Ear, Nose, & Throat care for your family
Georgetown ENT
a professional association

Scott W. Franklin, M.D.
3201 South Austin Avenue, Suite 370
Georgetown, Texas 78626-7537
Ph: 512.869.0604
Fax: 512.868.5936
www.Georgetown-ENT.com

Thank you for choosing Scott W. Franklin, MD and the GENT Group (Georgetown ENT, Georgetown Better Hearing Center and Georgetown Allergy and Sinus) for your ENT care. Please bring the following items to your appointment:

1. Your completed patient packet, which is attached.
2. Insurance card(s)
3. Valid government issued photo ID
4. Complete medications list

If you have completed all of your paperwork, please arrive 15 minutes PRIOR to your appointment time. There is additional paperwork that must be completed in the office.

If you have not completed all of your paperwork, please arrive 30 minutes PRIOR to your appointment; this will ensure that you have enough time to complete all the required forms before your appointment time.

We will contact your insurance company to get an outline of your benefits; this will allow us to estimate your financial responsibility related to your visit. Please give us a call the day before your appointment if you would like for us to provide you this information in advance.

Please contact us with any questions or concerns you might have regarding the paperwork or your upcoming visit in our clinic.

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PATIENT REGISTRATION

Patient Name: ____________________
Last Name First Name Middle Name

Address: ____________________
Street or Box City State Zip + 4

Phone: (Primary) ________ (Cell) ________ (Work) ________

Date of Birth: ______ / ______ / ______ Email: ________
Month Day Year

Gender: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Widow/Widower ☐ Divorced

Emergency Contact: ________ Relation: ________ Phone #: ________

Please check (✓) one from each column. This is solely for data collection and will not affect your care.
The question and answer categories below were developed by the Centers for Medicare and Medicaid Services (CMS) along with the Department of Health and Human Services (DHHS) in an attempt to collect standardized demographic information on patients.

Race:
- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or other Pacific Islander
- ☐ Some other Race
- ☐ White
- ☐ Decline to answer

Ethnicity:
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Decline to answer

Language:
- ☐ English
- ☐ Spanish
- ☐ Other ________

SPOUSE's Information or PARENT's Information for patients under age 18

Husband or Father ________
Address ________
City / Zip ________
Cell # ________ Wk # ________
Employer ________

Wife or Mother ________
Address ________
City / Zip ________
Cell # ________ Wk # ________
Employer ________

INSURANCE Information

Please present insurance card (and secondary card) with current driver's license or other government issued photo ID.
This information is required or your appointment may be rescheduled.

☐ **I DO have medical insurance coverage** OR ☐ **I DO NOT have medical insurance coverage**

A deposit of $300.00 will be collected before you are called back to see the physician. Any additional fees for services will be collected at checkout.

Primary Insurance

Insurance carrier ________
Policy holder ________
Policy holder's relationship to patient ________
Policy holder's date of birth ________
ID # ________ Group # ________

Secondary Insurance

Insurance carrier ________
Policy holder ________
Policy holder's relationship to patient ________
Policy holder's date of birth ________
ID # ________ Group # ________

Our office does not file secondary insurance claims. However, we need this information to release protected health information (PHI) to the secondary carrier. Occasionally secondary carriers will request "PHI" subsequent to a crossover claim from Medicare or for a claim that the patient has submitted for reimbursement.

________________________ ________________________
Patient's or Guardian's Signature Date

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PATIENT HEALTH HISTORY QUESTIONNAIRE

In order for us to obtain a complete medical history, it is important for you to fill out this form as completely as possible. This is very important information. **Please fill out every item.** It is important for Dr. Franklin to know that you have carefully reviewed every area of this form. Thank you.

Full Name ________________________ **Date of Birth** ________________________

Primary Care Physician ________________________ **Referred by**________________________

Preferred Local Pharmacy________________________ **Mail Order Pharmacy**________________________

History of tobacco use, current or previous ☐ **NO** ☐ **YES**

If yes, type________________________ **Date Started**____________ **Date Stopped**____________

Last Flu Vaccine________________________ **Last Pneumonia Vaccine**________________________

Last Mammogram, if applicable____________________ **Height**______________ **Weight**______________

What is the main reason you are seeing Dr. Franklin today?________________________

____

CURRENT MEDICATIONS:

Are you taking ANY kind of medication now? (This includes prescription, over-the counter, and/or herbal medications)

☐ **NO** ☐ **YES -- If yes, please list all medications below *and include dosages.***

Medication Name	Dosage	How often taken

MEDICATION ALLERGIES:

ARE YOU ALLERGIC TO ANY MEDICATIONS?

☐ **NO** ☐**YES -- If yes, please list below.**

Medication Name	Type of Reaction

SURGERIES AND HOSPITALIZATIONS:

Have you ever had any problems with anesthesia (being numbed or put to sleep)? ☐ **NO** ☐ **YES**

If **YES**, please list what sort of problems.____

Have you ever had EAR, NOSE, or THROAT surgery?

☐ **NO** ☐ **YES -- If YES, please list below**

Type of Surgery	Date of Surgery

Have you ever had HEART SURGERY or JOINT REPLACEMENT?

☐ **NO** ☐ **YES -- If YES, please list below**

Type of Surgery	Date of Surgery

Have you ever been hospitalized for a RESPIRATORY or CARDIAC problem?

☐ **NO** ☐ **YES -- If YES, please list below**

Type of Problem	Date of Hospitalization

Have you ever been ALLERGY TESTED?

☐ **NO** ☐ **YES -- If YES, please provide date of test and all positive allergens**

Date of Test:	

Positive allergens:	

Statement of Financial Policy

Thank you for choosing Georgetown Ear, Nose, and Throat Center as your healthcare provider. We are committed to providing the best medical care possible.

Your clear understanding of our financial policy is important to our relationship and payment of your bill is considered a part of your treatment. The following statement explains our financial policy and we ask you to read, sign and return it to us prior to your treatment. **Please ask any questions you have about our fees, financial policy or your financial responsibility before seeing the doctor**.

________ Initial

Payment for services

1) *Payment in full is due at the time of service*; this includes, but is not limited to, the following:
   a) All applicable co-pays, co-insurance and outstanding deductible amounts,
   b) Services covered by out-of-network and secondary and Medicare supplemental insurance companies, and
   c) Services not covered by insurance or third party payers.
2) To obtain the most accurate diagnosis, Dr. Franklin may recommend procedures or tests to be performed during your visit. These procedures may include, but are not limited to:
   a) Nasal endoscopy – an in office surgical procedure using a sterile small scope to examine the nasal cavity.
   b) Laryngoscopy – an in office surgical procedure using a sterile small scope to examine the larynx (throat).
   c) Comprehensive hearing tests, ear cleanings and biopsies.

   These procedures are billed as surgery charges, but there is no surgery involved! Many times, these services are not covered by co-pays but are subject to deductibles and co-insurance. Payment of outstanding deductibles and co-insurance related to any of these services is due at the time of service. If you do not authorize any procedures / tests to be performed during your visit, please understand that this may limit the information the doctor has available to determine the diagnosis and subsequent treatment.
3) All outstanding balances owed by you or your family members must be paid before any additional services can be rendered.
4) For minors, the adult accompanying the minor is responsible for full payment. If a minor is accompanied by anyone other than the parent or legal guardian, a written release is required.
5) If a refund is due, patient refunds will be issued the last week of the month for claims that have been processed correctly by your insurance company.

________ Initial

Regarding insurance

1) Your insurance is filed as a courtesy to you. All services not paid within 60 days by your insurance company will become your responsibility.
2) We do not file claims with secondary, Medicare supplemental or out-of-network insurance carriers. Once any outstanding balances are paid in full by you, we will be happy to assist you with seeking reimbursement from your secondary/Medicare supplemental/out-of-network insurance carrier.
3) MEDICARE PATIENTS:
   a) We expect you to pay your unmet deductible and your 20% co-insurance or any amounts not covered by your Medicare supplement at the time of service.
   b) Please contact Medicare to verify that an automatic crossover is in effect between Medicare and your supplemental insurer. If not, you will need to file directly with your supplemental insurer for reimbursement.
4) It is your responsibility to make sure that Georgetown ENT and any of its providers are currently enrolled with your insurance plan; this may require a phone call to your insurance company. It is also your responsibility to understand and comply with any predetermination of benefits or referral requirements established by the insurance company.
5) Insurance is a contract between you and your insurance company. We are not a party to your contract; however, we may have a contractual fee schedule agreement with the insurance company.
6) All patients should provide accurate and complete personal and insurance information prior to being seen by the doctor. If this information is not correct in our records it may result in non-payment by your insurance carrier and the balance will transfer to you.
7) If you do not provide a current insurance card, you will be responsible for all charges at time of service and an insurance claim WILL NOT be filed on your behalf.
8) We will not become involved in disputes with your insurance company regarding deductibles, non-covered expenses, co-insurance or "reasonable and customary" charges other than to supply factual information as necessary.
9) Please be aware that some, and perhaps all, of the services provided may be non-covered services or may not be considered medically necessary by your medical insurance company. You agree to pay in full for all services considered "non-covered" services per your insurance company if you choose to have the service provided.

SIGNATURE REQUIRED ON PAGE 2

10) The patient responsibility portion of your bill cannot be finalized until a claim has been filed with your insurance company and an explanation of benefits has been received from your insurance company.

____
Initial

Administrative Charges and Policies

1) There is a $25.00 charge for administrative services that are outside the scope of medical care. These services include, but are not limited to, providing copies of medical records to patients, completion of Family Medical Leave paperwork, completion of short-term disability paperwork, etc. The fee is to be paid when the paperwork is submitted to our office.
2) Patients requesting a copy of hearing tests <u>only</u> will be charged $5.00 instead of $25.00.
3) Requests for release of medical records require the patient or patient's guardian to complete an authorization form for release of protected health information – we can provide you with a copy of this form. A release is not considered RECEIVED until a signed release form is in our possession.
4) Every attempt will be made to accommodate your request as quickly as possible; we are required to provide records within 15 days after the date of receipt of the request.
5) The records will be mailed to the authorized recipient.

____
Initial

Missed Appointments

1) Please help us to serve you better by keeping scheduled appointments. Unless cancelled 24 hours in advance, our policy is to charge $50.00 for a missed appointment. Future appointments cannot be scheduled until this fee is paid; this fee is not covered by insurance so it will be your personal responsibility.
2) If our agreement with your insurance provider prohibits us from charging you a missed appointment fee and you miss an appointment without canceling in advance, future appointments will not be scheduled.
3) Arriving more than 15 minutes late for an appointment will require your appointment to be rescheduled.

____
Initial

Surgery, Balance Studies (VNG) and Allergy Testing Cancellations & Rescheduling

1) Unless given 7 days advance notice, our policy is to charge $100.00 for cancelled surgeries.
2) After the first reschedule of a surgery, a $50.00 fee will be assessed for each subsequent rescheduling of a surgical case.
3) A $50.00 fee will be assessed for allergy testing if the cancellation is less than 7 days in advance or if you no show for your appointment.
4) A $50.00 fee will be assessed for VNG testing if cancellation is less than 3 days in advance of if you no show for your appointment.
5) Allergy and VNG testing require that you follow specific instructions to ensure accurate results. Failure to follow these instructions will result in the need to reschedule and a missed appointment fee of $50.00 will be assessed.
6) These charges will not apply when cancellation/rescheduling is initiated by Dr. Franklin or as a result of a patient illness or patient/family emergency.

____
Initial

Outside Providers of Service

Due to the wide variety of ailments treated in our practice, we refer or send out to many outside companies for tests that are necessary for developing the most efficient and/or best quality treatment plan.

1) We make a concentrated effort to refer our patients to providers that accept the patient's insurance; however, it is not possible for us to achieve 100% accuracy. Ultimately it is your responsibility to verify whether that company is in or out of network with your insurance carrier.
2) Specimens that are sent out to be evaluated by pathology may be sent on for second and third opinions by the pathology department. Georgetown ENT has no control over this or the resulting bills.

____
Initial

Past Due Accounts and Returned Checks

1) Unpaid balances in excess of 30 days will be subject to a service charge of 1 ½% per month (18% annual percentage rate) on the outstanding balance.
2) Overdue accounts will be referred to a collection agency. Legal fees and collection fees that we pay to secure past due balances will be added to your account.
3) For checks returned to us as unpaid by your bank, we will charge a $40.00 fee.

<u>I have read and understand the above Statement of Financial Policy.</u>

______________________________	______________________________	________________
Print Name	Signature	Date

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Patient Name ______________________ Date of Birth ______________

Receipt of
HIPAA Notice of Privacy Practices
Acknowledgement

I understand that as part of my healthcare, Scott W. Franklin, MD, Georgetown ENT, Georgetown Better Hearing Center and Georgetown Allergy and Sinus Center (collectively referred to as the GENT Group) maintain health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care and treatment. I understand that this information is utilized to plan my care and treatment, to bill for services provided to me, to communicate with other healthcare providers and other routine healthcare operations such as assessing quality and reviewing competence of healthcare professionals.

The GENT Group ***Notice of Privacy Practices*** provides specific information and a complete description of how my Protected Health Information (PHI) may be used and disclosed. The GENT Group is required by law to protect the privacy of health information that may reveal my identity, and to provide me access to this notice which describes the health information privacy practices of this office, its medical staff and affiliated healthcare providers that jointly perform payment activities and business operations with the office. PHI is information about me, including demographic information that may identify me and that relates to my past, present or future physical or mental health or condition and related health care services.

I hereby request the following restrictions on the use and/or disclosure (specify as applicable) of my information:

____

____

I have been provided access to and reviewed the GENT Group ***Notice of Privacy Practices*** prior to any services being provided to me by the GENT Group. I understand that if I have any questions or complaints, I may contact the practice's HIPAA Compliance Officer at 512-869-0604.

Signature of Patient or Personal Representative ______________ Relationship to Patient ______________ Date ______________

This section for office use only. Staff to complete, initial and date if applicable.

- ☐ Patient is unable to sign due to medical reasons
- ☐ Patient refuses to sign
- ☐ Other – please explain ______________________________

This Acknowledgement Form will become part of your permanent medical record.

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Please read and sign as indicated below; the following consents/authorizations/notifications apply to Scott W. Franklin, MD, Georgetown ENT, Georgetown Better Hearing Center and Georgetown Allergy and Sinus Center (collectively referred to as the ***GENT Group***).

Consent for Treatment

________ Initial

I authorize the GENT Group and/or authorized persons employed by the GENT Group to examine, treat and perform diagnostic tests and office procedures that the physician deems necessary. Additionally, I authorize the GENT group and its representatives to order related services on my behalf.

Assignment of Benefits

________ Initial

I authorize and request that the surgical and/or medical benefits, otherwise payable to me, be paid directly to the GENT Group for services provided by them. I understand that I am financially responsible to the GENT Group for charges not covered by this Assignment of Benefits. I further certify that I have provide the GENT Group a complete list of the insurance companies with which I have medical and/or surgical coverage.

Release of Information

________ Initial

I authorize the GENT Group to release any information to any physician or hospital involved in my care and/or my insurance company. The information to be released includes, but is not limited to, diagnosis and the records of any treatment or examination rendered to me during the period of such medical and surgical care.

Implied Consent (Patient or Authorized Representative)

________ Initial

Protected Health Information (PHI), including hepatitis and HIV information, will be discussed freely in the exam room by the patient and the medical staff of the GENT Group. It will be assumed that the patient and/or the patient's parent/guardian consents to sharing PHI with anyone else in the exam room such as a spouse, parent, child or friend.

I understand that PHI will be discussed during my appointment and that it is my choice to invite or not to invite people into the exam room with me.

Non-Participation with Medicaid

________ Initial

We do not participate with any Medicaid or county indigent service programs. By signing below, you understand we will not file a claim with any Medicaid or county indigent service program for services provided to you. You acknowledge that you will be responsible for paying for any services rendered that would otherwise be covered by Medicaid or a county indigent service program since we are not a participating provider.

Patient Name (please print) ______________________________

______________________________ Patient or Parent/Guardian Signature

______________ Date

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Patient Name ______________________ Date of Birth ______________

Release of Protected Health Information to Family and Friends

I grant permission for Scott W. Franklin, MD, Georgetown ENT, Georgetown Better Hearing Center and Georgetown Allergy and Sinus Center (collectively referred to as the GENT Group) and the representatives of the GENT Group to disclose my protected health information to the individual(s) listed below. The purpose of this disclosure is to authorize the GENT Group and its representatives the opportunity to share relevant information about healthcare or discuss financial information for payment on a patient's account with family and friends.

Are there any specific family members or friends that you would like our staff to disclose medical, appointment, and/or financial information to on your behalf? If the patient is a minor, please include the family members or friends with whom our staff should disclose protected health information to on behalf of the minor child. ***OUR OFFICE WILL NOT TALK TO ANY FAMILY MEMBERS OR FRIENDS THAT ARE NOT ON THIS FORM, INCLUDING A SPOUSE, PARENT OR CHILDREN!***

COMPLETE SECTION A OR B:

A. Release my protected health information to the following person(s)/entity:

Name: ______________ Phone: ______________ Relationship: ______________
Name: ______________ Phone: ______________ Relationship: ______________
Name: ______________ Phone: ______________ Relationship: ______________

The information you may release subject to this authorization is the following:

Appointment date/time ☐ Yes ☐ No   Explanation of diagnosis and/or procedures ☐ Yes ☐ No

Lab reports ☐ Yes ☐ No   Billing information ☐ Yes ☐ No

------ OR ------

B. ______ I do not want any of my information shared with family or friends
Initial

This consent will be considered valid until such time that I revoke it. I reserve the right to revoke it at any time. I understand that to revoke this consent, I must provide written notice to the GENT Group.

Signature of Patient or Personal Representative ______________ Relationship to Patient ______________ Date ______________