Philip D. Heichel, MD

(Patient Name)	(Date of Birth)	(Social Security #)

ACKNOWLEDGEMENT OF PRIVACY POLICY: I have been advised of Superior Ear, Nose and Throat Specialists, P.C. Office Privacy Policy. A copy of the Policy is available upon request to review or retain.

INSURANCE AUTHORIZATION: I authorize release of any medical or other information necessary to all my insurance companies. I understand I am responsible for my bill including deductible and co-pays. I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies. I authorize payment direct to the provider.

CONSENT TO EXAMINE AND TREAT: I consent to the examination, treatment and procedures, which may be performed during the visit, including emergency treatment, considered necessary by Dr. David Heichel and/or such assistants or designees as may be selected by him.

PATIENT CONSENT FOR MEDICAL PHOTOGRAPHY: I consent for medical photographs to be taken of me, my child or person for whom I am legal guardian. I understand that the photograph will be part of my medical record and will be used for identification purposes only.

NO SHOW POLICY: **Please be advised that if you fail to cancel 24 hours prior to your appointment or do not show up for your scheduled appointment, a $50 charge will be applied to your account. This fee will need to be paid in full before being seen for any future appointments. Insurance companies do not pay for this fee, so you will be billed directly for this charge.**

PATIENT / PAYMENT RESPONSIBILITY NOTIFICATION: As you know, most insurance companies have very specific regulations about billing for healthcare services. As your healthcare provider we are obligated to follow those regulations in how we report services provided to you. All physicians/providers must report services using a variety of codes. These codes tell the insurance company what was done and why. These services are a way for your physician/provider to monitor your current health status or detect early signs of disease.

It is not uncommon for patients in the course of a visit to receive both management/treatment for a problem, as well as routine or preventative services. When this occurs, both services must be reported to the insurance company. Coding for your visit is standard to all insurance providers, however, each insurance company interprets and classifies the codes (i.e. office procedure, surgery, etc.) to determine payment under your individual policy. Because there are thousands of different insurance companies and plans, each with rules and regulations specific to the plan, it is impossible for our practice to know every patient's coverage. Please be sure that you are familiar with what your insurance plan does and does not cover. This will prevent any unexpected delays in payment or denial of services. If you have any questions, please check with your insurance plan.

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UPDATE OF ELECTRONIC INFORMATION: Following is the e-mail address to be utilized in conjunction with the Patient Portal. I understand that I will receive an e-vite to register for Follow My Health where I can access my personal health information on-line in a secure location:

E-Mail Address: _____

INFORMATION RELEASE FORM: We understand that your health information is personal, and we are committed to making sure that information that identifies you is kept private and only disclosed as permitted by law. You may, however, provide us with written authorization to disclose your protected health information not covered by our Notice of Privacy Practices. I authorize the following individual(s) to receive verbally or in writing any and all of my medical information (to include clinical and billing):

Name	Relationship
_____	_____
_____	_____
_____	_____

ELECTRONIC HEALTH RECORD INFORMATION UPDATE: The following information is utilized for the monitoring of Electronic Health Record Usage. No identifying patient information is provided in these reports, it is only used to maintain reporting requirements for our practice. Thank you for updating this information for our files.

LANGUAGE: (Please Circle)	English	Other:

ETHNICITY: (Please Circle)	Hispanic	Non-Hispanic

RACE: (Please Circle)		
African American	American Indian/Alaskan Native	Asian
Caucasian	Native Hawaiian	Pacific Islander
More than One Race	Declined	

MARITAL STATUS:	(Please Circle)	
Single	Married	Divorced
Widowed	Legally Separated	Declined

EMPLOYMENT STATUS:	(Please Circle)	
Full-Time	Part-Time	Self Employed
Active Duty	Retired	Not Employed

STUDENT STATUS: (Please Circle)	Full-Time	Part-Time	Non-Student

_____ _____

Signature of Patient or Legal Guardian Date

_____ _____

Guardian Name (Printed) Witness