HNSA

PATIENT REGISTRATION

HEAD+NECK SURGICAL ASSOCIATES

PATIENT INFORMATION

Name _____ (Last / First / M.I.) Social Security No. _____

Home Address _____ (Street / City / State / Zip)

Mailing Address (if different) _____ Email: _____

Date of Birth _____ Sex M F Marital Status M S D W O Home Phone (____) _____ Cell Phone (____) _____

Pharmacy's Name _____ Phone (____) _____

Referring Doctor _____ Phone (____) _____

General Dentist _____ Phone (____) _____

Primary Care Doctor _____ Phone (____) _____

Orthodontist _____ Phone (____) _____

PERSON RESPONSIBLE FOR PAYMENT/ PARENT IF MINOR

Name _____ (Last / First / M.I.) Relationship to patient _____ Soc. Sec. No. _____

Date of Birth _____ Address (if different) _____ (Street / City / State / Zip)

Home Phone (____) _____ Employer _____ Phone (____) _____

EMERGENCY CONTACT (OTHER THAN PATIENT)

Name _____ (Last / First / M.I.) Relationship _____ Phone No. (____) _____

Address _____ (Street / City / State / Zip) Work Phone. (____) _____

MEDICAL INSURANCE (NEED COPY OF CARD)

Primary Insurance _____ Group No. _____ ID No. _____

Subscriber's Name _____ Relationship to patient _____ Employer _____

Subscriber's SS# _____ D.O.B. _____

Secondary Insurance _____ Group No. _____ ID No. _____

Subscriber's Name _____ Relationship to patient _____ Employer _____

Subscriber's SS# _____ D.O.B. _____

DENTAL INSURANCE (NEED COPY OF CARD)

Dental Insurance _____ Group No. _____ ID No. _____

Subscriber's Name _____ Relationship to patient _____ Insured's Date of Birth: _____

Subscriber's SS# _____ D.O.B. _____

INJURY INFORMATION

WORKER'S COMPENSATION / MVA / INJURY:

Case Worker / Attorney Name: _____ Phone: (____) _____

Company / Law Firm Name: _____ Claim No. _____

Date of Injury: _____ Auto Accident: Yes or No

On The Job Injury: Yes or No If yes, Employer Name _____

I hereby authorize my physician to release any medical information necessary to process claims with any insurance companies. I also assign my physician all payments to which I am entitled for medical and surgical expenses related to the services reported herewith. I understand that I am financially responsible for all charges whether covered by insurance or not. I also understand that balances outstanding for more than 90 days will be subject to a processing fee.

❑ I authorize HNSA to communicate with me via email. The information translated could include financial information, diagnosis, treatment, and/or appointment scheduling.

X _____ SIGNATURE	❑ UPDATE	RELATIONSHIP TO PATIENT	DATE
X _____ SIGNATURE	❑ UPDATE	RELATIONSHIP TO PATIENT	DATE
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Medical History:

Past Surgical History:

Medication List:

Allergies/ Reaction:

HNSA
www.head-neck.com

HEAD+NECK
SURGICAL ASSOCIATES
1849 N.W. Kearney, Suite 300
Portland, Oregon 97209-1412
Tel: 503-224-1371
Fax: 503-224-0722

CREDIT POLICY

Patient Responsibility:

Our practice is committed to providing the best treatment for our patients. Patients are responsible for all charges resulting from treatment provided by their physician. As a service to you, we will bill most insurance carriers directly. However, primary responsibility for the account is yours. **Please confirm your insurance benefits and coverage with your insurance company.** While we do this for you as a courtesy, there have been (rare) occasions we were misquoted by your insurance company during the verification process. Providing correct insurance billing information is the responsibility of the patient. If your insurance changes, please present your insurance card at your next visit. All patients must complete our patient registration form before seeing the doctor.

- Minors: The undersigned will agree to be responsible for payment of balances for services rendered to minors.

Payment Arrangements:

*__New and Established Patients:__ The portion that insurance will not pay is due at the time of visit. Insurance companies ***do not guarantee payment.*** If there is a balance due after insurance pays, payment is due within 30 days of the first billing.
Accounts with balances over 90 days will be assessed a processing fee each month.
HMO/PPO co-payments and deductibles, if required by your plan, are due at the time of each visit.
*We accept Visa, Mastercard, Discover Card, checks, cash and money orders.

Referrals:

Many insurance carriers require referrals from your Primary Care Physician before you receive care from a specialist, it is your responsibility to obtain a referral or prior authorization if your medical coverage requires either.

- A phone will be provided for your call. Please get the name of the person who authorizes your visit.
- Authorizations can be difficult to obtain, especially after hours. Please be aware that if you choose to be seen before you have received valid authorization, your insurance will probably not reimburse you for today's visit. For this reason, we must ask that you either wait to discuss the situation with your PCP or pay in full.
- If the referral cannot be authorized, you will be required to sign a waiver form.

Insurance Billings:

Please be aware that some or perhaps all of the services you receive may be non-covered services and not considered reasonable and necessary under your insurance plan. In this instance, you will be responsible for payment.

Medicare: Our physicians are participating providers. Although we bill Medicare as your primary insurer, you are responsible for billing your supplemental insurance. **Note:** Medicare may be able to bill your supplemental insurance, please contact them at 800-444-4606.

Oregon/Washington Welfare and Oregon Health Plan: Please bring your current medical card with you to each appointment. If you are restricted to a primary care physician by Oregon's Medical Assistance Program or Washington's Department of Social and Health Services, you must obtain a referral from your primary care physician prior to your appointment with your specialist.

Workers' Compensation: In order to file a Workers' Compensation claim, you will need the name of your insurance carrier, the date of your injury, your case worker's name and phone number and your claim number, if available. Be sure to notify the registration desk at each appointment if your visit is due to an injury covered by Workers' Compensation.

Motor Vehicle or Other Liability Claims: Your physician is willing to bill insurance carriers in liability claims. While we understand that settlement of these claims can take many months, full payment for the visit(s) or financial arrangements must be made. We ask that you work with our Business Office to make suitable payment arrangement. We would appreciate your supplying our office with a copy of your private health insurance card.

Check Returned: It is our clinic's policy to charge all patients a $25.00 fee for checks that are returned unpaid by the bank.

Refunds:

A refund will not be issued:

- If your account shows a current balance.
- If the insurance company is requesting monies returned or there is a discrepancy in their payment to us.
- If there is a question as to the status/eligibility of your insurance coverage.
- If you have made a deposit and are still seeking treatment.
- Until our office receives payment from your insurance. Please note that the patient receives notification 2-3 weeks before we receive payment.

I have read and received a copy of this Credit Policy for my physician. I accept this policy for my treament with my physician.

_____
Print your name

_____ _____
Patient signature or guardian if patient is a minor. (Relationship to patient if Guardian) Date

HEAD AND NECK SURGICAL ASSOCIATES

PRIVACY NOTICE ACKNOWLEDGEMENT

To Our Patients:

Federal law requires that we provide you with a copy of our Privacy Notice. One is available for you upon request.

The Privacy Notice explains how we may use and disclose health information about you. We ask that you sign this form for our records so that we may document your receipt of the Notice.

If you have questions about the Privacy Notice, please feel free to direct these to our Privacy Officer at any time. The name and contact number of the Privacy Officer is listed on your copy of the Privacy Notice.

Patient Name:_____ Date of Birth:_____

Patient to complete this section

I have been offered a copy of the Privacy Notice for this organization on today's date.

Signed:_____ Date:_____

If patient is unable to acknowledge receipt, staff member providing notice to complete this section

The Privacy Notice was provided to

Patient Name:_____ On _____

The patient was unable to acknowledge receipt of the Privacy Notice for the following reason:

_____

_____

_____

Signed: _____

File this form in the patient's chart

Permission for Verbal Communications

Head and Neck Surgical Associates

(Print name of patient) (Date Of Birth)

(Street address) (City, state, zip code)

(Phone number)

I permit Head and Neck Surgical Associates, their physicians, nurses, and other personnel to discuss health information, in person or by telephone, with the following family members or friends involved in my medical care: (List family members/friends and state the person's relationship to the patient).

(Name)	**(Phone Number)**	**(Relationship)**
1.		
2.		
3.		
4.		
5.		

Release of information under this document is limited to verbal discussions with my Health Care Providers. This document does not permit release of any **written** health information to the individuals named above. This authorization is limited to the following time frame from _____ (date) to _____ (date). If no dates are indicated, this form will remain in effect for an unlimited amount of time.
If, at any time, I do not want verbal discussions to be permitted between my Health Care Providers and any of the individuals named above, I must notify my Health Care Provider by contacting the Medical Records Department at 503-553-3650

Patient's Signature: _____ Date: _____

If a representative on behalf of the patient signs this release, complete the following:

Representative's Name: _____

Relationship to Patient: _____

Head and Neck Surgical Associates
1849 NW Kearney Suite 300
Portland, Oregon 97209
P. 503-553-3650
F. 503-224-9081