



PATIENT REGISTRATION

Please PRINT clearly and legibly in ink

Date: _____

Please present insurance card & photo ID

Patient Last Name: _____ First Name: _____ MI: _____

Gender: male female Date of Birth: ____ / ____ / ____ Social Security #: _____

Address: _____ City: _____ State: ____ Zip: _____

Phones: Home (____) _____ Work (____) _____ Cell (____) _____

Email: _____ Contact Preference (circle one): Home / Work / Cell / Email

Preferred Language: _____ Race: _____ Ethnicity: _____

Marital Status: Married Single Divorce Widow

Who referred you to our practice?	Doctor (name) _____
Insurance Plan _____	Friend/Family (name) _____
Internet (website name) _____	Yellow Pages _____
Advertisement (paper) _____	Other (please specify) _____

(If patient is Minor) **Guardian** Last Name: _____ First Name: _____ MI: _____

Emergency Contact Name: _____ Relation to patient: _____

Emergency Contact Phone: (____) _____ Emergency Contact Cell: (____) _____

Employer Name: _____ Occupation _____

Responsible Party Information: _____ Patient's relationship to the Guarantor: _____

Guarantor Last Name: _____ First Name: _____ MI: _____

Date of Birth: ____ / ____ / ____ Is guarantor's address the same at the patient? Yes / No

Address: _____ City: _____ State: ____ Zip: _____

Guarantor Social Security #: _____ - _____ - _____ Guarantor Phone: (____) _____

Email: _____ Guarantor Employer Name: _____

Primary Insurance: _____

ID # _____ Group # _____ Phone #: _____

Policy Holder Last Name: _____ First Name: _____ MI: _____

Is policy holder's address the same at the patient? Yes / No

Address: _____ City: _____ State: ____ Zip: _____

Social Security #: _____ - _____ - _____ Date of Birth: ____ / ____ / ____ Gender: male female



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Referring Doctor: _____ Primary Care Physician: _____

Secondary Insurance: _____

ID # _____ Group # _____ Phone #: _____

Policy Holder Last Name: _____ First Name: _____ MI: _____

Is policy holder's address the same at the patient? Yes / No

Address: _____ City: _____ State: _____ Zip: _____

Social Security #: _____ - _____ - _____ Date of Birth: ____ / ____ / ____ Gender: male female

Preferred Pharmacy: _____ Pharmacy Location: _____
(shopping plaza or cross streets if address not known)

Consent to Treat

I hereby give my consent to all physicians and healthcare providers of Scotch Institute of Ear Nose & Throat, a division of Select Physicians Alliance, PL to provide medical treatment as deemed necessary.

Release of Information

I hereby authorize Scotch Institute of Ear Nose & Throat physicians and staff to obtain all necessary medical records from other doctor's offices, hospitals, clinics, surgery centers and laboratories. I hereby give my consent to use my individual identifiable information as needed in the course of routine healthcare operations. I hereby authorize Scotch Institute of Ear Nose & Throat to release any and all information necessary to secure reimbursement from any insurance company to which I have subscribed.

Assignment of Benefits

I hereby consent to allow a photocopy of my signature to be valid as the original, in order to process my current and any future Insurance / Medicare claims. I hereby assign Insurance / Medicare benefits to be paid directly to Select Physicians Alliance, PL.

Financial Responsibility

I understand that I am financially responsible for all charges incurred during the course of treatment, whether or not paid by any insurance. I am aware that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. I understand it is my responsibility to pay any **deductible amount, co-insurance**, or any other balance not paid for by my insurance or third payer within a reasonable period of time not to exceed 60 days.

I understand that insurance companies sometimes deny claims because of lack of information on the patient's part and will not pay these claims until the patient gives this information to them. If my insurance company has denied the claim because I have not given the **information that they need** to pay the claim, Scotch Institute of Ear Nose & Throat may transfer the balance to my responsibility.

I understand that if I am required to obtain a **prior authorization** for care and do not obtain that authorization, Scotch Institute of Ear Nose & Throat may transfer the balance to my responsibility.

I agree and understand that if payment is more than 60 days late, without having made any payments or payment arrangements, my account may be sent to **collections**, and Scotch Institute of Ear Nose & Throat may be entitled to interest, collection, and/or attorney fees as allowed by Florida law.

Print Patient Name: _____ Date: _____

Responsible Party Signature: _____



PATIENT REGISTRATION

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Notice of Privacy Practices Acknowledgement

Patient Name: _____ DOB: _____

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payors.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read, and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice from time to time and I may contact this organization at any time to obtain a current copy of the Notice.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

You may contact me by mail at home. You may contact me or leave a voice message at home and at any other numbers I provide on the registration sheet.

However, **do NOT leave a message** at the following telephone numbers: _____

However, **do NOT call** the following telephone numbers: _____

You **may** discuss any portion of my medical record with the following people:

(name) _____	(relationship) _____	Expiration Date*: ___/___/___
(name) _____	(relationship) _____	Expiration Date*: ___/___/___
(name) _____	(relationship) _____	Expiration Date*: ___/___/___

*if no date indicated, default expiration date of 12/31/2025 will be used

Signature: _____ **Relationship to Patient** _____

(If patient under 18 years old, must be signed by a parent or guardian.)

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement Form but was unable to do so as documented below:

Date:	Initials:	Reason:
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