Hoover
Ear, Nose and Throat
Associates, P.C.
2116 Data Park
Hoover, AL 35244
205-733-9595
205-733-9599 Fax

Hoover Hearing Clinic
A division of
Hoover ENT Associates, P.C.
2116 Data Park
Hoover, Alabama 35244
205-733-9694 Tel
205-733-9599 Fax

ACCOUNT #	DATE	MD	NEW	UPDATE

PATIENT INFORMATION

Patient's Full Name _____ DOB _____ Age_____

Patient's SSN _____ Sex: Male____ Female____ Preferred Language_____

Place of Birth: City _____ State _____ Country _____

Marital Status: Single____ Married____ Widowed ____ Divorced ____ Separated ____ / Student: Yes / No

Race: Cauc ____ Afr American ____ Asian ____ Other ____ Ethnicity: Hispanic ____ Non-Hispanic _____

Address _____ City/State _____ Zip _____

Home Phone _____ Mobile _____ Email _____

Employer _____ Occupation _____ Work Phone _____

Spouse _____ Spouse DOB_____ Spouse Phone _____

Spouse's Employer _____ Work Phone _____

In the case of emergency, contact: Name _____

Relationship: _____ Phone _____

If Patient is a MINOR, please complete the following:

Responsible Party Name _____ Relationship _____

Address _____ City/State _____ Zip _____

Mother's Name _____ Employer _____

Mother's DOB _____ SSN _____ Work Phone _____

Father's Name _____ Employer _____

Father's DOB _____ SSN _____ Work Phone _____

INSURANCE INFORMATION (If name on card is different from responsible party, DOB is required*)**

Primary Insurance _____ Contract # _____ Group # _____

Name of Insured _____ ***DOB** _____

Secondary Insurance _____ Contract # _____ Group # _____

Name of Insured _____ ***DOB** _____

NOTE: Adult bringing child for treatment is responsible for payment of account. If 18 or older, you are responsible for incurred charges. If patient is a student, parent/responsible party signature is required.

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Authorization to Disclose Protected Health Information

The HIPAA privacy rule gives individuals the right to request a restriction of uses and disclosures of their protected health information (PHI).

I wish to be contacted in the following manner (Please check all that apply and provide the phone number(s) or email below):

Home#_____ Work#_____

Cell#_____ Email_____

Okay to leave message with detailed information ☐Home ☐Work ☐Cell ☐Email

Leave message with call back number only ☐Home ☐Work ☐Cell ☐Email

I prefer to be contacted regarding appointment reminders in the following manner:

Home#☐ Cell#☐ Email☐ Text Message☐

My protected health information may be released to the following individuals:

Name:_____ Relationship:_____ Phone:_____

Name:_____ Relationship:_____ Phone:_____

Name:_____ Relationship:_____ Phone:_____

Name:_____ Relationship:_____ Phone:_____

I, the undersigned, understand that I have the right to change the above information at any time by completing another form.

_____ _____
Patient or Parent's/Guardian's Signature Date

_____ _____
Print name Birth Date

PATIENT CONSENT

CONSENT FOR TREATMENT, RELEASE OF MEDICAL INFORMATION, AND FINANCIAL RESPONSIBILITY

I, the undersigned, am being treated at Hoover ENT Associates and/or Hoover Hearing Clinic. I consent to all medical and surgical care, examinations and tests determined by my provider that are necessary for me. Though I expect the care given will meet customary standards, I understand there are no guarantees concerning the results of my care. I also understand that if I do not follow my physician's recommendations as they may relate to my health, the physician and this office will not be responsible for any injuries or damages that may result from my non-compliance. I further understand that this is a medical office and there is no guarantee that I will not be exposed to a bacterial or viral agent, such as SARS-COV2, the novel coronavirus which causes COVID-19.

CONSENT TO USE OF INFORMATION

I hereby authorize release of any medical records to the referring physicians, my insurance carriers, and those involved in the payment of the patient's account. I understand that this office may collaborate with other health care providers to coordinate, manage and provide health care to me and I consent to the sharing of my health information and records for the purposes of treatment, including improving the overall quality of health care services provided to me (e.g., avoiding unnecessary or duplicate testing, etc).

ASSIGNMENT OF BENEFITS / FINANCIAL RESPONSIBILITY

I hereby assign to and authorize payment of all insurance and health care benefits available to me directly to the provider's office for services provided to me. I further acknowledge full financial responsibility for any services rendered and understand that payment of charges incurred in the office are due at the time of service. I also understand that charges not covered by insurance remain my responsibility. Non-covered services may include those services determined to be medically necessary by my provider but are later determined unnecessary by the payer. In the event an account is more than 90 days past due, I agree to pay all costs of collection including collection fees, attorney's fees and hereby waive all rights of exemption under the Constitution of the State of Alabama.

PRESCRIPTION REFILLS, MESSAGES, AND AFTER-HOUR CALLS

I understand that prescriptions from other physicians will not be refilled by this office. If I have not seen the physician within one year, no refills will be given. Unless there is a true emergency, no messages will be answered after 3:30 p.m. If I have a true medical emergency, I understand that I am to dial the emergency 911 operator. No calls for Hoover Hearing Clinic will be answered or messages returned after 4:30 pm. Hoover Hearing Clinic does not have after-hours call availability.

To provide accurate and excellent medical care, I understand that the physician's office utilizes software that can obtain some information regarding past medications I have been prescribed or taken. I understand this information is obtained from the pharmacies I have used and a prescription clearing house service used by the pharmacies. This information will be used in facilitating my medical care and will be considered protected health information just like all the other health information I provide. I agree to allow the physician's office to obtain this information electronically.

FEES FOR MISSED APPOINTMENTS

I understand there will be a $25 fee if I do not show for a scheduled appointment or if I do not cancel my appointment at least 24 hours prior to the scheduled appointment time. There will be a $25 fee for rescheduling surgery from the original surgery date.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I received a copy of the Physician Office's Notice of Privacy Practices or know where I can view a copy of the notice. A copy of the notice can be found on the office website (*www.hooverent.com*).

_____ _____

Printed Name of Patient *Date of Birth*

_____ _____

Patient or Legal Representative Signature *Date of Signature*