Circle one: Mr. Mrs. Ms. Miss

Patient First Name: _____ M.I.:_____ Last Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Primary Phone: _____ Circle one: Home Cell Phone
Secondary Phone: _____ Circle one: Home Cell Phone
Email Address: _____ @ _____
Marital Status (circle one): Married Single Widowed Ethnicity: _____
Patient Social Security No: _____
Date of Birth: MM/_____DD/_____YEAR/_____ Age: _____Sex (circle one): M F NA
Employer Name: _____ Circle one: Full-time Part-time
Employer Address: _____
Number of Employees (circle one): 0-20 21-99 100 or more
Emergency Contact: _____ Phone: __( ) _____ - _____
Primary Care Physician: _____ Phone: __( ) _____ - _____
Name of Physician or other source who referred you to our practice:
Physician: _____ Other: _____

Responsible Party (If other than patient)

First Name: _____ M.I.:_____ Last Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Primary Phone: _____ Circle one: Home Cell Phone
Date of Birth: MM/_____DD/_____YEAR/_____ Social Security No: _____
Employer Name: _____ Circle one: Full-time Part-time
Employer Address: _____
Number of Employees (circle one): 0-20 21-99 100 or more

Insurance Information

Primary Insurance Co: _____ Phone: __( ) _____ - _____
ID #: _____ Group #:_____Effective Date: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Policy Holders Name: _____
Date of Birth: MM/_____DD/_____YEAR/_____ Social Security No: _____
Employer Name: _____ Circle one: Full-time Part-time
Secondary Insurance Co: _____ Phone: __( ) _____ - _____
ID #: _____ Group #:_____Effective Date: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Policy Holders Name: _____
Date of Birth: MM/_____DD/_____YEAR/_____ Social Security No: _____

HEINDEL ENT
ADULT AND PEDIATRIC OTOLARYNGOLOGY

Request for Release of Medical Records

Patient Name: _____

Date of Birth: _____

Signature: _____

Relationshp to Patient: _____

Please print the facility or doctor name, phone number, address, and fax number from which Heindel ENT is requesting records:

Name: _____

Address: _____

Phone: _____ Fax: _____

Please send medical record request to the following (fax is the perferred delivery method for medical records):

Heindel ENT
2080 Newnan Crossing Blvd. Suite 300
Newnan, Georgia 30265

Phone: 770-955-0270 Fax: 770-955-0271

HEINDEL ENT
ADULT AND PEDIATRIC OTOLARYNGOLOGY

Visit Date: _____

Health History

Welcome to Heindel ENT. As a new patient, please provide the information listed below to the best of your abilitly.

Patient Name: _____ Date of Birth: _____

Height: _____ Weight: _____

Reasons for today's visit: _____

Preferred Pharmacy: _____

Mail Order Pharmacy Name: _____

Medications (please list):	**Allergies to Medications:**
General Medical History:	**Surgical History:**
Smoking Status (please choose one): ☐ Current everyday smoker ☐ Current someday smoker ☐ Former smoker ☐ Never smoked ☐ Unkown if ever smoked ☐ VAPE or Smokeless Tobacco **Started smoking:** mm/dd/yyyy _____ **Quit smoking:** mm/dd/yyyy _____ **Number of packs per day:** _____ **Total years smoking:** _____	**Influenza:** **Have you had your flu shot this year?** ☐ Yes ☐ No **If no, why?** _____ **Covid History:** **Have you ever had the Covid vaccine and boosters?** **(if you are 65 years or over)** ☐ Yes ☐ No **If no, why?** _____

HEINDEL ENT
ADULT AND PEDIATRIC OTOLARYNGOLOGY

Financial Responsibility

A deductible is a specified portion of your bill that a patient must pay before an insurance company will pay his/her claim. While, generally, a co-payment is required for an office visit, some services and all procedures performed in the office will require the patient to meet the deductible before any benefits will be paid. If your deductible has not been met, you will be responsible for full or partial payment, depending on your insurance contract. Procedures performed in the office are considered the same as surgery by insurance companies and are billed as such.

Additionally, your office visit today, and/or in the future, may include the use of a scope for diagnostic purposes. This is considered a diagnostic procedure, which will likely be coded to your insurance company as a **SURGICAL PROCEDURE**. Depending on your particular policy, your insurance company will pay all, part, or none of the cost of this procedure. It is your responsibility to be aware of the terms and conditions of your policy prior to the procedure being performed. Any charges not covered by the insurance carrier will be the responsibility of the patient.

YOU HAVE THE RIGHT TO REFUSE THIS DIAGNOSTIC PROCEDURE.

By signing this consent form, you are acknowledging these terms.

INSURANCE INFORMATION: I acknowledge that the physician(s) of Heindel ENT may not be a part of the provider network for my insurance plan. I understand that it is my responsibility to verify this information with my insurance company.

In order to keep our charges as low as possible, we expect payment for services, deductible, co-insurance and co-pay at the time of service unless arrangements have been made in advance with the business manager. I will pay my portion of the services today by one of the following: Cash, Check, or Credit Card.

I hereby authorize the physician(s) of Heindel ENT to furnish the necessary information concerning my illness and treatment to my insurance company, and I hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. I understand I am responsible for any amount not covered by my insurance. My signature will also serve as authorization to treat my child if the patient is a minor.

Date: _____ Signature: _____ Relationship _____

HEINDEL ENT
ADULT AND PEDIATRIC OTOLARYNGOLOGY

Appointment Cancellation Policy

As a courtesy, we agree to confirm your visit one week before your scheduled appointment. You will at that time have the opportunity to confirm or cancel the scheduled appointment. If you have scheduled your appointment within 24 hours, you will not receive a confirmation call. The result of patients not cancelling their scheduled appointment is that the physician is then unable to accommodate those patients with sudden medical problems that require medical intervention.

Please call us at (770)-955-0270, Extension 1, by 2:00 p.m. on the day prior to your scheduled appointment to notify the office staff of any changes or cancellations.

To cancel a Monday appointment, please call our office by 2:00 p.m. on Friday.

If prior notification is not given, you will be charged a fee of $90 for the missed appointment.

I hereby acknowledge that I am aware and accept the financial responsibilty for fees assessed to my account for failing to provide the required cancellation notice of any scheduled appointments at Heindel ENT. I understand that this fee is not reimbursable by my insurance provider.

_____ _____

Signature of Patient or Authorized Person **Date**

HEINDEL ENT
ADULT AND PEDIATRIC OTOLARYNGOLOGY

Health Insurance Portability & Accountability Act (HIPAA)

In general, the HIPAA privacy rule gives individuals the right to request a restriction of their health information. The individual is also provided the right to request confidential communications or that a communication of PHI (Protected Health Information) be made by alternative means, such as, sending information to the individual's office instead of home.

It is Heindel ENT's policy not to release confidential and/or unauthorized information by home telephone, answering machine, work telephone, voicemail and/or cell phone. However, we will confirm appointments by telephone.

1. Do we have permission to leave a message on the phone number(s) you have provided to us?
   Yes ☐ No ☐

2. May we discuss your medical information with family & friends?
   Yes ☐ No ☐

Please list names of people with whom we can discuss your medical care:

Name:_____ Phone:_____
Patient's relationship to contact: Spouse ☐ Parent ☐ Child ☐ Friend ☐

Name:_____ Phone:_____
Patient's relationship to contact: Spouse ☐ Parent ☐ Child ☐ Friend ☐

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have read or had the opportunity to read this document. I understand the Notice of Privacy Practices.

Patient Signature: _____

Date: _____

Patient Printed Name:_____

Parent or Authorized Representative (if applicable):_____