HOLDERS NAME**: ____________________

DOB: ____________ SSN: ____________ EMPLOYER: ____________________

CLAIMS ADDRESS: ____________________

CITY: ____________________ STATE: ____________ ZIP: ____________

EMERGENCY CONTACT INFORMATON

1. NAME: ____________________ RELATIONSHIP TO PATIENT: ____________

PHONE: (_________) ____________________ CHECK ONE: HOME_____ OFFICE_____ CELL____ OTHER____

2. NAME: ____________________ RELATIONSHIP TO PATIENT: ____________

PHONE: (_________) ____________________ CHECK ONE: HOME_____ OFFICE_____ CELL_____ OTHER____

SIGN & DATE

I CERTIFIY THAT THE INFORMATION PROVIDED HERE IS ACCURATE, TO THE BEST OF MY KNOWLEDGE.

______________________________ ____________________

SIGNATURE OF PATIENT OR LEGAL GUARDIAN/REPRESENTATIVE DATE

____

PRINTED NAME

____

RELATIONSHIP TO PATIENT

Alamogordo Ear, Nose and Throat

Facial Plastic Surgery

Notification of Cancellation Policy

Alamogordo Ear, Nose, and Throat is a busy specialty office. Often our office sees emergency add-on appointments each clinic day. When patients do not show up to their scheduled appointments this prevents other patients in need from being seen. Due to the amount of “No Show” patients we have on a daily basis we have created a Notification of Cancellation Policy. Effective June 1, 2011, this policy allows our office to work at maximum efficiency by requiring our patients to notify our office of appointment cancellations. **It is the policy of Alamogordo Ear, Nose, and Throat that a minimum of a 24-business hour cancellation notice is required for all scheduled appointments. Any patient not giving a minimum of a 24-business hour notice of cancellation will be charged a $25.00 fee for the reserved appointment time.** This charge is not covered by insurance companies and will be billed directly to the patient or responsible party. This means that if your appointment is scheduled at 8:30am on Monday you need to notify our office no later than 8:30am the Friday before your appointment. This policy has been put into effect to insure that we are able to see as many patients in need as possible. Please have the courtesy to notify our office if you must cancel your appointment.

Thank you for your cooperation and understanding. Please do not hesitate to call our office with any questions or concerns. We are here to assist you.
(575-437-4533)
I have read and fully understand this policy:

____

Print Patient Name Date of Birth

____

Patient(or Guardian) Signature Date

Alamogordo Ear, Nose and Throat-Facial Plastic Surgery P.C.

PATIENT HEALTH HISTORY QUESTIONNAIRE

1401 Tenth Street, Suite C
Alamogordo, NM 88310
(575) 437-4533 Office
(575) 437-5009 Fax

Patient Name:________________________________ Date of Birth:_____________

Chief Complaint

Reason for today's visit? ____

Current problem is the result of a(n): **Check if this applies**
☐ Car Accident ☐ Work Accident ☐ Accident ☐ Other ________________

Past History

Please list any prior major illnesses and/or injuries:

Surgeries/Hospitalizations	Year	Complications

Have you ever had problems with anesthesia? ☐ Yes ☐ No

Current Medication(s) /Vitamin(s)	Dose	Frequency

ALLERGIES TO MEDICATIONS:

Family Member	Alive	Deceased	Age	Health status or cause of death
Grandmother (mom's)	A	D		
Grandfather (mom's)	A	D		
Grandmother (dad's)	A	D		
Grandfather (dad's)	A	D		
Father	A	D		
Mother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		

Patient Social History

Occupation: ____

Marital Status: □ Single □ Married □ Divorced □Widowed

Do you have children? □ Yes □ No How many? ____________________

Do you live alone? □ Yes □ No Who lives with you? ___________________

Do you smoke? □ Yes, I've smoked _____ packs of cigarettes per day for _____ years.

□ Yes, I smoke cigars or a pipe.

□ No, I have never smoked.

□ No, I quit _____years ago. At that time I was smoking _____ packs per day for ____ years.

Do you drink alcohol? o No, never (or rarely) o No, but I used to

□ Yes □ Daily □ 1 or more times a week □ 1 or more times a month

Are you at risk for AIDS (e.g. sexual orientation, drug abuse, previous blood transfusion)? □ No
□ Yes, please explain: ______________________________

Review of Systems

Are you currently, or have you had, problems with:

Constitutional	*Circle One*	
Fever	Yes	No
Weight loss	Yes	No
Excessive fatigue	Yes	No
Night sweats	Yes	No
Eyes		
Infections	Yes	No
Injuries	Yes	No
Glaucoma	Yes	No
Cataracts	Yes	No
Ear, Nose, Throat and Mouth		
Wear hearing aids	Yes	No
Hearing loss	Yes	No
Ear pain	Yes	No
Ear infections	Yes	No
Ringing in ears	Yes	No
Balance disturbance	Yes	No
Nosebleeds	Yes	No
Nasal congestion	Yes	No
Nasal drainage	Yes	No
Inability to smell	Yes	No
Sinus problems	Yes	No
Sinus headaches	Yes	No
Sore throats	Yes	No
Cardiovascular		
Chest pain or angina	Yes	No
High blood pressure	Yes	No
Irregular pulse	Yes	No
Heart murmur	Yes	No
High cholesterol	Yes	No
Swelling in feet	Yes	No
Leg pain	Yes	No

Respiratory	*Circle One*	
Asthma	Yes	No
Chronic cough	Yes	No
Emphysema	Yes	No
Shortness of breath	Yes	No
Bronchitis	Yes	No
Pneumonia	Yes	No
Lung cancer	Yes	No
Bloody sputum	Yes	No
Gastrointestinal		
Indigestion or pain	Yes	No
Nausea	Yes	No
Vomiting	Yes	No
Blood in your vomit	Yes	No
Liver disease	Yes	No
Jaundice	Yes	No
Abdominal pain	Yes	No
Change in your bowel habits	Yes	No
Ulcers or gastritis	Yes	No
Colon cancer	Yes	No
Genitourinary		
Urinary tract infections	Yes	No
Painful urination	Yes	No
Blood in your urine	Yes	No
Incontinence	Yes	No
Kidney stones	Yes	No
Musculoskeletal		
Broken bones	Yes	No
Arm or leg weakness	Yes	No
Back pain	Yes	No
Arm or leg pain	Yes	No
Joint pain or swelling	Yes	No
Arthritis	Yes	No

Integumentary	*Circle One*	
Skin disease	Yes	No
Skin cancer	Yes	No

Neurological		
Fainting spells or “blacking out”	Yes	No
Seizures	Yes	No
Problems with your memory	Yes	No
Disorientation	Yes	No
Difficulty with your speech	Yes	No
Double or blurred vision	Yes	No
Face weakness	Yes	No
Loss of coordination	Yes	No

Psychiatric		
Anxiety	Yes	No
Depression	Yes	No
Other psychiatric disorder/treatment	Yes	No

Endocrine	*Circle One*	
Diabetes	Yes	No
Thyroid disease	Yes	No
Increased appetite	Yes	No
Excessive thirst or urination	Yes	No
Hormone problems	Yes	No

Hematologic/Lymphatic		
Anemia	Yes	No
Hemophilia	Yes	No
Bleeding tendencies	Yes	No
Persistent swollen glands or lymph nodes	Yes	No
Blood transfusion	Yes	No

Allergic/Immunologic		
Food allergies	Yes	No
Inhalant (nasal) allergies	Yes	No

The above information is accurate to the best of my knowledge.

_______________________________ _____________

Patient Signature ***Date***

I have reviewed the above information with the patient.

_______________________________ _____________

Physician Signature *Date*

_______________________________ _____________

Physician Signature *Date*

_______________________________ _____________

Physician Signature *Date*

Alamogordo Ear, Nose & Throat
1401 10TH Street Suite C
Alamogordo, NM 88310

NOTICE OF PROTECTED HEALTH INFORMATION PRACTICES

This notice describes how Medical Information about you may be used and disclosed and how you can get access to this information.
Please review it carefully.

Purpose of Notice

Under the federal health care privacy regulations pertaining to the Health Insurance Portability and Accountability Act of 1996 set forth at 45 CFR § 160.101 et seq. (the "Privacy Regulations"), Alamogordo Ear, Nose & Throat ("the Practice") is required to protect the privacy of your individually identifiable health information, which includes information about your health history, symptoms, test results, diagnoses, treatment, and claims and payment history. We are also required to provide you with this Notice of Protected Health Information Practices regarding our legal duties, policies and procedures to protect and maintain the privacy of your health information ("the Notice"). We will not use or disclose your health information except as provided for in this Notice. However, we reserve the right to change the terms of this Notice and make new notice provisions for all your health information that we maintain. Should such terms change, we will mail a revised Notice to the mailing address most recently listed in your medical record.

Permitted Uses and Disclosures of Your Health Information

1. **Uses and Disclosures with Patient Consent:** Under the Privacy Regulations, after having made good faith efforts to obtain your acknowledgement of receipt of this Notice, we are permitted to use and disclose your health information for the following purposes:

   a. **Treatment**. We are permitted to use your health information in the provision and coordination of your health care. We may disclose information contained in your medical record to your primary health care provider, consulting providers, and to other health care personnel who have a need for such information for your care and treatment. For example, your physician may disclose your health information when consulting with another physician or specialist regarding your medical condition. Additionally, the Practice often takes pictures of patients to be used solely for treatment purposes relating to such patients. The use of such pictures is permitted by this Notice.

   b. **Payment**. We are permitted to use your health information for the purposes of determining coverage, billing, claims management, medical data processing and reimbursement. This information may be released to an insurance company, third party payor or other authorized entities involved in the payment of your medical bill and may include copies or portions of your medical record which are necessary for payment of your account. For example, a bill sent to your insurance company may include information that identifies you, your diagnosis, and the procedures and supplies used in your treatment.

   c. **Health Care Operations**. We are permitted to use and disclose your health information during the Practice's routine health care operations, including, but not limited to, quality assurance, utilization reviews, medical reviews, auditing, accreditation, certification, licensing or credentialing activities and for education purposes.

2. **Uses and Disclosures With Patient Authorization**. Under the Privacy Regulations, we can use and disclose your health information for purposes other than treatment, payment or health care operations with your written authorization. For example, with your authorization we can provide your name and medical condition to companies who might be able to provide you useful items or services. Under the Privacy Regulations, you may revoke your authorization; however, such revocation will not have any effect on uses or disclosures of your health information prior to our receipt of the revocation.

3. **Uses and Disclosures With Patient Opportunity to Verbally Agree or Object**. Under the Privacy Regulations, we are permitted to disclose your health information without your written consent or authorization to a family member, a close personal friend or any other person identified by you, if the information is directly relevant to that person's involvement in your care or treatment. You must be notified in advance of the use or disclosure and have the opportunity to verbally agree or object.

4. **Uses and Disclosures Without an Acknowledgement, Authorization or Opportunity to Verbally Agree or Object.** Under the Privacy Regulations, we are permitted to use or disclose your health information without your consent, authorization or the opportunity to verbally agree or object with regard to the following:

   a. **Uses and Disclosures Required by Law**. We will disclose your health information when required to do so by law.

   b. **Public Health Activities**. We may disclose your health information for public health reporting, reporting of communicable diseases and vital statistics and similar other circumstances.

   c. **Abuse and Neglect**. We may disclose your health information if we have a reasonable belief of abuse, neglect or domestic violence.

   d. **Regulatory Agencies**. We may disclose your health information to a health care oversight agency for activities authorized by law, including, but not limited to, licensure, certification, audits, investigations and inspections. These activities are necessary for the government and certain private health oversight agencies to monitor the health care system, government programs and compliance with civil rights.

   e. **Judicial and Administrative Proceedings**. We may disclose health information in judicial and administrative proceedings, as well as in response to an order of a court, administrative tribunal, or in response to a subpoena, summons, warrant, discovery request or similar legal request.

   f. **Law Enforcement Purposes**. We may disclose your health information to law enforcement officials when required to do so by law.

   g. **Coroners, Medical Examiners, Funeral Directors**. We may disclose your health information to a coroner or medical examiner. This may be necessary, for example, to determine a cause of death. We may also disclose your health information to funeral directors, as necessary, to carry out their duties.

h. **Research.** Under certain circumstances, we may disclose your health information to researchers when their clinical research study has been approved by an institutional review board that has reviewed the research proposal and provided that certain safeguards are in place to ensure the privacy and protection of your health information.

i. **Threats to Health and Safety**. We may use or disclose your health information if we believe, in good faith, the use or disclosure is necessary to prevent or lessen a serious or imminent threat to the health or safety of a person or the public.

j. **Military/Veterans**. If you are a member of the armed forces, we may disclose your health information as required by military command authorities.

k. **Workers' Compensation**. We may disclose your health information to the extent necessary to comply with laws relating to workers' compensation or other similar programs.

l. **Marketing**. We may use or disclose your health information to make a marketing communication to you, if such communication is conducted face-to-face, concerns products or services of nominal value, or identifies us as the communicating party and that we will receive remuneration for making the communication and, where required by the Privacy Regulations, instructions describing how you may verbally object to receiving future communications.

m. **Appointment Reminders**. We may use and disclose your health information to remind you of an appointment for treatment and medical care at our practice.

n. **Other Uses and Disclosures**. In addition to the reasons outlined above, we may use and disclose your health information for other purposes permitted by the Privacy Regulations.

5. **Uses and Disclosures to Business Associates**. With an acknowledgement or a proper authorization, we are permitted to disclose your health information to Business Associates and to allow Business Associates to receive your health information on our behalf. A Business Associate is defined under the Privacy Regulations as an individual or entity under contract with us to perform or assist us in a function or activity which requires the use of your health information. Examples of business associates include, but are not limited to, consultants, accountants, lawyers, medical transcriptionists and third party billing companies. We require all Business Associates to protect the confidentiality of your health information.

Patient Rights

Although your medical record is our property, you have the following rights concerning your medical record and health information:

1. **Right to Request Restrictions on the Use and Disclosure of Your Health Information**. You have the right to request restrictions on the use and disclosure of your health information for treatment, payment and health care operations. However, we are not required to agree with such a request. If, however, we agree to the requested restriction, it is binding on us.

2. **Right to Inspect and Copy Your Health Information**. You have the right to inspect and copy your own health information upon request. However, we are not required to provide you access to all the health information that we maintain. For example, this right does not extend to psychotherapy notes, information compiled in reasonable anticipation of, or for use in, a civil, criminal or administrative proceeding, or subject to or exempt from Clinical Laboratory Improvements Amendments of 1988. Access may also be denied if disclosure would reasonably endanger you or another person.

3. **Right to Verbally Object**. You have the right to verbally object to certain disclosures that are routinely made for treatment, payment or healthcare operations or for other purposes without an Authorization. For example, we are required to give you an opportunity to object to the sharing of your health information with a person or family member accompanying you for treatment.

4. **Right to Seek an Amendment of Your Health Information**. You have the right to request an amendment of your health information. If we disagree with the requested amendment, we will permit you to include a statement in the record. Moreover, we will provide you with a written explanation of the reasons for the denial and the procedures for filing appropriate complaints and appeals.

5. **Right to an Accounting of Disclosure of Your Health information**. You have the right to receive an accounting of disclosures made by us of your health information within six (6) years prior to the date of your request; provided, however that we need not provide an accounting for any information disclosed prior to April 14, 2003. The accounting will not include disclosures related to treatment, payment or health care operations, disclosures made to you, disclosures made pursuant to a validly executed authorization, disclosures permitted by the Privacy Regulations, disclosures to persons involved in your care, or disclosures that occurred prior to the April 14, 2003 compliance deadline under the Privacy Regulations. The accounting of disclosures shall include the date of each disclosure, name and address of the person or organization who received your health information, a brief description of the information disclosed, and the purpose for the disclosure.

6. **Right to Confidential Communications**. You have the right to receive confidential communications of your health information by alternative means or alternative locations. For example, you may request that we only contact you at work or by mail.

7. **Right to Revoke Your Authorization**. You have the right to revoke a validly executed authorization for the use or disclosure of your health information. However, such revocation will not have any effect on uses or disclosures prior to the receipt of the revocation.

8. **Right to Receive Copy of this Notice**. You have the right to receive a copy of this Notice.

Contact Information and How to Report a Privacy Rights Violation

If you have questions and would like additional information regarding the uses and disclosures of your health information, you may contact the Compliance Officer at 1401 10th Street, Suite C, Alamogordo, NM 88310. Moreover, the Practice has established an internal complaint process for reporting privacy rights violations. If you believe that your privacy rights have been violated, you may file a complaint with us or the Secretary of the Department of Health and Human Services at 200 Independence Avenue, S.W., Washington, D.C. 20201. To file a complaint with us, please contact the Compliance Officer at 1401 10th Street, Suite C, Alamogordo, NM 88310. All complaints must be submitted to the Practice in writing at 1401 10th Street, Suite C, Alamogordo, NM 88310. There will be no retaliation for filing a complaint.

Effective Date

The effective date of this Notice is April 14, 2003.

Alamogordo Ear, Nose & Throat
1401 10TH Street Suite C
Alamogordo, NM 88310

Acknowledgement of Receipt of Privacy Notice

Purpose of this Acknowledgement

This Acknowledgement, which allows the Practice to use and/or disclosure personally identifiable health information for treatment, payment or healthcare operations, is made pursuant to the requirements of 45 CFR §164.520(c)(2)(ii), part of the federal privacy regulations for the Health Insurance Privacy and Accountability Act of 1996 (the "Privacy Regulations").

Please read the following information carefully:

1. I understand and acknowledge that I am consenting to the use and/or disclosure of personally identifiable health information about me by Alamogordo Ear Nose and Throat for the purposes of treating me, obtaining payment for treatment of me, and as necessary in order to carry out any healthcare operations that are permitted in the Privacy Regulations.

2. I am aware that the Practice maintains a Privacy Notice which sets forth the types of uses and disclosures that the Practice is permitted to make under the Privacy Regulations and sets forth in detail the way in which the Practice will make such use or disclosure. By signing this Acknowledgement, I understand and acknowledge that I have received a copy of the Privacy Notice.

3. I understand and acknowledge that in its Privacy Notice, the Practice has reserved the right to change its Privacy Notice as it sees fit from time to time. If I wish to obtain a revised Privacy Notice, I need to send a written request for a revised Privacy Notice to the office of the Practice at the following address:

   Attention: Practice Compliance Director
   1401 10th Street
   Suite C
   Alamogordo, NM 88310

4. I understand and acknowledge that I have the right to request that the Practice restrict how my information is used or disclosed to carry out treatment, payment or healthcare operations. I understand and acknowledge that the Practice is not required to agree to restrictions requested by me, but if the Practice agrees to such a requested restriction it will be bound by that restriction until I notify it otherwise in writing.

   I request the following restrictions be placed on the Practice's use and/or disclosure of my health information (leave blank if no restrictions): ____
   ____
   ____

I understand the foregoing provisions, and I wish to sign this Acknowledgement authorizing the use of my personally identifiable health information for the purposes of treatment, payment for treatment and healthcare operations.

BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE REVIEWED AN EXECUTED COPY OF THIS ACKNOWLEDGEMENT AND A COPY OF THE PRACTICE'S POLICY NOTICE AND AGREE TO THE PRACTICE'S USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS.

______________________________________ ____________________

Signature of Patient or Representative Date

____

Patient's Name

____

Date of Birth

____

Social Security Number

______________________________________ ____________________

Name of Personal Representative (if applicable) Relationship to Patient

---

To Be Completed by the Practice

The requested restrictions on the use and/or disclosure of the patient’s health information set forth above are:

_______ Accepted _______ Denied _______ Not Applicable

_______Other (explain) ____

____ _____________

Signature of Authorized Practice Representative Date

The Waiting Room Blues

We know that waiting to see the doctor can be very frustrating! We do value your time, but there are obstacles to our staying on time.

This is what goes on behind the scenes that can lead to our slow downs.

1. Some medical problems take longer than expected. We unfortunately cannot always anticipate each patient's needs in advance.

2. Urgent or emergent patient problems commonly occur that demand attention outside the planned schedule.

3. Unfortunately, we have to schedule appointments to account for daily number of patients that "no show" or cancel at the last minute. If we did not do this, we would frequently find the office staff idle and caring for no patients at all during that time. We would be able to see fewer patients in a day and the result of this would be significantly longer waiting lists for office appointments and fewer patients ultimately getting care.

••*In a perfect world we could predict these variables exactly and could see each patient right at their appointment time, but in reality these factors are highly unpredictable.*

••*Sometimes we guess right and stay pretty close to schedule, but sometimes we don't, and during those times we can run as much as 30-45 minutes behind or occasionally even more.*

What you can do to help ease the frustration:

1. Try not to schedule another doctors appointment to follow soon after your appointment in our office.

2. Bring something to do while waiting in the office, such as a book to read, etc. Toys and books are available for children. Magazines are available for adults.

3. You may want to call ahead shortly before your visit to see if we are running behind and if so you may want to delay your arrival in the office accordingly. Unfortunately, even this is not a perfect solution because the situation can change rapidly at times.

4. Try to avoid particularly busy times such as after 4:00 PM, although almost no time is completely immune to delays.

We apologize for the wait and do appreciate your patience!

Dr. Frost and the Staff of Alamogordo ENT

I have read and understand this information.

SIGN AND DATE____

Alamogordo Ear Nose and Throat
Billing Policies, Authorizations, and Releases

FINANCIAL POLICY:

It is our office policy to inform you of our patient payment procedure. Please review the section below that is applicable to you.

____1. **Patient With Insurance:** You are responsible for deductibles, copays, non-covered services, coinsurance and items considered "not medically necessary" by your insurance company. Please pay co-payments and coinsurance amounts as services are rendered. The remaining balance should be taken care of within (1) month of notice from your insurance company. If you or your insurance carrier makes payment exceeding your balance, reimbursement will be remitted.

____2. **Patient Without Insurance (Private Pay):** Please make payment for your care at each patient visit. If payment cannot be made at each visit, please notify the office staff to make other arrangements.

____3. **Workers' Compensation Patient:** As a workers' compensation patient you may be covered by insurance **if** your injury is reported at work **and** verified with your employer. Be sure to inform the office personnel that your injury resulted during employment. You, as the patient, are ultimately responsible for the balance.

____4. **Personal Injury (Accident):** If you are a personal injury patient, our office will bill the appropriate insurance companies. If we are unable to obtain payment, the charges for the services rendered will be your responsibility. Please give all information needed for billing. If an attorney is involved and asks you not to submit insurance claims, a Doctor's lien must be signed by you and your attorney.

____5. **Medicare:** Our office will submit your Medicare charges to Medicare and also your secondary insurance. You are responsible for any deductibles, copays, or non-covered services.

_____6. **We do not participate with: ___________________________________,**
Please make payment for your care at each visit. If payment cannot be made at each visit, notify the office staff to make other arrangements.

_____7. **Medicaid**: You are responsible for providing current Medicaid card at each visit. If necessary, a referral for that visit is your responsibility. We must always be kept up to date with the proper Medicaid information. If no referral is obtained by you, or we have been provided incorrect information you will be responsible for payment.

ASSIGNMENT:

__________I assign the benefits from my insurance carrier(s) (request payment of benefits) to Alamogordo Ear Nose and Throat, Timothy Frost, MD, or Kelly Frost, MA for any service furnished by that provider.

RELEASE OF INFORMATION:

___√___I authorize Alamogordo Ear Nose and Throat to release to my insurance carrier(s) any information needed to determine benefits or benefits payable for related services.

___√___I have read and agree to the Payment Policy, Assignment, and release of Information paragraphs stated above, which apply to me.

X____

Patient **Date**

____

Person Signing on Behalf of Patient

Relationship to patient____