Prescott ENT & Allergy

EAR, NOSE & THROAT · HEAD & NECK SURGERY · ALLERGY · AUDIOLOGY

Mark D. Strasser, M.D. • Derek K. Hewitt, M.D. • David A. Holmes, Au.D.

PATIENT REGISTRATION

Today's Date: _____ Name: _____

Home Phone: _____ Email: _____ Cellphone: _____

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

Company: _____

Policy#: _____ Group#: _____

Insured's Name: _____

Insured's Birthday: _____ SS#: _____

Insured's Employer: _____

Relationship of Patient to Insured: _____

Secondary Insurance

Company: _____

Policy#: _____ Group#: _____

Insured's Name: _____

Insured's Birthday: _____ SS#: _____

Insured's Employer: _____

Relationship of Patient to Insured: _____

If you have a tertiary (third) insurance company, please provide the information here: _____

AUTHORIZATION/RESPONSIBILTY 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: _____

1125 IRON SPRINGS ROAD, PRESCOTT, ARIZONA 86305
TELEPHONE (928) 778-9190 • FAX (928) 714-7862

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 cellphone? ☐ Yes ☐ No

May we discuss your medical condition with any member of your family? ☐ Yes ☐ No

If **YES**, please name the members allowed: _____

This consent was signed by: _____

(PRINT NAME PLEASE)

Signature: _____ Date: _____