OCALA EAR, NOSE & THROAT SPECIALISTS

Main Office (Cala Hills) — **2120 SW 22nd Place, Ocala, FL 34471**

Dr. Scott Nadenik — **Dr. Stephen Reynolds**

Dr. T. Scott Keidel — **Jose Mercado, PA-C**

North Office (Cala Hills) — *2102 SW 20th Place, Blg 600, Ocala, FL 34471*

Dr. Christopher Schmidt — *Dr. Charles Grayson*

Dr. Jose Jiron, Jr. — *Dr. Thomas Thomason*

Megan Werbel, PA-C

REGISTRATION INFORMATION

PATIENT NAME: ____
First Middle Last

MAILING ADDRESS: ____
Street City/State/Zip

HOME PHONE: ___________________ CELL PHONE: ___________________ May we leave messages on both? Yes ☐ No ☐

EMPLOYER: ____

WORK PHONE: ______________________ WORK EXT:____________ May we contact you at work? Yes ☐ No ☐

SOCIAL SECURITY #: ______________________ DATE OF BIRTH: _____/_____/________ PATIENT SEX: Male ☐ Female ☐

EMAIL ADDRESS: ____

Preferred Method for Reminders (*MUST* select 1 Option): Web Message via Patient Portal ☐ Phone ☐ Postal Mail ☐

RESPONSIBLE PARTY NAME (if other than Patient): ____

MAILING ADDRESS: ____

HOME PHONE: ___________________ CELL PHONE: ___________________ May we leave messages on both? Yes ☐ No ☐

EMPLOYER: ____

WORK PHONE: ______________________ WORK EXT:____________ May we contact you at work? Yes ☐ No ☐

SOCIAL SECURITY #: ______________________ DATE OF BIRTH: _____/_____/________ SEX: Male ☐ Female ☐

EMAIL ADDRESS: ____

PRIMARY INSURANCE COMPANY: ____

POLICY NUMBER: ____ EFFECTIVE DATE: __________________

NAME OF INSURED (if other than Patient): _________________________________ RELATIONSHIP: Spouse/Parent/ Other

INSURED'S DATE OF BIRTH: _____/_____/________ INSURED'S SEX: Male ☐ Female ☐

INSURED'S HOME PHONE:______________________ INSURED'S WORK PHONE: :_________________ WORK EXT:_______

SECONDARY INSURANCE COMPANY: ____

POLICY NUMBER: ____ EFFECTIVE DATE: __________________

NAME OF INSURED (if other than Patient): _________________________________ RELATIONSHIP: Spouse/Parent/ Other

INSURED'S DATE OF BIRTH: _____/_____/________ INSURED'S SEX: Male ☐ Female ☐

INSURED'S HOME PHONE:______________________ INSURED'S WORK PHONE: :_________________ WORK EXT:_______

EMERGENCY CONTACT: Whom may we contact in case of emergency or if we are unable to reach you?

Name: ____ Relationship: __________________

Home Phone: ____________________________ Cell Phone: ____________________________

RELEASE OF INFORMATION: Whom are we permitted to discuss your private health information with?

Name: ____ Relationship: __________________

Home Phone: ____________________________ Cell Phone: ____________________________

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FINANCIAL AGREEMENT, AUTHORIZATION FOR TREATMENT, AND RELEASE OF INFORMATION

I, ____, AUTHORIZE treatment for ______________________________ and AGREE to
(Printed Name) (Print Patient Name)
pay all fees and charges for such treatment. I AGREE to pay for all charges (including those that exceed benefits or are not covered by insurance) for me and members of my family shown by statements, promptly upon presentment thereof, unless credit arrangements are agreed upon in writing. Charges shown by statements are agreed to be correct and reasonable unless protested in writing within thirty (30) days of billing. In the event legal action should become necessary to collect an unpaid balance due for medical services to me or my family, if the account is referred to an attorney or collection agency, I will pay reasonable attorney's fees and collection expenses. I hereby agree to pay any and all charges that exceed or that are not covered by insurance.

I AGREE that payments will not be delayed or withheld because of any insurance coverage or the pendency of claims thereon, and all proceeds of insurance are assigned to this office where applicable, but without their assuming responsibility for the collection thereof. A copy of this assignment is as valid as the original.

I have read and understand to the terms set forth in the Financial Policy and that a copy is provided upon request.

I hereby authorize Ocala Ear, Nose and Throat Specialists to release information necessary to process claims. I hereby authorize Ocala Ear, Nose and Throat Specialists to release and/or obtain information/medical records to any Hospital or Physician I may be referred to by this office.

SIGNATURE: ____ DATE: _________________

Relationship to Patient: ____

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REMINDER TO ALL PATIENTS

- Payment is expected at time of service. Copays & Deductibles are collected upon arrival for your appointment. If payment cannot be made at time of arrival, your appointment will be rescheduled. If you do not have insurance you will be expected to pay a deposit prior to being seen by our physicians.

- It is a federal mandate that all patients, new and established, must present their insurance cards & photo identification at each visit. Failure to do so will result in rescheduling of your appointment.

- We do our best to run on time out of respect for our patient's schedules. Please respect our schedule and call at least 24 hours before your appointment to cancel, if needed. We have eliminated our No-Show Fees, and we only ask for common courtesy – please give us time to fill your spot with another patient in need of an appointment in the event that you are unable to make it.

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Receipt of Notice of Privacy Practices
Written Acknowledgement Form

I am aware of the Health Information Portability and Accountability Act (HIPAA) and that a copy of our Notice of Privacy Practices is available upon request.

Patient Name: ____
(Please Print Name)

Patient Signature: ____ Date: ____________________

Parent/Guardian/Beneficiary Signature: ______________________________________ Date: _____________

If not signed by the patient, please indicate relationship:

- ☐ Parent or guardian of minor patient
- ☐ Guardian or conservator of an incompetent patient
- ☐ Beneficiary or personal representative of deceased patient

EAR, NOSE & THROAT SPECIALISTS (OCALA)

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		Megan Werbel, PA-C	

Assignment of Benefits

Patient Name: ____

Employer: ____

Insurance Company Name: ____

Social Security # / Policy ID #: ____

I hereby instruct and direct the above named insurance company to pay by check made out and mailed to:

Medical Management of Ocala/Ocala Ear, Nose & Throat
2120 SW 22nd Place
Ocala, FL 34471

OR

If my current policy prohibits direct payment to my doctor, I hereby instruct and direct the above named insurance company to make the check payable to me and mail it as follows:

____
(Policyholder/Patient's Name)
c/o Medical Management of Ocala/Ocala Ear, Nose & Throat
2120 SW 22nd Place
Ocala, FL 34471

For the professional or medical expense benefit allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. This is a direct assignment of my rights and benefits under this policy. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, and/or attorney involved in this case.

I authorize my doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Dated this ______ day of _____________________________, 20______.

____ ____________________________________

Signature of Policyholder Witness Signature

Here at Ocala Ear, Nose & Throat we are trying to get a better sense of the overall diversity of our patient population so that we have a better understanding of our practice and our patient needs.

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Many patient conditions can be inherited and or prevalent based on race and ethnicity. Preferred Language helps us to better communicate with each patient. In addition, this information assists in our ability to comply with initiatives prescribed by the Centers for Medicare and Medicaid and other insurance carriers.

This **confidential** information is for quality monitoring purposes only and will not affect the quality of care you receive at our office.

Patient's Name: ____-

Please select your Preferred Language from the options below. *****Please note: Preferred Language is required.***

☐ **AmericanSignLanguage**	☐ Greek	☐ Persian
☐ Arabic	☐ Gujarati	☐ Polish
☐ Armenian	☐ Hebrew	☐ Portuguese
☐ BrazilianPortuguese	☐ Hindi	☐ Russian
☐ Chinese	☐ Hmong	☐ Slovak
☐ Chinese(Cantonese)	☐ Hungarian	☐ Somali
☐ Chinese(Mandarin)	☐ Indian	☐ **Spanish**
☐ Croatian	☐ Indonesian	☐ Swahili
☐ Czech	☐ Italian	☐ Swedish
☐ Danish	☐ Japanese	☐ Tagalog
☐ Dutch	☐ Khmer	☐ Thai
☐ **English**	☐ Korean	☐ Tigrinya
☐ Farsi	☐ Lao	☐ Turkish
☐ Filipino	☐ Maori	☐ Ukrainian
☐ Finnish	☐ Mien	☐ Urdu
☐ French	☐ Navajo	☐ Vietnamese
☐ FrenchCanadian	☐ Norwegian	☐ Visayan
☐ FrenchCreole	☐ Oromo	☐ Yiddish
☐ German	☐ **Other**	☐

Please place a check mark to the left of whichever option applies. If you choose not to answer please place a check on the "Unreported/Refuse to Report" option.

Race: ☐ Asian ☐ American Indian or Alaska Native ☐ African American ☐ Native Hawaiian
☐ Other Pacific Islander ☐ White ☐ More than One Race ☐ Unreported/Refuse to Report

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unreported/Refuse to Report

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Medical History Questionnaire

Name:____ Age:________ Sex: ☐M ☐F

Reason for Visiting the Doctor(briefly):

____

____

____

____

____

PREFERRED PHARMACY: Please provide the name and either address, phone, or store number**.**

Name: ____ Store # __________________

Address: ____

Phone#: _________________________________

ALLERGIES:

Do you have allergies? Yes ☐ No ☐

If yes, please specify below

Drugs:____

Foods:____

Other:(dust, tape, etc..)____

FAMILY HISTORY- Who in your family has had:

Lung Disease_______________________________ _Family Deafness_______________________________

Stroke (CVA) _______________________________ _Heart Disease_______________________________

Diabetes_______________________________ Thyroid Problems_______________________________

Cancer____

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MEDICAL HISTORY- (past or present) include (circle all that apply)

Glaucoma	Heart Attack
Alcohol Abuse	Hiatal Hernia
Anemia	High Blood Pressure
Arthritis	Urinary Tract Infection
Asthma	Nasal Polyps
Chronic Ear Infections	Pneumnonia
Chronic Sinusitis	Vertigo
Colon Polyps	Rosacea
Ulcers	Coagulopathy (Bleeding)
Congestive Heart Failure	Sickle Cell Disease
COPD	Seizure Disorder
Coronary Artery Disease	Sudden Hearing Loss
CVA (Stroke)	Thrombophlebitis
Depression	Benign Tumor Thyroid
Diabetes Mellitus, Type I	Hyperthyroidism
Diabetes Mellitus, Type II	Hypothyroidism
Drug Dependence	Thyroid Nodule
Hearing Loss	TIA

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Have you suffered any of the following cancer? (Circle all that apply)

Breast	Ovarian	Prostate
Brain	Rectal	Skin
Throat	Mouth	Nose
Cervix	Stomach	Thyroid
Colon	Lung	Parathyroid

Other:____

What Surgery have you had? (Circle all that apply)

Appendectomy	Hysterectomy	Reduction Nasal Fracture
Joint Replacement	Inguinal Hernia	Colon Resection
Cataract	Laminectomy	Stomach Resection
Cesarean Section	Lumpectomy	Tubes tied
Gall Bladder	Mastectomy	Ovaries removed
Coronary Bypass	Prostate	Spleenectomy
Coronary Stents	Pacemaker	Tonsillectomy
Umbilical Hernia	Thyroid	Hiatal Hernia Repair

Other:____

Circle any injuries you have sustained:

Nasal Fracture	Facial Bone Fracture
Head Injury	Joint Injury
Neck Injury	Fracture of Arm or Leg

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Circle any of the following procedures you have had:

Allergy Testing Cardiovascular Stress Test

Bone Density Sleep Study

Bronchoscopy Cardiac Catheterization

Echo Cardiogram Endoscopy, GI

Hospitalizations: dates/reason:____

____

SOCIAL HISTORY

Recreational Drug Use: Yes ☐ No ☐

Alcohol Use: Yes ☐ No ☐

Quantity/Frequency:______________________

Smoking Use: Yes ☐ No ☐

How much/How long:_____________________

Ever smoked: Yes ☐ No ☐

Tobacco/smoke exposure: Yes ☐ No ☐

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MEDICATIONS

Please list all your current medications, including over the counter as well as prescriptions.

Medication	Dosage	Frequency

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Financial Policy

Thank you for choosing Ocala Ear, Nose & Throat Specialists as your health care provider. We are committed to providing excellent health care services to our patients. As part of our professional relationship it is important that you read and understand your responsibilities.

ALL PATIENTS MUST READ THIS PRIOR TO RECEIVING SERVICES

Self-Pay (No Insurance Coverage)

If you do not have insurance, payment in full is expected at the time of service unless you have made prior payment arrangements with our billing department. A deposit will be taken at the time of arrival for each appointment.

Insurance

As physicians, our relationship is with you, NOT your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are strictly your responsibility from the dates that services are rendered. We do our best to handle the process completely on our end, however, it is occasionally necessary for you to inquire about and explore your benefits with your insurance carrier.

If we participate with your insurance company, you will be expected to pay any contracted copays, coinsurances, and/or deductibles at the time of service. It is your responsibility to ensure your insurance information is current at the time of service. We will require a copy of your insurance card(s) before services are performed.
Payment for treatment is your responsibility whether your insurance pays or not. If your insurance company has not paid your account in full within 45 days, the balance will be billed directly to you. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical insurances.

If a procedure is done at the time of your office visit the procedure is ***not*** included in the Office Visit. You are responsible for payment of the separate copay/co-insurance/deductible at the time of service.

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any nonparticipating insurance company's determination of usual and customary rates.

Referrals

If your insurance company requires you to have a referral from your primary care physician in order to be treated by our physicians, please verify that this process has taken place. You are responsible for obtaining the referral and if one is not in place, you may not be seen until one is received.

Pre-Certification

Pre-certification (prior approval) may be required by your health plan before certain procedures, tests, or surgeries are performed. We will assist you in the pre-certification process by contacting your insurance company on your behalf. Be sure to confirm that you have been given pre-certification before your procedure. Pre-certification is not a guarantee of payment by the insurance company and you are ultimately responsible for all treatment.

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Minor Patients

The adult accompanying a minor and the parents (or guardians of the minor) are responsible for payment. It is not our policy to treat unaccompanied minors.

Student and Other Dependent Patients

Any patient over the age of 18 is considered an adult and will be listed as the Responsible Party for all services and will be governed by this Financial Policy.

Patient Billing

It is your responsibility to provide us with your most current billing information which includes current address, all available telephone numbers and other important contact information. Statements will be sent notifying you of any balances you may owe. If you have any questions or dispute the validity of the balance on the statement you must contact our billing department within 30 days of receipt of the initial statement. Patient balances not paid in full within 30-days of the statement date are deemed past due. Past due accounts may be subject to collection activity.

If you are unable to pay the balance in full, you must contact our billing office to discuss a payment schedule. If you fail to make payments as agreed your account may be referred to a professional collection agency.

Missed Appointments and Late Cancellations

Our office requires 24 hour notice if you are unable to keep an appointment. We have eliminated our No-Show Fees, and we only ask for common courtesy – please give us time to fill your spot with another patient in need of an appointment in the event that you are unable to make it.

Return Checks

Any account that has a check returned for Non-Sufficient Funds will be charged $25 per event. The Returned Check Fee(s) must be paid prior to the next appointment. In addition, we may seek all additional legal remedies provided to us under Florida law in order to recover the amount of the check. You will be responsible for all collection costs incurred, including attorney's fees and court costs.

Collection of Past Due Accounts

Accounts that are 90 days past due are subject to collection action. Any legal activity would cause a breach in the physician/patient relationship, which may result in discharge from the practice.

If your account is assigned to a professional collection agency, you will be notified by certified mail that you are no longer able to receive services from our physicians.

All accounts assigned to a professional collection agency are responsible for all collection costs incurred, including attorney's fees and court costs, if applicable.

Our practice firmly believes that a good physician/patient relationship is based upon understanding and good communication. Please contact our office if you have any questions. We are here to help you.