



The Center for ENT

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Adult & Pediatric Ear, Nose & Throat • Head and Neck Surgery • Audiology & Hearing Aids Services

To our valued patients,

For the past 30 years, The Center for ENT has been one of the premier otolaryngology (ear, nose and throat) practices in the Texas Medical Center. Taking care to treat each patient with focused attention and compassion, we provide state-of-the-art medical services. Merging classic techniques with the latest innovations in ENT research, we deliver the most effective treatment possible to our patients.

We are excited that you have chosen us to be your ear, nose and throat doctors. We have been and always will be available for your medical needs. Our appointments are created to allow patients to be seen by one of our doctors within 24-hours if necessary. Our hope is that you will enjoy your visit and recommend us to your friends and family in the future.

From the staff and Drs. Weber, Moses, Hung, Powitzky and Cordes.

PATIENT REGISTRATION FORM

PLEASE PRINT

TODAY'S DATE _____

IF REFERRED BY A DOCTOR GIVE NAME & PHONE # _____

■ **PATIENT'S NAME** _____
Last First M.I.

HOME ADDRESS _____

CITY, STATE, ZIP _____ AGE _____ GENDER MALE FEMALE

BIRTH DATE _____ MARITAL STATUS _____

HOME PHONE # _____ SOCIAL SEC. # _____

CELL PHONE # _____ DRIVERS LIC. # _____

■ **EMPLOYER NAME** _____ WORK ADDRESS _____

CITY, STATE, ZIP _____ WORK PHONE # _____

■ **SPOUSE'S NAME** _____ SOC. SEC. _____ BIRTH DATE _____

EMPLOYER NAME _____ WORK ADDRESS _____

CITY, STATE, ZIP _____ WORK PHONE # _____

EMERGENCY CONTACT NAME & PHONE # _____

YOUR PHARMACY NAME & PHONE # _____

IF THE PATIENT IS A MINOR PLEASE COMPLETE PARENTAL INFORMATION ON FOLLOWING PAGE:

PRIVACY PRACTICES

- **CONTACTS:** Please list other persons that we may inform about your health information.
- _____
- _____
- **PHONE NUMBERS:** Which phone numbers would you like to receive calls about appointment, financial or medical condition information? **[check all that apply]**
- Home Phone Cell phone Work Phone Other Phone: _____
- **VOICE MAIL:** May appointment, financial or medical information be left on your answering machine or voice mail?
- Yes No
- **EMAIL:** When responding to an Email, may we include appointment, financial or medical condition information?
- Yes No

Patient/Legal Guardian Signature: _____

IF THE PATIENT IS A MINOR PLEASE COMPLETE THE FOLLOWING INFORMATION:

The parent accompanying a child of a divorced family will be responsible for payment of charges incurred for that date of service regardless of insurance or divorce decree status.

FATHER'S NAME _____ BIRTH DATE _____

SOCIAL SEC # _____ DRIVERS LIC # _____

ADDRESS _____

CITY, ST, ZIP _____ HOME PHONE # _____

EMPLOYER _____

ADDRESS _____

CITY, ST, ZIP _____ WORK PHONE # _____

MOTHER'S NAME _____ BIRTH DATE _____

SOCIAL SEC # _____ DRIVERS LIC # _____

ADDRESS _____

CITY, ST, ZIP _____ HOME PHONE # _____

EMPLOYER _____

ADDRESS _____

CITY, ST, ZIP _____ WORK PHONE # _____

Patient Medical History

Please provide the following confidential information regarding your medical history. Thank you.

Name: _____ Age: _____

Reason for appointment: _____

■ Who is your **referring physician**? _____

■ **Current medications?** No Yes; please list: _____

■ Are you pregnant? No Yes; how many months? _____

■ **Medical History.** Which medical conditions apply to you? Please provide a brief explanation.

	NO	YES	Explanation
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	
Bleeding / Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>	
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	
Heart Disease / Murmur	<input type="checkbox"/>	<input type="checkbox"/>	
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	
Kidney / Urinary	<input type="checkbox"/>	<input type="checkbox"/>	
Liver problems / Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	
Nervous Disorders	<input type="checkbox"/>	<input type="checkbox"/>	
Seizures or Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	
Stomach problems	<input type="checkbox"/>	<input type="checkbox"/>	
Thyroid Disorders	<input type="checkbox"/>	<input type="checkbox"/>	
Other	<input type="checkbox"/>	<input type="checkbox"/>	

■ **Allergies** to medicine? No Yes; please list: _____

■ **Previous surgeries?** No Yes; please list: _____

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Sam C. Weber, MD, FACS
Richard T. Hung, MD, FACS

Ron L. Moses, MD, FACS
Eric S. Powitzky, M.D.

FINANCIAL POLICY

WELCOME!

We are committed to providing you with quality medical care and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. **Please ask if you have any questions about our fees, financial policy or your responsibility.**

ANY CHANGES IN INSURANCE COVERAGE, ADDRESS, AND TELEPHONE OR OTHER DEMOGRAPHICS MUST BE GIVEN TO THE RECEPTIONIST WHEN YOU SIGN IN FOR YOUR APPOINTMENT.

TO ASSIST US IN ESTABLISHING YOUR ACCOUNT PLEASE PROVIDE THE FOLLOWING:

- 1.) Current insurance information on your registration form.
- 2.) Please present your insurance card so that a copy can be made for your chart.
- 3.) A separately **signed consent disclosure** for authorization for the release of information necessary for filing your insurance claim(s), faxing orders, releasing medical information to other physicians and/or for insurance pre-certifications.
- 4.) All **co-pays** designated by your PPO or HMO will be **PAID UPON CHECK-IN.**

INSURANCE

Insurance is a contract between you and your insurance company. We are not a party to your contract though we may have a contractual fee schedule agreement with the insurance company. We will not become involved in disputes with your insurance company regarding deductibles, non-covered/covered expenses, co-insurance or "reasonable and customary" charges other than to supply factual information as necessary. **You are responsible for timely payment of your account and office visit claim follow-up with your insurance company.** Because this is a surgical practice there can be large co-insurance and/or surgery deposit amounts due at your pre-operative appointment. Payment plans are available but arrangements must be made in advance with our Practice Manager or Patient Account Manager. We accept checks, cash and credit cards (Visa, MasterCard, Discover and American Express).

Medicare: We are participating providers with Medicare. We will also file with your secondary or supplementary policy. Our office **does not file third** insurance policies. Please make sure that you provide our receptionist with your Medicare and supplementary cards.

Indemnity/Fee for Service: As a courtesy to our patients we will file with your insurance provided you have met your annual deductible and pay your coinsurance at the time of service. *If you have not met your yearly deductible you must pay at the time of service and a claim will be filed with your insurance, upon request.*

Contracted Managed Health Care: (HMO's, PPO's, EPO's) **It is your responsibility to make sure that OUR Physician(s) is currently enrolled with your plan. All necessary referrals must have been obtained prior to each visit.** If your referral has not been completed prior to your arrival in the office it may mean a delay in being seen by the physician and the possible rescheduling of your appointment. You are obligated by your insurance company to pay the copay at the time of your visit. **We may not bill patients for their copay.**

Worker's Compensation: We DO NOT ACCEPT Worker's Compensation patients as of 7-1-02.

Medicaid: We do accept Medicaid patients. We are providers for the following Medicaid HMO's – TDH network and Star Plus. We also accept traditional Medicaid. **If you are on a Medicaid HMO plan, you are responsible for obtaining the referral from your primary care physician prior to your office visit.** Patients must bring their current Medicaid card at every office visit. Failure to do so will result in rescheduling your appointment.

SURGERY

Insurance will be verified including deductible and co-insurance prior to your pre-operative surgical visit. **A DEPOSIT WILL BE REQUIRED** if insurance benefits are assigned to the doctor due to individual policy deductibles and percentage of coverage. Payment in full is required in advance if insurance benefits are not assigned or in the event there is no insurance. Any overpayment by the insurance will be promptly refunded to the patient (or parents). **PLEASE PROVIDE YOUR INSURANCE FORMS ON THE DAY OF YOUR PRE-OP APPOINTMENT.** Other financial arrangements may be discussed with our Insurance Department or Patient Account Manager.

Due to frequent rescheduling and/or cancellations of surgeries by our patients in the past, it has become necessary to apply an administrative charge for surgery changes. **A PATIENT WHO RESCHEDULES OR CANCELS SURGERY FOR ANY REASON OTHER THAN A MEDICAL CONDITION OR A DEATH IN THE IMMEDIATE FAMILY WILL BE CHARGED \$50.00 WHICH WILL NOT BE APPLIED TOWARD SURGICAL FEES AND IS NON REFUNDABLE.**

Our staff is very knowledgeable in referral authorization, pre-certifications and pre-authorization procedures for all insurance plans. At times, you may be required to obtain additional information from your insurance plan regarding specific out-patient services.

Being knowledgeable about your insurance policy and referrals is to your benefit and proper claim(s) payment.

Hearing aid services: If you have insurance benefits for hearing aids our office will provide you with the necessary forms to file with your insurance plan.

Minors/Unaccompanied Minors:

The parent accompanying a child of a divorced family will be responsible for payment of charges incurred for that date of service regardless of insurance or divorce decree status. Unaccompanied minors must have authorization for medical treatment signed by his/her parent or legal guardian and is responsible for providing current insurance information and any necessary payment at the time of service.

Returned Check Fee: There will be a \$25.00 charge on all returned checks.

I have read and understand the above terms and conditions and will verify so by giving my signature.

Patient's signature

Date

Witness's signature

Date

INSURANCE VERIFICATION

INSURANCE IS NOT FILED AS A ROUTINE OFFICE VISIT UNLESS WE PARTICIPATE WITH YOUR INSURANCE PLAN.

DO YOU HAVE PRIVATE INSURANCE? YES NO

IF YES, PLEASE GIVE YOUR INSURANCE CARD TO RECEPTIONIST.

Please note: The parent accompanying a child of a divorced family will be responsible for payment of charges incurred for that date of service regardless of insurance or divorce decree status.

PLEASE COMPLETE THIS SECTION IF SOMEONE OTHER THAN THE PATIENT IS RESPONSIBLE FOR THE PAYMENT OF SERVICES

NAME OF RESPONSIBLE PARTY	RELATIONSHIP	PHONE #
ADDRESS: STREET	CITY	STATE ZIP
EMPLOYER	ADDRESS	PHONE #

MEDICARE?

DO YOU HAVE MEDICARE AND SUPPLEMENT INSURANCE? YES NO

DO YOU HAVE A MEDICARE SUPPLEMENT OF 2ND INSURANCE? YES NO

IF YES, PLEASE GIVE MEDICARE AND SUPPLEMENT CARDS TO RECEPTIONIST.

ACCIDENT CASE? YES NO

If Yes, date of the accident: _____

Where did the accident occur? _____

How did the accident occur? _____

I UNDERSTAND AND AGREE THAT (REGARDLESS OF MY INSURANCE STATUS) I AM ULTIMATELY RESPONSIBLE FOR THE BALANCE OF MY ACCOUNT FOR ANY PROFESSIONAL SERVICES RENDERED. I AUTHORIZE PAYMENT OF INSURANCE BENEFITS TO BE PAID DIRECTLY TO THE PHYSICIAN. I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY CLAIMS. I HAVE READ AND CERTIFY THAT ALL THE ABOVE INFORMATION IS TRUE, COMPLETE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I WILL NOTIFY THE OFFICE STAFF OF ANY CHANGES IN MY HEALTH STATUS OR THE ABOVE INFORMATION.

SIGNATURE OF PATIENT OF RESPONSIBLE PARTY

**CONSENT OF PRIVACY PRACTICES FOR
PURPOSES OF PROTECTED HEALTH INFORMATION
FOR TREATMENT, PAYMENT, AND/OR HEALTHCARE OPERATIONS**

I, _____, consent to the use or disclosure of my Protected Health Information by The Center for ENT, for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations by The Center for ENT. I understand that diagnosis or treatment of me by my Center for ENT Physician may be conditional upon my consent as evidenced by my signature on this document. The release of Protected Health Information with regard to my medical treatment may be sent by fax, telephone, mail or email to other physicians, healthcare facilities or insurance companies.

I understand I have the right to request a restriction as to how my Protected Health Information is used or disclosed to carry out treatment, payment or healthcare operations of this practice. My treating physician at The Center for ENT is not required to agree to the restrictions that I, the patient, may request if the restriction falls within the exceptions to confidentiality by law. However, if The Center of ENT agrees to a restriction that I request, the restriction is binding on The Center for ENT and my treating physician.

I have the right to revoke this consent, in writing, at any time, except to the extent that The Center for ENT or its physicians has taken action in reliance on this consent.

My "Protected Health Information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health insurance plan, my employer or a health care clearinghouse. This relates to my past, present or future physical or mental health or condition that may identify me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review and request a copy of The Center for ENT's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my Protected Health Information that will occur in my treatment, payment of my bills or in the performance of health care operations of The Center for ENT. The Notice of Privacy Practices for The Center for ENT is posted in the waiting room area (laminated copies) and on The Center for ENT's website at www.CenterForENT.com. This Notice of Privacy Practices also describes my rights and the Center for ENT's duties with respect to my Protected Health Information.

- A. You have the right to request and be provided with a description of the procedures for exercising, the following with respect to your Protected Health Information:
- (i) Inspecting and copying;
 - (ii) Amending or correcting; and
 - (iii) An accounting of the disclosures of such information by The Center for ENT.

THE CENTER FOR ENT may change its policies and procedures relating to Protected Health Information at anytime. Should the Protected Health Information policies change, a revised Notice will be available at The Center for ENT's office and posted on The Center for ENT's website at www.CenterForENT.com. If you believe that there has been a violation of your Privacy Rights, a complaint may be filed with THE CENTER FOR ENT, by contacting Cheryl Y. Kennedy, Practice Manager, address; 6624 Fannin, Suite 1480, Houston, TX 77030, or at (713) 795-5343 or Eric S. Powitzky, M. D., Privacy Officer. Further, a complaint may be filed with the U.S. Department of Health and Human Services.

I have read and received a copy of the Notice of Privacy Practices.

I have read and refuse to accept a copy of the Notice of Privacy Practices.

Signed this _____ day of _____, 20____.

Signature

Printed Name

Special Restrictions:

This revised healthcare privacy rights policy is effective April 14, 2003.