

# PRESCOTT EAR, NOSE, THROAT, AND ALLERGY P.L.L.C

DISEASES AND SURGERY OF THE EAR, NOSE & THROAT  
HEAD AND NECK SURGERY • ALLERGY

MARK D. STRASSER, M.D. • DEREK K. HEWITT, M.D.  
DAVID A. HOLMES, AU.D.

TODAY'S DATE \_\_\_\_\_ NAME \_\_\_\_\_ Home Phone \_\_\_\_\_

Email \_\_\_\_\_ Cell Phone \_\_\_\_\_

Social Security # \_\_\_\_\_ Sex \_\_\_\_ Marital Status \_\_\_\_\_ Birthday \_\_\_\_\_ Age \_\_\_\_\_

Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Employed  Retired

Employer \_\_\_\_\_ Phone \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Pharmacy \_\_\_\_\_

**Immediate** relatives treated by Dr. Mark Strasser or Dr. Derek Hewitt \_\_\_\_\_

Who to contact in case of emergency: Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

## **IF PATIENT IS A CHILD:**

Mother's Name \_\_\_\_\_ SS# \_\_\_\_\_ Work Phone \_\_\_\_\_

Father's Name \_\_\_\_\_ SS# \_\_\_\_\_ Work Phone \_\_\_\_\_

Legal Guardian \_\_\_\_\_ SS# \_\_\_\_\_ Work Phone \_\_\_\_\_

**INSURANCE INFORMATION: FOR PROPER INSURANCE REIMBURSEMENT THIS SECTION MUST BE COMPLETED. IF THIS SECTION IS LEFT BLANK YOU MUST BE NON-INSURED & PAYMENT IN FULL IS DUE AT THE TIME OF SERVICE.**

### **Primary Insurance**

### **Secondary Insurance**

Company \_\_\_\_\_

Company \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Insured Name \_\_\_\_\_

Insured's Name \_\_\_\_\_

Insured's Birthday \_\_\_\_\_ SS# \_\_\_\_\_

Insured's Birthday \_\_\_\_\_ SS# \_\_\_\_\_

Insured's Employer \_\_\_\_\_

Insured's Employer \_\_\_\_\_

Relationship of Patient to Insured \_\_\_\_\_

Relationship of Patient to Insured \_\_\_\_\_

If you have a Tertiary (third) Insurance Company, please provide the information here: \_\_\_\_\_

## **AUTHORIZATION/RESPONSIBILITY AGREEMENT:**

I understand that the filing of my primary insurance is a courtesy provided by this office and does not relieve me of my financial obligation or the responsibility to pay for services rendered. In the event that the doctors are not contracted with my insurance, including all Medicare replacement carriers, I further acknowledge and agree that it is my responsibility to pay for services rendered.

Signed: \_\_\_\_\_

Date: \_\_\_\_\_

## HIPAA COMPLIANCE PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The complete Notice is available upon request to provide you with detailed information about how we may use and disclose protected health information about you. You have a right to review our Notice before signing this consent. Your signature acknowledges that our notice is available to you and you are aware of our privacy practices.

The terms of the notice may change; if so, you will be notified at your next visit to update your signature.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or our operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or our operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or our operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The patient has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we call or send an email to you to confirm your appointment? YES                      NO

May we leave a message on your answering machine at home or on your cell phone? YES                      NO

May we discuss your medical condition with any member of your family? YES                      NO

If YES, please name the members allowed:

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This consent was signed by : \_\_\_\_\_  
(PRINT NAME PLEASE)

Signature: \_\_\_\_\_ Date: \_\_\_\_\_