727.329.5400 phone
727.329.5401 fax

Pediatric Ear, Nose & Throat Specialists™

new patient information

Please fill in ALL fields completely

patient name_____
Nombre del paciente first (primero) middle (segundo) last (apellido)

ss# ___-___-____ date of birth _____ gender_____ nickname _____
fecha de nacimiento género apodo

address_____
dirección city (ciudad) state (estado) zip (código postal)

primary # (___) ___-____ ☐ **This number can receive text messages.** (*Este número puede recibir mensajes de texto*) ☐ **This number can receive voice messages only.** (*Este número sólo puede recibir mensajes de voz*)
número de teléfono primario

referring physician_____ referring physician phone # (___) ___-____
médico de referencia número de teléfono del medico de referencia

pediatrician_____ pediatrician phone # (___) ___-____
Pediatra número de teléfono del pediatra

DUE TO RECENT REFORMS MANDATED BY THE GOVERNMENT, DOCTORS ARE REQUIRED TO ASK ALL PATIENTS FOR THEIR RACE AND ETHNICITY REGARDLESS OF YOUR INSURANCE TO MEET MEANINGFUL USE REQUIREMENTS.

Race:_____ **Ethnicity:** _____

☐ **American Indian/Alaska Native** ☐ **Asian** ☐ **Black/African American** ☐ **Declined** ☐ **Hispanic or Latino**
☐ **Declined** ☐ **Nat. Hawaiian/Pacific Islander** ☐ **Other Race** ☐ **White** ☐ **Not Hispanic or Latino**

Primary language: _____

Who has legal custody of Patient? ☐ Parent ☐ Mother ☐ Father ☐ Foster Parent ☐ Grandparent ☐ HRS/OTHER

****IF NOT LEGAL PARENT, COURT DOCUMENTS MUST BE SUBMITTED TO CORPORATE OFFICE PRIOR TO VISIT (FAX: 727.329.5402)**

parent information

parent 1_____ ss# ___-___-____ date of birth _____
Padre uno fecha de nacimiento

address (if different from child)_____
Dirección (Si es diferente del niño) city (ciudad) state (estado) zip (código postal)

home # (___) ___-____ cell # (___) ___-____ email address:_____
número de teléfono de casa el número de teléfono cellular el email

work # (___) ___-____ ext: ___ place of employment:_____ occupation:_____
número de teléfono de trabajo la extensión lugar de empleo la ocupación

parent 2_____ ss#___-___-____ date of birth_____
Padre uno fecha de nacimiento

address (if different from child)_____
Dirección (Si es diferente del niño) city (ciudad) state (estado) zip (código postal)

home # (___) ___-____ cell # (___) ___-____ email address:_____
número de teléfono de casa el número de teléfono cellular el email

work # (___) ___-____ ext: ___ employer:_____ occupation:_____
número de teléfono de trabajo la extensión lugar de empleo la ocupación

insurance information

primary insurance carrier:_____ policy #_____
primer seguro número de póliza de seguro

group #_____ phone #(___) ___-____ **PLEASE GIVE CARD TO FRONT DESK**
número de grupo teléfono

policyholder:_____ date of birth _____ SS# ___-___-____
el asegurado fecha de nacimiento

secondary insurance information

☐ NOT applicable

secondary insurance carrier:_____ policy #_____
segundo seguro *número de póliza de seguro*

group #_____ phone #(___) ___-____
número de grupo *teléfono*

PLEASE GIVE CARD TO FRONT DESK

policyholder:_____ date of birth _____ SS# ____-___-_____
el asegurado *fecha de nacimiento*

communication information

In order to provide you with timely information, we may need to contact you regarding appointments, test results, payment requirements, insurance authorizations, physician referrals, etc. In addition, you may receive appointment reminders via our automated text system. Please check the appropriate boxes where you would like this information sent. ☐ Home phone ☐ Cell phone ☐ Work phone ☐ Email

Your signature below confirms your approval of these communication preferences with Pediatric Ear, Nose & Throat Specialists.

Signature:_____ **Date:**_____
firma *fecha*

Pharmacy Name:_____ **Address:**_____ **Phone:**_____
la farmacia *la dirección* *teléfono*

emergency contact

Name _____ Relation _____ Phone #_____
nombre del contacto de emergencia *el pariente* *teléfono*

Name _____ Relation _____ Phone #_____
nombre del contacto de emergencia *el pariente* *teléfono*

If the legal mother and/or legal father are unable to bring the above named patient for an office visit and/or treatment, I hereby authorize the following individual(s) to (1) accompany my child, (2) make healthcare decisions and (3) receive copies of his/her medical records in my absence. I give consent to all medical treatment to be rendered. I understand that this authorization does not apply to bringing my child for surgery. I must accompany my child to surgery.

Name _____ Relation to patient _____
nombre *el pariente*

Name _____ Relation to patient _____
nombre *el pariente*

authorization

I hereby authorize the physician(s), physician assistant(s), nurse practitioner(s), resident physician, audiologist, and/or nursing staff of POHNS to provide diagnostic procedures & medical treatment including, but not limited to, suctioning of ears, nose, throat & suture removal, IV line removal & any other routine services deemed necessary at the time of the office visit to the patient named on this form. In addition, I hereby authorize the treating person(s) to take photographic pictures of the treated area and I understand that these pictures will be safely stored in the patient's clinical record.

I hereby authorize third parties to pay directly to the physician(s)/POHNS any insurance benefits due for services rendered on behalf of the named patient. I authorize the physician(s) of POHNS to furnish my insurance company and/or third party payers (or representatives), any medical information necessary to process our insurance claims. I hereby authorize the release of any medical records to and/or from POHNS regarding the above named patient to include: office/procedure/surgical notes from outside treating physicians, lab/x-ray/CT/MRI/audiological reports/results and/or diagnostic testing. I authorize mailing of my records to outside medical facilities and/or physicians if necessary.

The parent, foster parent, grandparent(s), legal guardian is responsible to pay all sums unpaid by insurance. If it becomes necessary to collect any sum due through an attorney then the parent, foster parent, grandparent(s), legal guardian agrees to pay all reasonable costs of collection, including the attorney's fees, whether suit is filed or not.

I have read and fully understand the above insurance authorization/financial responsibilities, consent for treatment and release of medical information.

This authorization will expire in twelve (12) months following the date of signature, unless otherwise specified below. I hereby acknowledge receipt of Pediatric Otolaryngology Head & Neck Surgery Assoc. PA's SUMMARY OF PRIVACY PRACTICES with respect to this child.

_____ _____
Signature of Parent, Foster Parent, Grandparent(s), Legal Guardian (Circle one) **Today's Date**
firma del padre, padre adoptivo, abuelo, tutor legal (círculo uno) *fecha de hoy*

_____ _____
Authorized Facility Signature **Today's Date**
firma de instalaciones autorizadas *fecha de hoy*

Photo ID Required at Check In

Year:_____

Pediatric Ear, Nose & Throat Specialists™

THOMAS M. ANDREWS, M.D. • WADE R. CRESSMAN, M.D.
ROSE S. TROWBRIDGE, M.D. • KATHLEEN M. WASYLIK, M.D.
Telephone: (727) 329-5400
Web Site: www.pediatric-ent.com

FINANCIAL POLICY

This is an agreement between the treating physician/physician extender of Pediatric Ear, Nose and Throat Specialists, as creditor, and the Patient/Debtor named on this form.

In this agreement the words "you", "your", and "yours" mean the Patient/Debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we", "us", and "our" refer to the physician/physician extender of Pediatric Ear, Nose and Throat Specialists.

By executing this agreement, you are agreeing to pay for all services that are received.

Monthly Statement: If you have a balance on your child's account, you will receive a monthly statement. It will show separately the previous balance, any new charges to the account, and any payment(s) or credit(s) applied to your child's account during the month.

Payments: Unless other arrangements are approved by us in writing, the balance on your billing statement is due and payable when the statement is issued, and is past due if not paid by the end of the month.

Required Payments: Any co-payments required by an insurance company must be paid at the time of service. **Because this is an insurance requirement, we cannot bill you for these.** Any outstanding deductible balance must be paid at the time of service. Because the deductible is a component of an agreement between you and your insurance carrier, **we cannot bill you for this.**

Contracted Insurance: If we are contracted with your insurance carrier, we are required to follow our contract and their requirements. If you have a co-pay or deductible, you must pay that at the time of service. It is the insurance carrier that makes the final determination of your eligibility. If your insurance carrier requires an office referral and/or pre-authorization, you are responsible for obtaining it. Failure to obtain the referral and/or pre-authorization may result in the cancellation of your child's appointment. Our surgery pre-certification staff will obtain the necessary authorization for the surgery procedure(s).

Non-contracted Insurance: Insurance is a contract between you and your insurance carrier. As a courtesy to you, we will file an insurance claim to your primary insurance carrier and your secondary carrier, if applicable. It is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by your insurance carrier. If your insurance carrier requires a referral and/or pre-authorization for the office visit **you are responsible for obtaining it.** Failure to obtain the referral and/or pre-authorization may result in the cancellation of your child's appointment. Our surgery pre-certification staff will obtain the necessary authorization for the surgery procedure(s).

Divorce: In the case of a divorce or separation, the party responsible for the child's account remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

CONTINUED ON REVERSE SIDE

Past Due Accounts: If your child's account becomes past due, we will take necessary steps to collect this debt. If we have to refer the account to a collection agency, you agree to pay all of the collection costs which are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyer's fees which we incur, plus all court costs. In the case of suit, you agree the venue shall be in Pinellas County, Florida.

Returned Checks: There is a fee (currently $35.00) for any check returned by the bank.

Missed Appointment: A patient with two (2) consecutive no show or missed appointments will be asked to seek care elsewhere.

Transferring of Medical Records: To receive a copy of your child's medical records, we must receive a signed request in writing. All copies of the medical records are subject to a fee, which is dependent upon the number of copies made for you. You authorize us to include all relevant information. If you are requesting your child's records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information.

Waiver of Confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if the past due status is reported to a credit reporting agency, the fact that your child received treatment at our office may become a matter of public record.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

Payment Option if you have no insurance:

1. You choose to pay the total cost on the day that treatment is rendered.

Payment Options if you have insurance:

1. You choose to pay your co-payment or your deductible of $_____ and any out-of-pocket portions (your co-insurance requirement or any remaining unpaid balance existing on your account), at the time services are rendered.

2. You choose to pay in full for all services. We will request your insurance carrier send their payment directly to you.

Patient's Name: _____ **Date of Birth:**_____

Responsible Party: _____

Signature: _____ **Date:** _____

Witness: _____ **Date:**_____