

# Patient Information

Patient Name: \_\_\_\_\_ MI: \_\_\_\_\_  
 DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_ SSN: \_\_\_\_\_ Marital Status: S M D W  
 Street Address: \_\_\_\_\_ City: \_\_\_\_\_ St: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Email Address: \_\_\_\_\_

Preferred Contact Method:  Call  Text  Email  Opt Out

*\*You agree to our office staff contacting you via email or text for non-urgent matters such as appointment reminders, office updates, etc. We respect your privacy and will not share your information with third parties.*

Name of referring physician: \_\_\_\_\_ Name of PCP (if different): \_\_\_\_\_  
 Preferred Pharmacy: \_\_\_\_\_ Pharmacy Address: \_\_\_\_\_

*Only required if Legal Guardian, POA or parent of minor*

Responsible Party Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender: \_\_\_\_\_  
 Street Address: \_\_\_\_\_ City: \_\_\_\_\_ St: \_\_\_\_\_  
 Zip Code: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

## EMERGENCY CONTACT

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

The following questions are required for compliance with reporting requirements for the Centers for Medicare & Medicaid Services

**Race (Circle):** American Indian or Alaskan | Asian | Black/African American | Native Hawaiian/Other Pacific Islander | White  
 Other \_\_\_\_\_ | Decline to State

**Ethnicity (Circle):** Hispanic or Latino | Not Hispanic or Latino | Decline to State

**Language (Circle):** English | Spanish | Other: \_\_\_\_\_

## INSURANCE INFORMATION:

**Primary Insurance:** \_\_\_\_\_ Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_  
 Policy Holder's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_  
 Employer: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

**Secondary Insurance:** \_\_\_\_\_ Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_  
 Policy Holder's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_  
 Employer: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

**Workman's Comp?**  Yes  No If yes, Date of Injury: \_\_\_\_\_ Claim #: \_\_\_\_\_  
 Employer: \_\_\_\_\_ MCO: \_\_\_\_\_

Self Pay:

## Authorization, Consent, Disclosure & Financial Responsibility

I authorize examination, diagnosis, and general treatment (including but not limited to the use of x-rays and other non-invasive procedures such as diagnostic tests) to be performed by physicians and staff of Ohio Valley Medical Group (“OVMG”) DBA Ohio Valley Ear, Nose & Throat (“OVENT”). I realize that if a medical procedure or surgery is required, I will be given additional information.

I consent to OVENT using and disclosing my protected health information to carryout treatment, payment, and health care operations. I understand and have been provided a written copy of the Notice of Privacy Practices, which provides a more complete description of how my protected health information may be used or disclosed. I understand that I have the right to review the notice prior to signing this consent. I understand that OVENT reserves the right to change their notice of privacy practices and that I will be offered a copy if it changes. I have the right to revoke this consent by notifying OVENT in writing, except to the extent that OVENT has taken action in reliance on my consent.

I hereby authorize any holder of medical information about me to release to the Centers for Medicare/Medicaid Services and its agents any information needed to determine those benefits payable for related services. I hereby authorize Medicare/Medicaid to furnish to OVENT any information regarding my Medicare claims under title XVII and XIX of the Social Security Act.

I realize the bill is my responsibility. I assign and authorize payments be made directly to OVENT of all insurance benefits and agree to pay any balance due. I consent to receive telephone, text, and email messages to any cellular or telephone number or email address provided to OVENT using live, artificial, pre-recorded, automated voice calls or emails related to the financial servicing of my accounts, or debt collection. I agree to notify OVENT immediately if, at any time, I am no longer the owner of any telephone number or email address provided herein.

**Specialty Tests & Procedures:** Specialty appointments will incur a \$75 hold fee.

**Self Pay Patients:** If payment is made at the time of services, OVENT will reduce the cost of services by 20%. If payment cannot be made in full at the time of services, a budget agreement can be made to have services paid within 90 days with the 1st payment payable the day the services are rendered.

**Surgical Information:** In accordance with CMG regulations, OVENT would like to inform you of the physician limited ownership of certain equipment, companies or hospitals. If you have any concerns about this, please talk to a member of our staff and we will be able to discuss other options.

## Appointment Cancellation/No Show Policy

As part of our continued effort to provide you with the best care and accommodate all appointment requests, we have implemented a Cancellation/No Show Policy. Time has been specifically reserved for your office appointment and we ask that you please call our office at least 24 hours in advance to cancel and/or reschedule an appointment.

All patients, excluding allergy follow-up appointments, will receive a reminder call 48 hours prior to their appointment. Any patient who fails to cancel and/or reschedule their appointment at least 24 hours in advance will receive a letter after the first offense, will receive a letter and will be subject to a \$25 fee after the second offense and will be subject to dismissal from the practice and a \$25 fee after the third offense.

**\*\* All specialty appointments will incur a fee of \$75.**

All fees charged by OVENT pursuant to this Cancellation/No Show policy are not payable by your insurance company. All fees are payable prior to your next office visit or within 30 days of receipt of a billing statement from OVENT, whichever is earlier.

Please remember that it is your responsibility to assure that we have updated, accurate phone numbers so that we may contact you.

\_\_\_\_\_  
 Print Name of Patient or Patient’s Representative

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Date of Birth

\_\_\_\_\_  
 Signature of Patient or Guardian

\_\_\_\_\_  
 Relation to Patient

\_\_\_\_\_  
 Official Witness Initials