Medical Arts Unlimited, Corp. & APEX Sinus Center Patient Information Sheet

First name: _____ Middle initial: _____ Last name: _____ Sex: ☐M ☐F

Date of Birth: _____ Primary Care Physician: _____
NAME CITY

Home Address: _____
ADDRESS CITY STATE ZIP

Home phone: _____ Cell phone: _____ Work: _____

E-mail address: _____

Preferred method of communication: ☐ Home number ☐ Cell number ☐ Email ☐ Other: _____

Marital Status: ☐Single ☐Married ☐Other: _____ Employment Status: ☐FT ☐PT ☐Retired ☐Other ☐N/A

Responsible Party/Name of Insured _____ Date of Birth_____

Emergency contact: _____ Relationship: _____
NAME PHONE NUMBER

Do we have permission to contact this person regarding matters concerning your care? ☐ Yes ☐ No

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Ethnicity (check one):
- ☐ Non-Hispanic
- ☐ Hispanic
- ☐ Refused to Report

Primary race (check one):
- ☐ White
- ☐ Native American
- ☐ African American/Black
- ☐ Asian
- ☐ Other Race
- ☐ Native Hawaiian
- ☐ Other Pacific Islander
- ☐ Unreported/Refused
- ☐ Hispanic

Preferred Language (check one): ☐ English ☐ Spanish ☐ Other: _____ Interpreter Needed? ☐Yes ☐No

Do you have an advanced directive such as a living will or medical power of attorney? ☐ Yes ☐ No
Is your visit with us today due to an automobile accident or work place accident? ☐ Yes ☐ No

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Preferred Pharmacy #1: _____ Mail Order? ☐ Yes ☐ No
NAME CITY

Preferred Pharmacy #2: _____ Mail Order? ☐ Yes ☐ No
NAME CITY

ELECTRONIC PRESCRIPTIONS: *Our electronic medical record program accesses your prescription/medication history in order for us to safely prescribe your medication. By signing this, you authorize us to do so.*

PAYMENT POLICY: *Our policy requires that all payments are made at the time of service by patients who do not have health insurance coverage; or whose insurance will not cover a particular service, such as cosmetic procedures. In instances where insurance is provided, as a courtesy to you, we will bill your insurance. It is to be understood that you are responsible for charges incurred during your visit. Therefore, in the event that your insurance carrier does not pay the bill for any reason, the entire balance will be your responsibility, and must be paid in full. If the provider is a participating provider in your health plan, you are responsible for co-pay/ co-insurance or any unmet portion of your deductible. By signing this, you acknowledge that you understand the above payment policy and agree to abide by it. Moreover, you agree to authorize your insurance carrier to pay any medical benefits directly to Medical Arts Unlimited, Corp.*

Signature: _____ *Date:* _____
PATIENT/GUARDIAN RELATIONSHIP TO PATIENT

Advocate Physician Partners

SynAPPS

Specially Protected Health Information Authorization Form

Authorization to use and/or disclose protected health information in the Electronic Health Information Exchange.

____YES. I authorize this practice to use and/or disclose a copy of my protected health information in the Electronic Health Information Exchange (eEHX) for the purpose of coordinating my medical care amongst my healthcare providers. I understand that including this information in eEHX enables any provider with authorized access to the eEHX to review my protected health information, including the following specially protected health information:

I acknowledge that I have been given sufficient information and have had the opportunity to have my questions answered about the Electronic Health Information Exchange (eEHX).

I understand that future withdrawal of permission to include this information in the Electronic Health Information Exchange (eEHX) will be effective except to the extent action has already been taken in reliance on this permission. When I withdraw permission my protected health information will be inactivated and the eEHX and will no longer be able to be accessed. This permission will expire if the eEHX program is discontinued.

I understand that my eligibility for treatment or any health care benefits cannot be conditioned on whether I sign this authorization form. However, to the extent I have indicated "YES" to the sharing of my protected health information, I understand that an electronic Health Information Exchange record will be available to other eEHX authorized users.

_____

Authorized date(s) or date range

_____

Printed Name of Patient/Representative

_____ _____

Signature of Patient/Representative Date

AUTHORIZATION OF REPRESENTATIVE:

I,_____, do hereby state that I am authorized to sign this permission on behalf of the patient on the following basis:

Relationship to Patient _____

[A signed copy of this permission will be provided to the patient/representative]

Acknowledgment of Receipt of Notice of Privacy Practices Form

Medical Arts Unlimited, Corp. & APEX Rhinology and Cosmetic Surgery Center

I have been presented with a copy of the physician's Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal state law. It outlines my rights regarding my health information.

I have also received information on the education and training of the physician.

Date: _____

Signature of Patient/Patient's Representative: _____

Patient Name (Please Print): _____ Date of birth: _____

If you are not the patient, please fill out the following:

Patient Representative Name (Please Print): _____

Relationship: _____

Internal Use Only

If Patient/ Patient Representative refuses to sign acknowledgment, please document date and time notice was presented to patient and sign below.

Presented on (Date): _____ Time: _____ (circle) AM PM

By (Name and Title): _____

*To be filed in patients' medical records

PATIENT'S FINANCIAL RESPONSIBILITY AND PAYMENT POLICY

APEX RHINOLOGY &COSMETIC SURGERY CENTER

Our policy guidelines are designed to ensure transparency and simplicity of financial transactions between you, your insurance provider, and our practice.

The patient/legal guardian is ultimately responsible for all copayments and deductibles accrued during an office visit for services provided at the time of that visit.
Initials _____

Full payment for "non-covered" procedures such as cosmetic, elective and "self-pay" services is expected on the day of service.
Initials _____

Insurance is a contract between the patient and their insurance provider. All questions regarding insurance payments, coverage, denials, balances, etc. are ultimately the patient's responsibility.
Initials _____

When you consent to a procedure, you authorize Apex Rhinology and Cosmetic Surgery Center to bill your insurance provider. When billing visits or procedures, we will submit only CPT codes based on Current Professional Guidelines. We do not bill specific dollar amounts and cannot predict the "final" payment from your insurance company.
Initials _____

For exact CPT codes submitted or proposed, please access your records through our online portal (please ask the front desk for specific instructions). If you still need help with explanations, please contact our billing department prior to scheduling any procedures.
Initials _____

According to insurance guidelines, procedures like cerumen removal, nosebleed control and endoscopies are billed as surgery. This distinguishes them from regular office visits. Please note that those procedures are routinely performed and will appear separate on your bill, listed as surgery.
Initials _____

Procedures such as CT sinuses, sleep studies, allergy tests, endoscopies are billed to your insurance. Each procedure is submitted with a separate CPT code and will be reflected in your overall charge. By law, we cannot discount your financial obligation such as co-pays or deductibles. We can, however, discount "self-pay" services. Please be aware that a "self-pay" option is sometimes less expensive than the charges accrued through your insurance provider. Please ask about this option prior to having a procedure.
Initials _____

The above policy of financial responsibility was reviewed and explained to me in detail. My questions were answered in a simple and honest manner.

Patient's signature _____ **Date** _____

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