GEORGIA NASAL AND SINUS INSTITUTE, P.C.

Patient Information

Date_____ Social Sec. Number _____-_____-_____ Male _____ Female _____

FULL LEGAL NAME_____

Ethnicity (Circle one): White/Caucasian, Black/African American, Asian, Hispanic, Other _____

Address _____

Street City State Zip

E-mail _____

Date of Birth _____--_____--_____ Home Phone (_____) _____ Student? FT ___ PT ___

Employer _____ Work Phone (_____) _____ Employed? FT ___ PT ___

Marital Status S M D W Cell Phone (_____) _____

Name of Spouse _____ Work/Cell Phone (_____) _____

Emergency Contact _____ Phone(_____) _____ Relationship _____

Pharmacy that you use regularly: Name_____ Phone (_____) _____

---

*Responsible Party (Please complete if **different** from above or if the patient is a minor)*

Name _____ SS#_____ Date of Birth _____--_____--_____

Address _____

Street City State Zip

Phone _____ Relationship to Patient _____

Primary Insurance

_____ ID# _____ Group# _____

Insured _____ Date of Birth_ ____--_____--_____ SS#_____

Relationship to Patient_____ Employer _____

Secondary Insurance (if applicable)

_____ ID# _____ Group# _____

Insured _____ Date of Birth_ ____--_____--_____ SS#_____

Relationship to Patient_____ Employer _____

I authorize the release of any medical information, including information related to psychiatric care, drug and alcohol abuse, and HIV/AIDS confidential information, necessary to process insurance claims or to facilitate treatment.

Signature_____ Date _____

I assign all medical and/or surgical benefits, to which I am entitled, to Georgia Nasal and Sinus Institute. This assignment will remain in effect until revoked in writing by myself or an authorized person. A photocopy of this authorization will be considered as effective and valid as the original.

Signature_____ Date _____

I understand that if I or an authorized person does not cancel a scheduled appointment within 24 hours prior to that appointment, or present documentation of an emergency situation in a timely manner, I will be charged with a negligent cancellation fee.

Signature_____ Date _____

MEDICAL HISTORY

Name _____ Age _____ Today's Date _____
Last First Middle

Chief Complaint _____
(What is the main problem that brings you here?)

Current Medications_____

_____

_____

Drug Allergies _____

Referring Doctor_____ **Primary Care Physician** _____

Phone (_____) _____ Phone (_____) _____

REVIEW OF SYSTEMS - *(FOR THE LAST 2 MONTHS- please check all that apply to you)*

GENERAL
____ Weight Loss
____ Fever or Chills
____ Bad Reaction to Anesthesia
Describe _____
____ Easy Bleeding or Bruising
____ Recent Trauma or Injury
Describe _____

HEAD, EYE, EAR, NOSE, AND THROAT
____ Headache
____ Seizures
____ Stroke
____ Double Vision
____ Hearing Loss
____ Ear Pain
____ Dizziness
____ Nasal Obstruction
____ Hay Fever
____ Hoarseness
____ Thyroid Problems
____ Other _____

CHEST
____ Asthma
____ Shortness of Breath
____ Cough
____ Coughing up Blood
____ Emphysema
____ Lung Disease
____ Other _____

CARDIOVASCULAR
____ Chest Pain
____ Heart Disease
____ High Blood Pressure
____ Heart Murmur
____ Shortness of Breath at Night
____ Other _____

GASTROINTESTINAL
____ Difficulty Swallowing
____ Nausea or Vomiting
____ Stomach Pain
____ Ulcers
____ Liver Disease
____ Blood in Stool
____ Other _____

GENITOURINARY
____ Painful Urination
____ Difficult Urination
____ Blood in Urine
____ Other _____

MISCELLANEOUS
____ Diabetes
____ Arthritis
____ Cancer _____
type
____ Other _____

PAST HISTORY

Medical Problems _____ Dr. _____
_____ Dr. _____
_____ Dr. _____
_____ Dr. _____

Have you ever had allergy testing? Y N

By what doctor? _____ Did you take allergy shots? Y N

What were you allergic to?_____

Surgical Procedures _____ Date or Year_____ Dr. _____
_____ Date or Year_____ Dr. _____
_____ Date or Year_____ Dr. _____
_____ Date or Year_____ Dr. _____

Hospitalizations _____ Date or Year_____ Dr. _____
_____ Date or Year_____ Dr. _____

FAMILY HISTORY

Mother is: _____ Alive _____ Deceased

Medical Problems _____

Father is: _____ Alive _____ Deceased

Medical Problems _____

Other Blood Relatives' Medical Problems_____

SOCIAL HISTORY

Do you exercise? Y N How often? _____ Occupation _____

Do you currently smoke? Y N Cigarettes per day _____ Cigars? _____ Pipe? _____Chewing Tobacco? _____

Were you a tobacco user in the past? Y N How long did you smoke? _____ Average packs a day? _____

Do you "vape" (electronic cigarettes)? Y N

Do you currently drink alcohol? Y N Social Heavy Approx drinks per week _____

Have you ever been a heavy drinker? Y N Ever addicted? Y N *Date Sober* _____

Do you take or have you ever taken recreational drugs? Y N Prior Addiction *Date Sober* _____

If yes, what type of drug? _____ How Long/ How Often? _____

GEORGIA
NASAL & SINUS
INSTITUTE

FINANCIAL AGREEMENT

I hereby agree to pay for all office visits at the time service is rendered, unless I make arrangements in advance. I understand payment is due upon receipt of statement indicating the balance is due and payable by me. I also understand that having insurance does not relieve me of the responsibility to pay.

DATE_____SIGNATURE_____

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize GEORGIA NASAL & SINUS INSTITUTE, to furnish my insurance company(s), hospital, referring physicians and attorneys all information with regard to my medical care.

DATE_____SIGNATURE_____

MEDICARE /MEDICAID BENEFIT AUTHORIZATION *(if applicable)*

I request that payment of authorized Medicare/Medicaid benefits be made either to me or on my behalf to GEORGIA NASAL & SINUS INSTITUTE for any services furnished me by that physician/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents, any information needed to determine these benefits or the benefits payable to related services.

I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 on HCFA-1500 claim form is completed, my signature authorizes release of the information to the insurer of agency shown.

In Medicare/Medicaid assigned cases the physician agrees to accept the charge determination of the Medicare/Medicaid carrier as the full charge. I am responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and deductibles are based upon charge determination of the Medicare/Medicaid carrier.

DATE_____SIGNATURE_____

TRICARE BENEFIT AUTHORIZATION *(if applicable)*

I request the payment of authorized benefits be made either to me or on my behalf to GEORGIA NASAL & SINUS INSTITUTE for any services furnished to me by that physician. I authorize any holder of medical information about me to release to CHAMPUS and its agents any information needed to determine these benefits or the benefits payable for related services.

DATE_____SIGNATURE_____

PRACTICE DIRECTIVE ON DISCLOSURE OF PROTECTED HEALTH INFORMATION

Frequently it becomes necessary for our Practice to contact you about information concerning your health. This includes appointment reminders, test results, prescription changes, etc. On occasion we may attempt to contact you by telephone and if we do not reach you directly but rather are connected to an answering machine or voice mail, we are required to inquire whether you authorize us to leave messages concerning information about your health. It is out practice to leave our telephone number and request that you return our call. Please advise us as to your preference.

_____ The physician(s), staff and employees of Georgia Nasal and Sinus Institute, PC, are hereby authorized to leave messages containing health information about me on my answering machine and/or voice mail should they not be able to speak with me directly.

_____ The physician(s), staff and employees of Georgia Nasal and Sinus Institute, PC, may only leave a message for me to return their call.

Further, it may on occasion be necessary to disclose your protected health information to a member of your family, other relative(s), or close friend(s). Example — When others pick up prescriptions or test results on your behalf; or when they provide care for you.

If there are individuals whom you wish to authorize to receive health information about you, please list their names and relationships below:

I hereby consent to the disclosure of protected health information about me to:

Name	**Relationship**

I understand that this list is not exhaustive, and that considering the circumstances disclosure of my protected health information may be made to other family members, relatives, and/or friends not specifically listed here.

_____ _____

Patient signature Date

GEORGIA NASAL AND SINUS INSTITUTE, P.C.
4750 WATERS AVENUE
SUITE 112
SAVANNAH, GEORGIA 31404

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PROVISIONS

I hereby acknowledge that I was provided with a copy of Georgia Nasal and Sinus Institute, P.C.'s Notice of Privacy Practices on this date.

_____ _____
Patient's (or Guardian's) signature Date

* * * * * * * * * * * * * * *

PRACTICE USE ONLY

* * * * * * * * * * * * * * *

Attempt to deliver Notice of Privacy Practices was made on:

_____ on the _____ day of _____, 20____.
(Patient)

However, delivery could not be made because _____

_____

_____

_____ _____
Signature of Practice employee Date

_____
Title

GEORGIA NASAL & SINUS INSTITUTE

Christopher T. Melroy, M.D., FARS Adam P. Campbell, M.D., FARS

Financial Policy

November 1, 2021

We are dedicated to providing the highest quality of care and service possible. Please understand that our financial policies are an important part of your care and treatment. To deliver the best possible care at the lowest cost, we find it necessary to implement the following policies. If you have any questions, please discuss them with our staff.

Payment is due at the time service is rendered. For your convenience we accept cash, check, money order, Visa, Master Card, and FSA cards.

No patient will be seen who has an outstanding balance for which payment arrangements have not been made and kept current.

Please understand that your insurance is a contract between you and your insurance carrier and that you are ultimately responsible for your bill. We will help you receive your maximum allowable benefits and will file claims for services rendered. Please be aware that few insurance carriers cover all healthcare costs. Some pay fixed allowances for each visit/procedure, while others pay a percentage only of the costs.

All co-pays, cost shares or deductibles are due at the time of service. **The entire balance on your account is your responsibility whether your insurance pays or not.**

As a courtesy, we allow 30 days for insurance payments to be processed and received. **If your insurance carrier fails to pay its portion of your charges within 30 days or if there is a remaining balance after the insurance payment then that amount becomes your responsibility.**

If you have insurance coverage from more than one carrier, we will file a claim with the primary insurance after services are rendered. **You are responsible for any portion of the fees not paid by your primary carrier.** As a courtesy, we will submit a claim on your behalf to your secondary carrier.

All checks returned for insufficient funds will be subject to a $35 fee. Returned checks outstanding for more than 30 days and account balances older than 60

days may be subject to an additional collection fee of 5% per month. Returned checks may, in some cases, be referred to the District Attorney for collection.

If your account is turned over to our collection agency, a charge of 35% of the outstanding balance will be assessed to your account to cover the cost of collection fees.

We reserve the right to charge you for excessive appointment cancellations and "no show" appointments.

We know you have a choice among healthcare providers and appreciate the opportunity to serve you.

I have read and understand the financial policy of the Georgia Nasal and Sinus Institute, PC and agree to be bound by its terms and conditions.

_____ _____

Patient or Responsible Party Signature Date

Endoscopy Billing Information

Please be advised that your physician may need to perform a procedure during your visit. This most commonly involves use of an endoscope to investigate or treat conditions of the ears, nose and throat. Endoscopy is a quick in-office procedure where a thin tube is inserted into the nasal passages to better visualize the internal anatomy of the nasal passage, sinuses or throat. The risks are minimal and include pain and/or bleeding.

These procedures may be classified by your insurance as an in-office surgical procedure. Insurance companies may apply these procedures to your coinsurance or deductible. We have no control over how these procedures are processed by insurance companies. This form is to notify you in advance when you receive your explanation of benefits stating a surgical service was provided or if you owe more than your office co-payment.

I have read the above information and understand that my insurance company may reimburse these procedures as a surgical service with the deductible/co-insurance guidelines applied. I agree to the financial responsibility established by my insurance carrier according to my individual policy and consent to these procedures for my evaluation and treatment if my physician finds it medically necessary.

_____ _____

Patient or Responsible Party Signature Date