EXCELENT

Allergy and Hearing Solutions

Please review and update the information below to the best of your ability.

Patient Registration

CURRENT PATIENT INFORMATION - PLEASE PRINT

Last Name:
First Name:
Middle Name:
Address:
City: State:
Zip:
Home Phone:
Work Phone:
Mobile Phone:
Sex:
Date of Birth:
Social Security No.:
Patient email:
Required by government mandate [although you may refuse]:
Language:
Race:
Ethnicity:
Marital Status:

Guarantor Information (to whom statements are sent)

Name:
Address:

Relationship to patient: _____
Date of Birth:
Social Security No.:
Phone:

Emergency Contact Information

Name:
Relationship:
Phone:
Mobile Phone: _____

Other

Patient Referred by:
Primary Care Provider:

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests to PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

In general, the HIPPA privacy rules gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The Individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home:

Release of Information

[ ] Authorize the release of information including the diagnosis, records, examination rendered to me and claims information. This information may be released to:
[ ] Spouse: _____
[ ] Child(ren): _____
[ ] Other: _____
[ ] Information is not to be released to anyone.
This **Release of Information** will remain in effect until terminated by me in writing.

Messages to be left on the PATIENT'S preferred contact number
Please call [ ] Home [ ] Work [ ] Mobile Number: _____
If unable to reach me:
[ ] you may leave a detailed message
[ ] please leave a message asking me to return your call
[ ] other: _____
The best time to reach me is [ ] day (8:00 - 5:00) or [ ] evening (anytime after 5:00)

To the best of my knowledge the above information is complete and accurate.
Signed _____ **Date** _____

Guarantor _____ **Date:** _____

1. ASSIGNMENT OF INSURANCE BENEFITSIPROMISETO PAY:

I hereby assign and authorize payment directly to the Facility, and to any facility-based physician, all insurance benefits, sick benefits, injury benefits due because of liability of a third-party, or proceeds of a claims resulting from the ability of a third party, payable by any party, organization, et cetera, to or for the patient unless the account for this Facility, outpatient visit or series of outpatient visits is paid in full upon discharge or upon completion of the outpatient series. If eligible for Medicare, I request Medicare services and benefits. I further agree that this assignment will not be withdrawn or voided at any time until the account is paid in full. I understand that I am responsible for any charges not covered by my insurance company.

I understand that I am obligated to pay the account of the Facility in accordance with the regular rates and terms of the Facility. If I fail to make payment when due and the account becomes delinquent or is turned over to a connection agency or an attorney for collection, I agree lo pay all connection agency fees, court costs and attorney's fees. I also agree that any patient or guarantor overpayments on the above Facility visit may be applied directly to any delinquent account for which I or my guarantor is legally responsible at the time of the collection of the overpayment. I consent for the Facility to appeal on my behalf any denial for reimbursement, coverage, or payment for services or care provided to me.

2. PATIENT CONSENT FOR E-PRESCRIBING (ELECTRONIC PRESCRIBING):

I have been made aware and understand that the medical practices and offices may use an electronic prescription system which allows prescriptions and related information to be electronically sent between my providers and my pharmacy. I have been informed and understand that my providers using the electronic prescribing system will be able to see information about medications I am already taking, including those prescribed by other providers. I give my consent to my providers to see this protected health information,

I have been provided the Electronic Prescribing Notice included in the Notice of Privacy Practices.

3. NOTICE OF PRIVACY PRACTICES:

Required pursuant to Health Insurance Portability and Accountability Act of 1996 (HIPAA), I acknowledge that I have received a copy of the Facility's Notice of Privacy Practices. I hereby consent to the use and disclosure of my protected health information as described in the Notice of Privacy Practices. This will include all of my protected health information generated during hospitalization and outpatient treatment at the Facility, including but not limited to treatment for mental health, drug and alcohol abuse, communicable diseases such as HIV/AIDS, developmental disabilities, genetic testing, and other types of treatment received.

4. GENERAL CONSENT FOR TESTS, TREATMENT, AND SERVICES:

I agree and understand that all physicians (including fellows, residents, physician assistants, nurse practitioners, and interns) involved in my care in any way are responsible and liable for their own acts and omissions, and the facility/practice is not responsible or liable for the acts or omissions of the aforementioned . Services may be performed by independent contractors who are not employed by the Facility. I am aware that the practice of medicine is not an exact science and further understand that no guarantee has been or can be made as to the results of the treatments, care or examinations in the Facility.

I have been informed of the treatment procedures considered necessary for me and that the treatments/procedures will be directed by a physician and may be performed by such physician and/or one or more additional physicians, fellows, residents, interns, and employees of the Facility. I understand that one or more physicians, fellows, residents, and/or interns at the Facility may treat me or participate in my treatment. I understand that no guarantee or assurance has been made regarding (1) which physicians and/or fellows, residents, or interns will treat me or participate in my treatment and/or (2) the results that may be obtained from treatment.

5. CONSENT TO PHOTOGRAPH AT THE TIME OF REGISTRATION:

☐ Yes ☐ No I, or my authorized legal representative, hereby give consent to the medical practice to take my photograph at the time of registration. I understand this photograph will be stored in the medical practice's ambulatory medical record electronically as my photo identification.

6. EMAIL:

☐ Yes ☐ I hereby consent to provide my e-mail address, so that representatives from the Facility can e-mail information to me about health education or disease prevention and up-to-date information about the Facility, its affiliated physicians. and our services. I understand I will be able to change my preference at any time.

7. IMAGING SERVICES:

☐ Please check this box to allow the facility's Imaging Services to share your images with affiliated facilities, when requested, for continuing medical treatment.

8. CELL PHONES:

☐ Yes ☐ I hereby consent to provide my telephone number(s), including my wireless telephone number(s), so that representatives from the Facility, its successors or assigns can contact me in any manner including but not limited to by manually placing a call, by using an automatic telephone dialing system or an artificial or prerecorded voice, by texting, or by emailing, regarding any matter, including but not limited to my medical treatment, prescriptions, insurance eligibility, insurance coverage, scheduling, billing or collection matters. This consent includes any updated or additional contact information that I may provide. I understand that I will be able to change my preference at any time.

The undersigned certifies that s/he has read the foregoing, understands it, accepts its terms, has received a copy of it and is the patient or is duly authorized by the patient as their agent to execute the above.

Patient's Signature or Legal Representative		Date
Relationship to Patient	Interpreter, if Utilized	Date

Consent to Medical Treatment

FINANCIAL POLICY

Thank you for choosing the office of Dr. Scott Blumer as your health care provider. We are committed to building a successful physician-patientrelationship with you and your family. Your clear understanding of our Patient Financial Policy is important to our professional relationship.Please understand that payment for services is a part of that relationship.

Insurance Cards, co-payments and co-Insurances are expected at the time of service.

As a courtesy, charges for services will be submitted to your insurance company. You are responsible for all copays, coinsurance, deductibles, and non-covered services. We are obligated to collect your copay at the time of service per your insurance company. In the event your insurance company determines a service is non-covered or does not pay the services in full, the unpaid balance is the responsibility of the patient. If you have no insurance you will be asked to pay for the services at the time rendered. We accept VISA, MasterCard, Discover and/or American Express.

Self-pay Accounts

Self-pay accounts are patients without insurance coverage, patients covered by insurance plans in which the office does not participate, or patients without an insurance card on file with us. It is always the patient's responsibility to know if our office is participating with their plan. A self-pay discount is available for patients without medical coverage if paid at the time of service. Payment is due at the time of service for cosmetic or elective procedures.

No-Show Policy

Any established patient who fails to show or cancels/reschedules an appointment and has not contacted our office with at least 24 hours' notice will be considered a No Show and charged a $40 fee. Any new patient who fails to show for their initial visit will not be rescheduled. The fee is charged to the patient, not the insurance company, and is due at the time of the patient's next office visit. As a courtesy, when time allows, we make reminder calls for appointments.

Returned Checks

The charge for a returned check is $35 payable by cash or money order. This will be applied to your account in addition to the insufficient funds amount. You may be placed on a cash only basis following any returned check.

Minors

For services rendered to minor patients, the parent(s) or guardian (s) of the minor are responsible for payment. A signed release to treat may be required for unaccompanied minors.

Videotaping

No videotaping is permitted in the waiting room or any exam rooms.

Motor Vehicle Accident (MVA) and Third Party Billing

We do not do any third party billing. Our relationship is with you and not with the third party liability insurance (auto, homeowner, etc.) It is your responsibility to seek reimbursement from them. However, at your request, we will submit a claim to your primary health insurance carrier.

Workers' Compensation

For work related injuries or illnesses, we are **NOT** a provider of Workers Compensation.

Medical Record Copies

There will be a charge for copies of medical records in accordance to the State of Ohio (Ohio law 3701.741).

Outstanding Balance Policy

It is our office policy that all past due accounts be sent two statements. If payment is not made on the account, a single phone call will be made to try to make payment arrangements. If no resolution can be made, the account will be sent to the collection agency and possible discharge from the practice.

Terms and Conditions of Use for Patient Portal

☐ Patient Refused Access to the Portal

Patient Consent and Agreement:

- I consent to participation in the facility Patient Portal (Portal), and understand that my personal health and individually identifying information is made available to me in the Portal.
- I understand that the use of the Portal is for non-emergency purposes.
- I understand that I have the ability to provide Portal access to my Authorized Representatives (Representatives), and that those Representatives may have the ability to perform all of the functions I am able to perform, including viewing, downloading and transmitting my health and individually identifying information.
- I understand there are risks associated with web-based applications and that I am responsible for safeguarding my access information.
- I understand that my e-mail address is required to initiate Portal access, and will be used for communications related to the Portal. I agree to communicate my e-mail address changes.
- I have read and understand the Terms and Conditions of Use, and I have been provided with an opportunity to ask questions.
- I understand that my access to the Portal requires my acceptance of the Terms and Conditions of Use. If I refuse to sign at this time, I understand that I may change that decision in the future and can contact the Facility to obtain access to the Portal.
- I understand that failure to follow the Terms and Conditions of Use may result In termination of access to the Portal.

Signature of Responsible Party _____ Date _____

Relationship to patient: (circle one) Self Parent Spouse POA Guardian

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MEDICATIONS

Patient Name: Date of Birth:

Please complete this form and bring it with you to your appointment. Thank you.

MEDICATION	DOSAGE	TYPE (e.g. Pill / Patch / Injection)	FREQUENCY (How many times per day)
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
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