ROANOKE VALLEY
ENT
& ALLERGY

Patient Registration Form

PATIENT INFORMATION

Patient Name: _______________________________ _______________________________ _______________________________
(First) (Middle) (Last)
Sex: ❑ Female ❑ Male Marital Status: ❑ Married ❑ Divorced ❑ Single ❑ Separated ❑ Domestic Partner ❑ Widowed

Date of Birth: ______/______/_______ Social Security Number: __________- ________ -____________

Mobile Number: (_____) _______- ___________ Email Address: ____

Home Number: (_____) _______- ____________ Work Number: (_____) _______- _____________

Home Address:____

City: ____ State: _______ Zipcode: _______________________________

How did you hear about Roanoke Valley ENT P.C.:____

ETHNICITY/ RACE:

❑ Hispanic or Latino
❑ White or Caucasian
❑ Patient declines to specify
❑ Asian
❑ American Indian or Alaska Native
❑ Black or African American
❑ Native Hawaiian or Other Pacific Islander

EMERGENCY CONTACT:

Name: ____ Relationship to patient: ___________________ ___________________________

Phone: ____

RESPONSIBLE PARTY (if other than patient)

Guarantor's Name: _________________________________ Phone Number: (_____) _______- ___________

Address: ____ City: ______________________ State: _______ Zipcode: ____________________
(If different from above)

Patient Relation to Guarantor: _________________________________ Guarantor's Employer: ____

Employer Address: ____

City: ____ State: _______ Zipcode: ____________________

Guarantor Social Security #: ____ ____ ____- ____ ____ - ____ ____ ____ ____ Guarantor D.O.B.: ______/______/_______

Insurance Information (you may leave blank if you can present your card to the receptionist)

PRIMARY

Name of Insurance Company: _______________________________________ Policy Holder: ____

ID Number: ____ Group Number: ____

SECONDARY

Name of Insurance Company: _______________________________________ Policy Holder: ____

ID Number: ____ Group Number: ____

I hereby authorize Roanoke Valley ENT P.C. to release medical information to any of my physicians or insurance companies that may be pertinent to my case. I hereby authorize payment directly to Roanoke Valley ENT P.C. of benefits otherwise payable to me. I hereby authorize the release of medical records to third party insurers or other authorized persons to whom disclosure is necessary to establish or collect a fee for the service. I understand that I am financially responsible for charges not covered by this authorization. A photocopy of this authorization shall be valid as the original.

I certify that I have read and fully understand the above statement and consent fully and voluntarily to its contents.

Patient's signature (or responsible party) ____ Date ______________________________

PATIENT ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

I hereby authorize Roanoke Valley ENT P.C. to release medical information to any of my physicians or insurance companies that may be pertinent to my case. I hereby authorize payment directly to Roanoke Valley ENT P.C. of benefits otherwise payable to me. I hereby authorize the release of medical records to third party insurers or other authorized persons to whom disclosure is necessary to establish or collect a fee for the service. I understand that I am financially responsible for charges not covered by this authorization. A photocopy of this authorization shall be valid as the original.

I certify that I have read and fully understand the above statement and consent fully and voluntarily to its contents.

____ ____________________
Patient's signature (or responsible party) Date

____ ____________________
Printed Name of Patient or Personal Representative Relationship to Patient

SPECIFIC INFORMATION RELEASE (If applicable)

I request and authorize Roanoke Valley ENT, P.C. to disclose protected health care information to the individual(s) listed below.

Name ______________________________ Contact # ______________________________

Name ______________________________ Contact # ______________________________

Name ______________________________ Contact # ______________________________

NOTICE OF PRIVACY PRACTICES (HIPAA)

I acknowledge the Practice has provided me a copy of its Notice of Privacy Practices, which provides a detailed description of the uses and disclosures allowed by this consent, as well as other rights I have regarding my protected health information.

____ ____________________
Patient's signature (or responsible party) Date

____ ____________________
Printed Name of Patient or Personal Representative Relationship to Patient

CONSENT FOR USE OR DISCLOSURE OF PATIENT INFORMATION FOR THE PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I hereby consent to Roanoke Valley ENT P.C. using or disclosing my protected health information for the purpose of providing treatment to me, obtaining payment for health care services rendered to me or to carry out the Practice's health care operations. I also consent to Roanoke Valley ENT P.C. using or disclosing my protected health information for treatment activities provided by another provider or entity. I further consent to the disclosure of my protected health information in order for another provider or health care entity to conduct health care operation including quality assessment and reviewing the competence of health care professionals.

____ ____________________
Patient's signature (or responsible party) Date

____ ____________________
Printed Name of Patient or Personal Representative Relationship to Patient

Acknowledgment of Receipt of Notice of Privacy Practices

I acknowledge that I have received from the Group a copy of a separate document, titled "Notice of Privacy Practices" which sets forth this Group's privacy practices and my rights regarding privacy of my protected health information.

____

Patient's Printed Name

____ ____________________

Patient's signature (or responsible party) Date

2154 McVitty Road, Roanoke, VA 24018 • 540 YOUR ENT (540 968 7368) • Fax:1-844-212-0402 • www.RoVaENT.com

ROANOKE VALLEY
ENT
& ALLERGY

Cancellation / No Show Policy

1. Cancellation / No Show for Scheduled Appointment:

   We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book. If an appointment is not canceled at least 24 hours in advance you will be charged a Thirty Five Dollar ($35) fee; this will not be covered by your insurance company. This appointment will also be marked as a No Show since adequate cancellation notice was not given. We will limit the number of No Shows or late cancellations allowed per patient. If you are a No Show three (3) times, we will no longer schedule appointments for you at our practice.

2. Late Arrival for Scheduled Appointments:

   We understand that delays can happen; however, we must try to keep the other patients and doctors on time. If a patient arrives 15 minutes past their scheduled time we will have to reschedule the appointment.

____

Patient's Printed Name

____ _______________

Patient's signature (or responsible party) Date