UPPER VALLEY ENT & ALLERGY

Upper Valley ENT & Allergy – Jay McMaster D.O. – Barry Peterson, D.O. – Dan Weber, PA-C

256 North 2nd East Rexburg, ID 83440 – ph: (208) 656-9646 – fax: (208) 656-9645 – www.uventallergy.com

PATIENT NAME:_____ DATE OF BIRTH ____/____/____

Last First Middle Initial Month/Day/Year

FEMALE ☐ MALE ☐ MARITAL STATUS: M ☐ S ☐ W ☐ D ☐

PERMANENT MAILING ADDRESS:

_____ CITY:_____ STATE:_____ZIP:_____

STREET ADDRESS (IF DIFFERENT THAN MAILING ADDRESS):

_____ CITY:_____ STATE:_____ZIP:_____

PRIMARY PHONE:_____ SECONDARY PHONE:_____

EMPLOYER:_____ OCCUPATION:_____

EMAIL ADDRESS:_____

PHARMACY:_____

RACE:

☐ NATIVE INDIAN
☐ ASIAN
☐ BLACK/AFRICAN AMERICAN
☐ HISPANIC
☐ NATIVE HAWAIIN/OTHER PACIFIC
☐ OTHER _____
☐ WHITE
☐ REFUSE TO ANSWER

ETHNICITY:

☐ HISPANIC/LATINO
☐ NOT HISPANIC/LATINO
☐ REFUSE TO ANSWER

STUDENT STATUS:

☐ FULL TIME
☐ PART TIME
☐ NOT A STUDENT

PREFERRED LANGUAGE:

☐ ENGLISH
☐ OTHER _____
☐ SPANISH
☐ REFUSE TO ANSWER

TRANSLATOR NEEDED?
YES ☐ NO ☐

RESPONSIBLE PARTY ("SELF" IF PATIENT IS OVER THE AGE OF 18):

NAME:_____ RELATIONSHIP:_____BIRTHDATE: _____

ADDRESS:_____ PHONE NUMBER:_____

Is this person authorized to receive medical information on your behalf? YES ☐ NO ☐

RELEASE OF PROTECTED HEALTH INFORMATION / FINANCIAL INFORMATION

I authorize Upper Valley ENT & Allergy to **disclose my protected health information and/or financial information** to the following person (if different from Responsible Party):

NAME:_____ RELATIONSHIP:_____

HOME PHONE:_____ WORK PHONE:_____ CELL:_____

PRIMARY INSURANCE:_____ POLICY NUMBER:_____

GROUP NUMBER:_____ **POLICY HOLDER DOB:**_____

POLICY HOLDER NAME:_____ **POLICY HOLDER PHONE:**_____

SECONDARY INSURANCE:_____ POLICY NUMBER:_____

GROUP NUMBER:_____ POLICY HOLDER DOB:_____

POLICY HOLDER NAME:_____ **POLICY HOLDER PHONE**:_____

PRIMARY CARE PHYSICIAN:_____ OFFICE PHONE:_____

CITY:_____ STATE:_____ZIP:_____

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HOW DID YOU FIND US?

- ☐ Friend/Family
- ☐ Physician Referral
- ☐ Commercial
- ☐ Phonebook
- ☐ Ad
- ☐ Sign on Street
- ☐ Internet
- ☐ Other _____

I certify that any and all information in any form is truthful and correct to the best of my knowledge. If I learn that any such information that has been submitted was not correct, I agree to notify Upper Valley ENT & Allergy of this immediately.

Responsible Party Signature: _____ Date:_____

Print Name: _____ Relationship: _____

ACKNOWLEDGEMENT OF RECEIPT OF UPPER VALLEY ENT & ALLERGY NOTICE OF PRIVACY PRACTICES

By signing this document, I acknowledge that I have had the opportunity to review the privacy policy and may receive my own copy at my request.

_____	_____	_____
Signature	Relationship to Patient	Date

Please note:

In addition to your office visit, you may receive a bill for the following services:

CT Scan
Lab work
Pathology
Procedures
Scopes (nasal and/or oral)

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FINANCIAL INFORMATION

APPOINTMENTS – As a courtesy to our office as well as to those patients who are waiting to see our providers, if you are 10 minutes late you will be asked to reschedule your appointment.

NO SHOW- We schedule our appointments so that each patient receives the right amount of time to be seen by our providers. If you fail to show for an appointment (without providing 24-hour notice) we will allow you to reschedule. If you "no show" a 2nd time, a $25.00 fee will be added to your account and will be expected to be paid prior to rescheduling. After your 3rd "no-show", our practice may decide to terminate its relationship with you.

REFERRALS – If your plan requires a referral from your primary care physician, it is YOUR responsibility to obtain it prior to your appointment and have it with you at the time of your visit. If you do not have your referral, **YOUR VISIT MAY NOT BE COVERED AND YOU WILL BE PERSONALLY RESPONSIBLE FOR THE SERVICE**.

PRIVATE INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS/INFORMATION RELEASE: I, the undersigned, authorize payment of medical benefits to Upper Valley ENT & Allergy PLLC for any services furnished. I understand that I am financially responsible for any amount not covered by my contract. I also authorize any holder of medical information about me to release to my insurance company (or their agent) information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

MEDICARE LIFETIME SIGNATURE ON FILE: I, the undersigned request that payment of authorized Medicare benefits be made on my behalf to Upper Valley ENT & Allergy PLLC for any services furnished to me. I authorize any holder of medical information about me to release to the CMS (and its agents) any information to determine these benefits payable for related services. This information will be used for the purpose of evaluating and administering claims of benefits. I am responsible for my deductible and 20% coinsurance as Medicare assigns.

MEDICAID – Upper Valley ENT & Allergy is a Medicaid Provider. Any charges not covered by Medicaid may be the patient's responsibility to pay. If your Healthy Connection Provider does not refer you to Upper Valley ENT & Allergy, Medicaid will NOT pay and you will become responsible for the charges associated with your services.

OUT OF NETWORK PLANS – You will be responsible for any balance your plan indicates as due on their explanation of benefits form. We will adjust the charges to coincide with your plan's UCR (Usual, Customary and Reasonable) charges. All patients will be responsible for their co-insurance and deductible. If we do not 'participate' with your plan, we will send a courtesy bill to that carrier on your behalf. However, should they not pay your claim within 60 days, you will be responsible for the full amount due. Should you receive payment from your insurance carrier, please forward it to the physician's office.

CO-PAYMENTS – Please be prepared to pay the co-pay at each visit.

SELF-PAY PATIENTS – Payment is expected at the time of service.

WE ACCEPT CASH, CHECKS, MASTERCARD, VISA, OR DISCOVER CARD. If your check is returned unpaid, your account will be debited electronically for the original amount and electronically or via paper for the state's maximum allowable service fee. Payment by check constitutes authorization of these transactions. You may revoke this authorization by calling (800) 666-5222 ext 2, to arrange payment for any outstanding checks and service fees due.

FINANCE CHARGES – If the balance due is not paid within 20 days of the billing date a finance charge of 1.5% (18% annual percentage rate) on the unpaid balance may be imposed.

COLLECTIONS – You are responsible for the timely payment of your account. Should it become necessary for us to use an outside agency to collect payment from you, you will be additionally responsible for whatever charges we incur as a result of this.

DIVORCED/SEPERATED PARENTS OF MINOR PATIENTS – The parent who consents to the treatment of a minor child is responsible for payment of services rendered; Upper Valley ENT & Allergy LLC will not be involved with separation or divorce disputes.

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

Patient's Name: _____ DOB: _____

Responsible Party Signature: _____ Date: _____

Print Name: _____ Relationship: _____

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PATIENT RIGHTS AND RESPONSIBILITIES

Patients have the right to:

1) Considerate, respectful and dignified care provided in a safe environment, free from all forms of abuse, neglect, harassment and/or exploitation.
2) Personal and informal privacy and privacy of his/her health information as required by HIPPA.
3) Information concerning your diagnosis, treatment and prognosis, to the degree known in a language or manner you understand, or to an individual designated by you or to a legally authorize individual as part of the informed consent process.
4) Appropriate assessment and management of pain.
5) The opportunity to participate in decisions involving your health care, unless contraindicated by concerns for your health.
6) Impartial access to treatment regardless of race, color, sex, national origin, religion, handicap or disability.
7) Be advised and refuse to participate in any research without risk of compromising your right to access care, treatment and/or services.
8) Know the identity and professional status of individual providing service.
9) Request a change in providers of care if other qualified providers are available and at his/her own expense obtain a second opinion.
10) Express complaints about the care they received and to submit their grievance by contacting Taylor Thompson at 656-9646.

Patients are responsible for:

1) Providing accurate complete information regarding your present health status (including past & present medications), past medical history, and for reporting any unexpected changes to the appropriate practitioner(s).
2) Following the treatment plan recommended by the primary practitioner.
3) Following the rules and regulations of the facility affecting patient care and conduct.
4) In the case of a pediatric patient, a parent or guardian is to remain in the facility for the duration of the patient's stay in the facility.
5) Being considerate and respectful of the rights of other patients and facility personnel.
6) Providing a responsible adult to transport you home after surgery and an adult to be responsible for you at home for the first 24 hours after surgery/anesthesia.
7) Indicating whether you clearly understand a contemplated course of action and what is expected of you.
8) Your actions if you refuse treatment leave the facility against the advice of the practitioner and/or do not follow the practitioner's instructions relating to care.
9) Assuring financial obligations of your health care are fulfilled as expediently as possible.
10) Providing information about any living will, medical power of attorney or other directive that could affect his/her care.

Initials: ____