DeFatta ENT
FACIAL PLASTIC SURGERY

Thank you for choosing our office! In order to serve you properly, we need the following information. Please Print.

Patient's Legal Name _____Maiden/Previous Names: _____

Address_____City_____State_____Zip_____

SSN_____ Birthdate_____ ☐ Male ☐ Female

Home Phone#_____ Cell Phone#_____

Email Address: _____ Preferred Contact Method: _____

Please Check One: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Race: ☐ White ☐ Asian ☐ African American ☐ American Indian ☐ Hispanic ☐ decline to specify ☐ other:

Ethnicity: ☐ Not Hispanic/Latino ☐ Hispanic/Latino

Emergency Contact Name: _____ Phone Number _____

Relationship to patient_____ Who is your Primary Care Physician/Provider? _____

Name of referring physician_____ Is this the result of an auto accident? Yes No

Is this a work related injury? Yes No If yes, has a first report of injury been filed with your employer? Yes No

Patient's Employer_____ Work Phone _____

Employer Address _____City _____State_____ Zip_____

How did you hear about DeFatta ENT & Facial Plastic Surgery? _____

Patient Treatment Waiver

I understand that in the event that I do not have the proper referral from my Primary Care Physician to cover services that I am requesting from DeFatta ENT & Facial Plastic Surgery I agree that I shall be responsible for payment in full for any charges related to services provided to me or my dependent(s).

Authorization to perform in-office SCOPE, EAR CLEANING, BLOOD DRAW AND/OR BIOPSY.

A separate procedural fee will be submitted to your insurance carrier for these procedures. You will be obligated to pay any deductible and/or co-payments that are applied to this claim.

Medical Care Request and Authorization

I understand that I may have a condition that requires medical care. I am requesting and authorizing medical care by Defatta ENT & Facial Plastic Surgery, any of the physicians associated with DeFatta ENT & Facial Plastic Surgery or the facility at which the medical care is rendered whom DeFatta ENT & Facial Plastic Surgery considers reasonably necessary for my care. I recognize that I may, at any time, be a participant in and make decisions regarding my health care, including the right to accept or refuse medical or surgical treatment, the right to formulate advance directives, and to provide any such directive for my physicians and health care providers to be aware of and to rely on.

I acknowledge by my initials/signature that I understand all of the above and agree to abide by the terms of this document

Please initial

_____ FINANCIAL POLICY
_____ PATIENT TREATMENT WAIVER
_____ AUTHORIZATION TO PERFORM IN OFFICE
_____ MEDICAL CARE REQUEST & AUTHORIZATION

Acknowledgement of Receipt of Privacy Notice

(Please ask assistant if you'd like to have a copy of the privacy notice.)

By signing this form, you acknowledge that **DeFatta ENT and Facial Plastic Surgery** has given you a copy of its Privacy Notice.

Check all that are true:

[ ] I have been offered DeFatta ENT and Facial Plastic Surgery's Privacy Notice.

[ ] DeFatta ENT and Facial Plastic Surgery has given me the opportunity to discuss my concerns and questions about the privacy of my health information

_____ _____

Patient or Legal Guardian Signature Date

Disclosure of Health Information

In compliance with DeFatta ENT & Facial Plastic Surgery privacy practices, you may designate individual(s) to whom DeFatta ENT & Facial Plastic Surgery may disclose your protected health information. This may include individually identifiable information related to past, present, or future appointments, medical or financial information. This does not include information relating to mental health treatment or HIV test results as releasing that information requires separate written consent. *If you do not wish to designate individual(s) to receive your protected health information, indicate "none" below.* I understand that I have an option to revoke Disclose of Health and Information authorization at any time.

I grant the following person(s) permission to speak to my Doctor and/or Doctor's assistant regarding my medical records and treatment:

_____ _____ _____

Name Relationship to Patient Telephone number

Accepted and agreed: _____ _____

Patient or Legal Guardian Signature Date

Witnessed: _____ _____

Employee Signature Date

RESPONSIBLE PARTY (*if different from patient)*

Name of person responsible for this account _____Relationship to Patient _____

Address (if different from patient)_____ Phone _____

Birthdate_____Employer_____ Work Phone _____

INSURANCE INFORMATION *(Required, unless you are self-pay.)*

Primary Insurance _____ID #_____Group #_____

Policy Holder_____ Employer_____ Work Phone_____

Relationship to Patient _____Birthdate _____SSN_____

Secondary Insurance _____ID # _____ Group #_____

Policy Holder_____ Employer_____ Work Phone_____

Relationship to Patient _____ Birthdate _____ SSN_____

Assignment of Benefits: I hereby assign all medical and/or surgical benefits to which I am entitled and authorize the release of any information relating to all claims submitted on behalf of myself and/or dependents. I hereby authorize and direct my current and future insurance carrier(s), including Medicare, private insurance, and any health/medical plan, to issue payment directly to **DeFatta ENT & Facial Plastic Surgery** for services rendered to myself and/or my dependents regardless of my insurance benefits, if any. **I understand that I am responsible for any amount not covered by insurance**. This assignment will remain in effect until revoked by me in writing.

Signature _____ Date _____