EAR, NOSE & THROAT ASSOCIATES OF NASSAU COUNTY, P.C.

2870 Hempstead Turnpike, Suite 203, Levittown, NY 11756 Telephone: (516) 731-6644 Fax: (516) 731-8746
165 North Village Ave, Suite 117, Rockville Centre, N.Y., 11570 Telephone: (516) 764-1055 Fax: (516) 764-1062
333 Glen Head Road, Suite 110, Old Brookville, N.Y. 11545 Telephone: (516) 671-5511 Fax: (516) 671-5210

Referred by:_____
(last, first, town, phone)

Family Physician:_____
(last, first, town, phone)

Patient:_____
(last, first, middle)

SS#:_____ **Date of Birth:**_____ **Age:**_____

Address: _____
(street, apt. #, town, state, zip)

Phone#: (___)_____ **Sex:**_____ **Marital Status:**_____

Cell Phone #: _____ **Email Address:** _____

Pharmacy: _____
(name, address, phone)

Employed by:_____
(name, address, phone)

Parent or Spouse:_____
(circle one) (name, address if different from patient)

Nearest Friend or Relative:_____
(name, phone, relationship)

Primary Insurance:_____
(name, ID #, group #, address, phone #)

Primary Insured:_____
(name, social security #, date of birth)

Secondary Insurance:_____
(name, ID #, group #, address, phone #)

Known Allergies to Medication:_____

Reason for Visit:_____

Signature on File: By signing below, I **1.** Authorize use of this form on all my insurance submissions. **2.** Authorize release of information to all my insurance companies. **3.** Authorize my health care provider to act as my agent in helping me obtain payment from my insurance company. **4.** Authorize payment directly to my healthcare provider(s)—Ear, Nose & Throat Associates of Nassau County, PC. **5.** Permit a copy of this authorization to be used in place of the original. **6.** Understand that I am responsible for my bill. **7.** Understand that if my health care providers accept assignment, I am responsible for any amount not paid by my insurance company.

Patient Name (print):_____ **Date:**_____

Patient/Guardian Signature:_____

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Please fill out either section I or II and sign below:

Section I.

A. I, _____, give Ear, Nose & Throat Associates of Nassau County, P.C., designated representative(s) as noted below:

- ☐ Answering machine(s) at the following number(s):_____
- ☐ Family member(s) or designated representative(s): **(Please print and list full name and relationship)**:_____

B. Please check **all** information that can be left on the above answering machine(s) or with the above representative(s):

- ☐ Test Results
- ☐ Lab Results
- ☐ Confirming Appointments
- ☐ Medication Changes
- ☐ Billing/Insurance Inquiries
- ☐ Any information pertaining to all aspects of my medical care, including all of the above.

Section II.

- ☐ I, _____, do not want any information pertaining to all aspects of medical care left on my answering machine or with anyone other than myself.

I understand that: **1.** I may revoke/amend this authorization at any time, provided that the revocation/amendment is in writing. **2.** Information disclosed in coordinance with this authorization may be redisclosed by the recipient and no longer protected by HIPPA privacy rules. **3.** This practice will not condition treatment on my providing the above authorization. **4.** I have the right to access my protected health information.

Signature:_____ **Date:**_____

Expiration Date:_____

Relationship to patient (if minor, or signed by personal representative):_____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received this practice's Notice of Privacy Practices, which provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. I have been provided an opportunity to review the Notice of Privacy Practices and understand that I can obtain a copy on request.

Signature_____ **Date:**_____

Relationship to patient (if minor, or signed by personal representative:_____