

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 _____

PEDIATRIC MEDICAL HISTORY

Date _____

(Confidential)

Name _____ Age _____ SS# _____
Last First Middle

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

Current Medications _____

Drug Allergies _____

Has your child taken any Aspirin, Ibuprofen in the last two weeks? **Y** **N**

If so, when? _____ Do they bleed or bruise easily? _____

Referring Doctor _____

Phone (_____) _____

Address _____

Pediatrician _____

Phone (_____) _____

Address _____

REVIEW OF SYSTEMS

(Please check all that apply)

GENERAL

____ Birth Defects
Describe _____

____ Weight Loss
____ Fever or Chills
____ Bad Reaction to Anesthesia

Self _____ Family _____
Describe _____

____ Easy Bleeding or Bruising
Self _____ Family _____

Describe _____

____ Recent Trauma or Injury
Describe _____

HEAD, EYE, EAR, NOSE AND THROAT

____ Headache
____ Yellow or Green Nasal Drainage
____ Clear Nasal Drainage
____ Cough
____ Bad Breath
____ Personality Changes (Irritable, Lack of Energy etc.)
____ Hearing Loss
____ Delayed Speech Development
____ Ear Drainage

____ Ear Pain
____ Double Vision/Lazy Eye
____ Dizziness
____ Nasal Obstruction
____ Snoring
____ Stops Breathing at Night
____ Noisy Breathing
____ Hay Fever
____ Hoarseness
____ Thyroid Problems
____ Other _____

CHEST

____ Asthma
____ Shortness of Breath
____ Lung Disease
____ Cystic Fibrosis
____ Other _____

CARDIOVASCULAR

____ Heart Disease (Congenital)
____ High Blood Pressure
____ Heart Murmur
____ Other _____

GASTROINTESTINAL

☐ Difficulty Swallowing
☐ Nausea or Vomiting
☐ Stomach Pain
☐ Ulcers
☐ Liver Disease
☐ Reflux
☐ Hernia
☐ Other _____

GENITOURINARY

☐ Painful Urination
☐ Blood in Urine

____ Other _____

NEUROLOGIC

☐ Seizures
☐ Weakness
☐ Daytime Sleepiness

PSYCHOLOGICAL

☐ Depressed
☐ Hyperactive
☐ Attention Deficit Disorder

PAST HISTORY

Please list all surgical procedures; particularly sinus, ear, tonsil and/or adenoid surgeries:

Surgical Procedures _____ Date _____ Dr. _____

_____ Date _____ Dr. _____

_____ Date _____ Dr. _____

Medical Illness _____ Date _____ Dr. _____

_____ Date _____ Dr. _____

_____ Date _____ Dr. _____

Hospitalizations _____ Date _____ Dr. _____

_____ Date _____ Dr. _____

BIRTH HISTORY

Birth Weight: _____ Pounds _____ Ounces Was this child born early? Y N

Did this child pass his/her Newborn Hearing Screen? Y N

WERE THERE ANY PROBLEMS

During pregnancy or immediately after birth? Y N If Yes, Please Describe _____

In the first six months of life? Y N If Yes, Please Describe _____

FAMILY HISTORY

Mother is _____ Alive _____ Deceased

Father is _____ Alive _____ Deceased

Medical Problems _____ Medical Problems _____

Does anyone in the family have Cystic Fibrosis, Sickle Cell Anemia, or Deafness? Y N

Blood Relatives' Medical Problems _____

SOCIAL HISTORY

Is your child currently in Day Care? Y N Does anyone in the family smoke? Y N

Is your child around Cigarette Smoke? Y N If yes, How Frequently? _____ How Much? _____

Does your child have difficulty sleeping? Never Often Sometimes Getting to Sleep Staying Asleep

Does your child have behavioral problems? Y N If Yes, Please Describe _____

Any history of allergy testing? Y N by Dr. _____ Allergic to _____

Any history of allergy shots? Y N What school does the child attend? _____

**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 our 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



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