Colden
Ear, Nose, Throat & Allergy
adult & pediatric care
hearing & balance center
sinus & sleep specialists

Patient:_____ **Date of Birth:**_____

Under Age (18) name of parent/guardian**:**_____Relationship: _____

Marital Status: □ Married □ Single □ Widowed □ Divorced Email:_____

Race:_____ **Ethnicity:** _____ **Preferred Language:** _____

Address: _____ _____ _____ _____
Street City State Zip code

Home phone: _____**Cell:** _____**Work:** _____

*Address/Phone of parent/guarantor if different from above:*_____

Name of Emergency Contact:_____**Phone:**_____**Relationship:**_____

Primary Care Physician (PCP) Name: _____**Phone:**_____

Address: _____

Referring Physician (If different from PCP):_____

Preferred Pharmacy: _____ _____ _____
Pharmacy Name City State

Patient employer _____

Occupation:_____

Name of Primary Insurance: _____**Subscriber:**_____

Name of Secondary Insurance:_____**Subscriber:**_____

Work related injury: □ Yes □ No If yes, please complete a workers compensation information form.

How did you hear about this practice/doctors?_____

I, the undersigned, have insurance coverage with _____*and assign directly to Colden Ear Nose and Throat & Allergy medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefit. I authorize the use of this signature on all my insurance submissions. If my insurance requires a referral and I do not secure one, I will be responsible for payment.*

Signature:_____**Date:** _____
(patient signature or signature of parent/guardian if patient is a minor under 18years)

PLEASE SEE BACK PAGE FOR GENERAL CONSENT FOR TREATMENT ------->>

COLDEN EAR NOSE THROAT & ALLERGY
Adult & Pediatric Care/ Hearing & Balance Center
Sinus & Sleep Specialists/ Facial Plastic Surgery
1 Wallace Bashaw Jr. Way Suite 3002
Newburyport, MA 01950
Tel: 978-997-1550

GENERAL CONSENT FOR TREATMENT

1. I am asking for medical care and treatment at this facility and agree to accept services which may diagnose a medical condition, procedures to treat my condition and further routine medical care. I understand that these services will be provided to me by physicians, physician assistants, medical assistants, and other health care providers, some of whom may be in training. Medical scribes may also be present in the room for documentation purposes on behalf of the providers.
2. I have not been given any guarantees as to the results of the services I will receive. I understand that my agreement to accept these services will remain in effect unless I say that I no longer want these services or until my treatment is completed.
3. I understand that my agreement to accept these services is called a General Consent and that it includes any routine procedure(s) or treatment(s) such as allergy testing, physical examination, administration of medication(s), taking X-rays, use of local anesthesia and other non-invasive procedures.

Consent Form to give Permission to Someone Other than Guardians.

In presenting my son/daughter for diagnosis and treatment

Name: _____ for _____ (patient name)
☐ Mother ☐ Father ☐ Legal Guardian ☐ Son ☐ Daughter

hereby voluntarily consent to the rendering of such care, including diagnosis procedures, surgical and medical treatment, by authorized members of the office staff or their designees, as may in their professional judgment be necessary.

I hereby acknowledge that no guarantees have been made to me as to the effect of such examinations or treatment on my child's condition.

I have read this form and certify that I understand its contents.
We/I hereby give our/my consent to _____

who will be caring for our/my child _____ DOB: _____
(Name of Child)

We/I acknowledge that we are/ I am responsible for all reasonable charges with the care and treatment rendered.

Signature: _____ Date: _____
Mother, Father or Legal Guardian

In case of emergency, I can be reached at: _____

Consent to Discuss Medical Care and Treatment with someone other than a Primary Care Physician or Referring Physician

I hereby authorize the office of Colden Ear Nose Throat & Allergy to discuss my medical care and treatment with

Name: _____
☐ Mother ☐ Father ☐ Spouse ☐ Other (please specify)

Patient Signature_____ Date_____ DOB: _____
(patient must be 18 years or older)

COLDEN EAR NOSE THROAT AND ALLERGY FINANCIAL 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.

- Full payment is due at the time of service (unless we have contracted with your insurance carrier and all appropriate Referrals/authorizations have been issued). After full payment is made, you will receive an itemized receipt which you can submit for direct reimbursement.

- Insurance companies require you to have a referral from a primary care physician in order for your visit to be covered unless you have a PPO (Preferred Provider Organization) plan type. It is the patient's responsibility to request/obtain an insurance referral if needed for their upcoming appointment. Contact your insurance carrier with any questions.

- Your insurance carrier requires we collect designated copayment due at each and every visit. You are responsible for any deductible/coinsurance as indicated by your insurance plan. We reserve the right to collect these fees prior to rendering professional service (s), if applicable.

- During your evaluation, additional procedures may be done if medically necessary. These include hearing tests, allergy evaluation, wax removal, endoscopy of the nose or throat and cautery and/or packing for nasal bleeding.

- They are billed in addition to the office evaluation. If you prefer not to have any of these procedures done, please let us know in advance

- Non-emergency treatment may be denied if:
  - A minor under eighteen is unaccompanied by an adult.
  - A patient does not have a valid insurance card.
  - A referral is unobtainable (when required by the insurance)
  - A patient has been delinquent on balance and/or the account has been sent to our "collection agency."
  - A patient has missed more than three previous appointments and has been advised of being denied another appointment.

- We accept CASH, CHECKS, MASTERCARD, VISA, DISCOVER and AMERICAN EXPRESS.

- Failure to show for an appointment will result in a $50.00 administration fee.

- Cancellations less than 48 hours' notice will result in a $50.00 administration fee.

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

I, _____have read and understand the conditions for payment to Colden Ear Nose Throat & Allergy as outlined above.

Signature_____DATE _____
(patient signature or signature of parent/guardian if patient is a minor under 18)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (HIPPA)

I have received a copy of the Notice of Privacy Practices from the office of Colden Ear Nose Throat & Allergy

Name of Patient (Please print) _____

Signature of Patient _____DATE _____
(patient signature or signature of parent/guardian if patient is a minor under 18)

Notice of Health Information Privacy Practices

Our use of your health and demographic information

1. Basis for planning your medical treatment.
2. Means of communication among health professions involved in your treatment.
3. Legal document describing your treatment.
4. Basis for obtaining payment including third party payer verification of services billed.
5. Basis for regular health operations including risk or quality improvement.
6. Tool in educating health professionals.
7. Source of information for public health officials, law enforcement, correction institutions, workers compensation as required by law.

Your health information rights.

1. Obtain a copy of this notice of information practices upon request.
2. Obtain a copy of your health information as provided for in (45CFR 164.524).
3. Amend your health information (45 CFR 164.528)
4. Obtain an accounting of disclosures of your health information (45 CFR 164.528)
5. Request disclosure of your health information by alternative means or at alternative locations
6. Request restriction on uses and disclosure of your health information (45 CFR 164.522)
7. Revoke your authorization to use or disclose your health information except to the extent that action has already been taken.
8. Receive a copy of any revisions to this notice.

Our responsibilities and rights

1. Maintain the privacy of your health information.
2. Provide you with this notice.
3. Abide by the terms of this notice.
4. Notify you if we are unable to agree to a requested restriction.
5. Accommodate reasonable requests regarding disclosure of health information by alternative means or at alternative locations.
6. Discontinue use or disclosure of your health information with receipt of your written revocation of authorization.
7. Reserve the right to revise this notice (CFR164.520)
8. Provide a copy of any revisions to this notice to the address provided by you.

For more information or to report a problem

If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer or With the Office for Civil Rights without retaliation:
Office of Civil Rights
US Department of Health and Human Services
200 Independence Avenue, SW Room 509F, HHH Bldg.
Washington, DC 20201