

**This form must be completed (front and back) prior to your arrival and mailed to our office in the envelope provided or faxed to 213-3895.**

### PATIENT INFORMATION

What Physician requested this consultation: \_\_\_\_\_ Office Phone \_\_\_\_\_  
Patient's Primary Care Physician: \_\_\_\_\_ Office Phone \_\_\_\_\_  
Patient's Full Name \_\_\_\_\_  
Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age \_\_\_\_\_ Sex:  Male  Female **Social Security #** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Patient's Home Address \_\_\_\_\_ Apt. # \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Home Phone ( \_\_\_\_\_ ) \_\_\_\_\_ Work Phone ( \_\_\_\_\_ ) \_\_\_\_\_ Cell Phone ( \_\_\_\_\_ ) \_\_\_\_\_  
Home Email \_\_\_\_\_ Patient's Employer \_\_\_\_\_  
Spouse's Full Name \_\_\_\_\_ Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Spouse's Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Spouse's Work Phone ( \_\_\_\_\_ ) \_\_\_\_\_  
Spouse's Employer \_\_\_\_\_

### RESPONSIBLE PARTY

If you are providing the information above for a patient under the age of 18 yrs. old, please complete the section below:

Father/Guardian's Name \_\_\_\_\_ **SSN** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
DOB \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Phone ( \_\_\_\_\_ ) \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Address (if different from above) \_\_\_\_\_  
Employer \_\_\_\_\_ Work Phone ( \_\_\_\_\_ ) \_\_\_\_\_  
Mother/Guardian's Name \_\_\_\_\_ **SSN** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
DOB \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Phone ( \_\_\_\_\_ ) \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Address (if different from above) \_\_\_\_\_  
Employer \_\_\_\_\_ Work Phone ( \_\_\_\_\_ ) \_\_\_\_\_

### INSURANCE INFORMATION

Insurance Company \_\_\_\_\_ Policy Holder ID# \_\_\_\_\_ Group# \_\_\_\_\_  
Policy Holder Name \_\_\_\_\_ **DOB** \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Address \_\_\_\_\_ Phone ( \_\_\_\_\_ ) \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Co-Pay Amt. \$ \_\_\_\_\_ Deductible Amt. \$ \_\_\_\_\_  
Secondary Insurance Company \_\_\_\_\_ Policy Holder ID# \_\_\_\_\_ Group# \_\_\_\_\_  
Policy Holder Name \_\_\_\_\_ **DOB** \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Address \_\_\_\_\_ Phone ( \_\_\_\_\_ ) \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Co-Pay Amt. \$ \_\_\_\_\_ Deductible Amt. \$ \_\_\_\_\_

**Is today's visit pertaining to a motor vehicle accident or a workman's comp injury?**  Yes  No

**If you answer yes, please fill out the following information:**

Insurance Company Name \_\_\_\_\_  
Agent Name/Contact Name \_\_\_\_\_ Phone ( \_\_\_\_\_ ) \_\_\_\_\_  
Claims/Billing Address \_\_\_\_\_  
Claim # \_\_\_\_\_ Date of Accident or Injury? \_\_\_\_\_

### OTHER INFORMATION

Name of Nearest Relative NOT LIVING with the Patient \_\_\_\_\_  
Relation to Patient \_\_\_\_\_ Home Phone ( \_\_\_\_\_ ) \_\_\_\_\_  
Relative's Address \_\_\_\_\_ Apt. # \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Relative's Employer \_\_\_\_\_ Work Phone ( \_\_\_\_\_ ) \_\_\_\_\_

**PATIENT ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY, NO SHOW & COLLECTION FEES**

If our physician recommends you schedule a specialized diagnostic test with our in-house Audio, Allergy or CT Department please note we require 24 hour notice of cancellation. These specialized diagnostic tests take forty-five minutes to two hours to perform. If we schedule you for an Auditory Brainstem Response (ABR), Electronystagmography (ENG) and/or Electrocochleography (ECoG); Intra-dermal Skin Test (IDT) or a CAT Scan to be performed in our office - you must give 24 hour notice of cancellation. **Failure to call and cancel an ABR, ENG, ECoG, IDT or CAT Scan will result in a \$50 no show fee.** Please call our office to cancel if for any reason you cannot make your appointment for one of these specialized diagnostic tests.

I understand that if I have not secured appropriate authorizations and otherwise complied with the terms of my health benefit plan, there may be a decrease in my coverage or no coverage at all for some or all of the services which I am about to receive, and that I will be financially responsible for the services not covered.

If we have to refer your account to a collection agency, you agree to pay the past due amount in addition to all collection costs (30% of the balance turned over). If we have to refer collection of the balance to a lawyer, you agree to pay all lawyers' fees incurred plus all court costs. In case of suit, you agree the venue shall be in Jefferson County. (Louisville, KY.)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Patient or Personal Representative

\_\_\_\_\_  
Relationship to Patient

**CONSENT FOR USE OR DISCLOSURE OF PATIENT INFORMATION FOR THE PURPOSES OF TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS**

I hereby consent to Commonwealth ENT using or disclosing my protected health information for the purpose of providing treatment to me, obtaining payment for health care services rendered to me or to carry out the Practice's health care operations. I also consent to Commonwealth ENT using or disclosing my protected health information for treatment activities provided by another health care provider, as well as the payment activities conducted by another health care provider or entity. I further consent to the disclosure of my protected health information in order for another provider or health care entity to conduct health care operations including quality assessment and reviewing the competence of health care professionals.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Patient or Personal Representative

\_\_\_\_\_  
Relationship to Patient

**NOTICE OF PRIVACY PRACTICES (HIPAA)**

I acknowledge the Practice has provided me a copy of its Notice of Privacy Practices, which provides a detailed description of the uses and disclosures allowed by this consent, as well as other rights I have regarding my protected health information.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Patient or Personal Representative

\_\_\_\_\_  
Relationship to Patient

**SPECIFIC INFORMATION RELEASE (if applicable)**

I specifically authorize release of the following information for the purposes of treatment, payment and health care operations. If it is a part of my protected health information: (INITIAL ANY OR ALL YOU AGREE TO AUTHORIZE FOR RELEASE)

\_\_\_\_\_ Chemical Dependency/Substance Abuse

\_\_\_\_\_ Sexually Transmitted Diseases

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Patient or Personal Representative

\_\_\_\_\_  
Relationship to Patient