Adult & Pediatric ENT & Allergy OF THE WOODLANDS

*Indicates Required Fields

Demographics

*Patient Last Name: _____ *First Name: _____ Middle Initial: _____

*Date of Birth: _____/_____/_____ *Gender: ☐Male ☐Female *Prefix: ☐Mr. ☐Miss ☐Ms. ☐Mrs. ☐Dr. *Suffix: ☐II ☐III ☐IV ☐Jr ☐Sr

*Street Address: _____ Apt #: _____ *Marital Status:_____

*City: _____ *State: _____ *Zip: _____ *Email:_____

*Home Phone: (_____)_____-_____ *Cell Phone: (_____)_____-_____ Preferred: ☐Home ☐Cell

SSN: ___ -____-_____ Employer Name:_____ Work Phone: (_____)_____-_____Ext:_____

Employer Status: ☐Full-Time ☐Part-Time ☐Retired ☐N/A Student Status: ☐Full-Time ☐Part-Time ☐N/A

*Primary Care Physician: _____ *Referring Doctor: _____
(Print Full Name) (Print Full Name)

Address: _____ Address: _____

City: _____ State:_____ ZIP: _____ City: _____ State:_____ZIP:_____

*Phone #:(_____)_____-_____ *Phone #:(_____)_____-_____

Emergency Contact

*Full Name:_____ *Relation to Patient:_____

*Primary Contact Phone #:(_____)_____-_____ *Secondary Contact Phone #:(_____)_____-_____

Preferred Pharmacy

*Pharmacy Name:_____ *Phone #:(_____)_____-_____ Address:_____

DUE TO RECENT REFORMS MANDATED BY THE GOVERNMENT, DOCTORS ARE REQUIRED TO ASK *ALL* PATIENTS FOR THEIR RACE, ETHNICITY, AND PREFERRED LANGUAGE REGARDLESS OF YOUR INSURANCE TO MEET MEANINGFUL USE REQUIREMENTS.

***Race**: ❑American Indian/Alaskan Native ❑Asian ❑Native Hawaiian/Other Pacific Islander ❑Black/African American ❑White ❑Hispanic ❑ Other Pacific Islander ❑Other Race ❑Unreported/Refused to Report
***Ethnicity**: ❑Hispanic/Latino ❑Not Hispanic/Latino ❑Refused to Report
***Language**: ❑English ❑Other ❑Indian ❑Spanish

The above information is complete and accurate to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. If any changes occur I understand it is my responsibility to advise the office. I understand that I am financially responsible for any balance. I also authorize Woodlands ENT or insurance company to release any information required to process my claims.

***Print Patient Full Name:**_____

***Patient or Legal Guardian Signature:**_____ ***Date:**_____

****IF LEGAL GUARDIAN **COURT DOCUMENTS** MUST BE SUBMITTED TO OFFICE PRIOR TO VISIT (FAX: 936-271-2223)

17350 St. Luke's Way, Suite 140
The Woodlands, TX 77384
P: (936) 321-2222 (281) 203-5015 F: (936) 271-2223

Coordination of Benefits

* indicates REQUIRED fields, as applicable

*** Please PRINT All Fields LEGIBLY**

FULL NAME OF PATIENT:_____ **DATE OF BIRTH**:_____

INSURANCE COMPANY:_____ *Type of Plan: □PPO □HMO □ Other _____

*Policy Holder Full Name:_____ *Policy Holder DOB:_____

*Policy Holder Home Address:_____ Policy Holder Phone #:_____

Policy Holder Employer:_____*Relationship to Patient: □ Self □ Spouse □ Parent □ Other _____

*Subscriber / Member ID#: _____ *Group or Claim #:_____

Insurance Providers Phone#: _____ Insurance Carrier Claim Address: _____

Financially Responsible Party

******If SELF**, please put self and you will have completed the Financially Responsible Party portion of this form.
******Please note**: the financially responsible party **DOES NOT HAVE TO BE THE MAIN POLICY HOLDER**, but **MUST** be a legal adult and provide **ALL** of the required information below along with their **SIGNED CONSENT** at the bottom of this form.

***Full Name Of The Responsible Party For The Patient**:_____

***Date of Birth**: _____/_____/_____ ***Relationship to Patient**: □ Spouse □ Parent □ Other _____

***Mailing Address**: _____ **Apt #**: _____

***City**: _____ ***State**: _____ ***Zip**: _____ ***Phone** #:(_____)_____-_____

*Does the PATIENT have ANY additional insurance coverage?

□ YES » Continue with form □ NO » Go to **Signature** section

---

OTHER INSURANCE COMPANY:

* Name of **Secondary** Insurance Carrier: _____
* Name of the Policy Holder:_____ *Policy Holder DOB:_____
* Relationship to Patient: □ Self □ Spouse □ Parent □ Other _____
* Policy Holder Home Address (if different from patients):_____
* Policy Number: _____ *Group Number: _____
* Insurance Carrier Providers Phone Number: _____
  Insurance Carrier Claim Address: _____

OTHER INSURANCE COMPANY:

* Name of **Tertiary** Insurance Carrier: _____
* Name of the Policy Holder:_____ *Policy Holder DOB:_____
* Relationship to Patient: □ Self □ Spouse □ Parent □ Other _____
* Policy Holder Home Address (if different from patients):_____
* Policy Number: _____ *Group Number: _____
* Insurance Carrier Providers Phone Number: _____
  Insurance Carrier Claim Address: _____

I certify that the above information is correct and understand that I am obligated to provide this information to the appropriate insurance company. Failure to provide complete and accurate information may result in a delay in the payment of benefits or denial of claims. Texas Residents: any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

SIGNATURE:

***Print Full Name of Financially Responsible Party**: _____

***Signature of Financially Responsible Party**: _____ ***Date**: _____

Adult & Pediatric ENT & Allergy OF THE WOODLANDS

Authorization to Release Information

PROTECTED HEALTH INFORMATION TO DESIGNATED REPRESENTATIVE(S)

I,_____, give my authorization to **release** my protected health
(Patient/Legal Guardian Full Name)
information including results of my laboratory tests, X-rays, and/or other test results to the following designated representative(s).

*__Patient/Guardian Initials__

_____ My Spouse (Name) _____

_____ My Child (Name) _____

_____ Other (Name) _____

_____ Personal Representative _____

_____ May leave a **detailed message** on answering machine at home.

_____ May be left on my answering machine at work.

_____ May leave a **detailed message** on cell#: _____

_____ MAY NOT BE GIVEN TO ANYONE OTHER THAN MYSELF

***Print Patient Full Name:**_____

***Patient or Legal Guardian Signature:**_____ ***Date:**_____

As a patient, you have the right to revoke this authorization in writing at any time, except to the extent that action has been taken in reliance in this authorization or, if applicable, during contestability period. In order for the revocation of this authorization to be effective, Woodlands ENT must receive revocation in writing. The revocation must include, 1) The patients name, address, DOB, 2) The patient/legal guardians desire to revoke the authorization, 3) The date of the revocation and the patient/legal guardians signature. All revocations must be sent in writing to our office and will not be considered effective until receive by our office.

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Adult & Pediatric ENT & Allergy OF THE WOODLANDS

Notice of Privacy Practices

1. **THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.** The notice is provided in two layers: This layer briefly summarizes how we handle your health information, and the attached bottom layer provides further details of our privacy policies and procedures.

2. **How we may use and disclose your health information.** We use health information about you for treatment, to get paid for treatment, for administrative purposes, and to evaluate the quality of care that you receive. For example, your health information may be shared with other providers to whom you are referred. Information may be shared by paper, mail, electronic mail, fax, or other methods. We may use or disclose your health information without your authorization for several reasons. If you sign an authorization to disclose information, you can later revoke it to stop any future disclosures.

3. **Your rights.** In most cases, you have the right to look at or get a copy of your health information that we use to make decisions about you. You may request that we limit disclosure to family members, other relatives, caregivers, or close personal friends who may or may not be involved in your care. If you request copies, we may charge you a cost-based fee. You also have the right to request a list of certain types of disclosures of your information that we have made. If you believe that your health information is incorrect or information is missing, you have the right to request that we correct the existing information or add the missing information.

*May we **discuss** your medical condition with any member of your family? **YES NO**

*If **YES**, please print **full name** the members allowed:

_____

_____

4. **Our legal duty.** We are required by law to protect the privacy of your health information, provide this notice about our privacy practices, follow the privacy practices that are described in this notice, and see your acknowledgement of receipt of this notice. We may change our privacy policies any time. Before we make a significant change in our policies, we will change our notice. This notice will be prominently displayed at all ENT & Allergy of The Woodlands locations and on our website. You can also request a copy of our notice at any time. For more information about our privacy policies, contact our privacy officer.

5. **Privacy complaints.** If you are concerned that we have violated your privacy rights, our privacy policies, or if you disagree with a decision we made about access to your health information, you may contact our privacy officer. You may send a written complaint to the U.S. Department of Health and Human Services. Our privacy officer can provide you with the appropriate address upon request.

If you have any questions or complaints, please contact: Privacy Officer, 17350 St. Luke's Way, Suite 140, The Woodlands, Texas 77384. Phone number: (281) 203-5015.

Acknowledgement of receipt of Notice of Privacy Practices: Please sign and print your name and provide the date below to acknowledge that you have received both layers of the Notice of Privacy Practices.

***Print Patient Full Name:**_____

***Patient or Legal Guardian Signature:**_____ ***Date:**_____

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Financial and Billing Policy

NOT A GUARANTEE Of Benefits: Deductibles, co-insurance, and co-payments are **due at the time of service**. Uncovered services are the patient's responsibility. Delays in processing due to pre-existing clauses or administrative delays become the patient's immediate responsibility. If the insurance premium has not been paid prior to the patients' appointment, the patient will be subject to self-pay pricing or the appointment will be cancelled. A statement will be sent if additional payment is owed after insurance processing. These procedures, including others may be subject to more than just your copay: *Nasal debridement, removal of cerumen, tongue-tie, lip-tie, allergy testing and treatment*. In accordance with Texas Admin Code 28 TAC 3.3703 (a) (28) you may be referred for non-emergency treatment to a facility that is out of network. Please ask our staff if you have questions about the above services mentioned. If we are contracted with your insurance carrier, we are required to follow our contract and their requirements. If you have a co-pay or deductible, you must pay that at the time of service. It is the insurance carrier that makes the final determination of your eligibility. Our surgery pre-certification staff will obtain the necessary authorization for the surgery procedure(s). Insurance is a contract between you and your insurance carrier. As a courtesy to you, we will file an insurance claim to your primary insurance carrier and your secondary, if applicable. It is the insurance company that makes the final determination of your eligibility. Estimates given by insurance specialist's are never a guarantee of eligibility. You agree to pay any portion of the charges not covered by your insurance carrier.

Appointment Cancellation: Failure to provide 2 business days/48 hours advance notice of the cancellation of your appointment for *Tongue-tie/lip tie and Lactation appointments* will result in a 'no-show' fee of $50 per provider appointment, which must be paid prior to rescheduling the next appointment. New patients who no-show their first appointment will not be rescheduled. Patients with 3 consecutive no show or rescheduled appointments will be asked to seek a new provider. **If a patient is in a grace period because their insurance premium has not been paid to date, or they have a term date their appointment may be cancelled.**

Referrals: If your insurance carrier requires an office referral and/or pre-authorization, **you are responsible for obtaining it**. Failure to obtain the referral and/or pre-authorization may result in the cancellation of you or your child's appointment. If your insurance plan requires a current referral, it is your responsibility to ensure that the referral is in this office before your visit. If you see the doctor without a referral, your claim may get denied by your insurance and you will be responsible for the cost of the visit.

Minors/Divorce: Responsibility for payment for treatment of minor children, regardless of the legal status between the parents, rests with the parent who seeks the treatment on that date of service. In the case of a divorce or separation, the party responsible for the child's account remains responsible for the account. After a divorce or separation, the parent authorizing treatment for the child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Copies of Medical Records: Texas law allows the provider to collect a $25.00 fee, with additional charges due if the records exceed 20 pages. However, we want to provide this service at a cost that simply covers the expense of record retrieval and duplication. This charge is $6.50, payable before the records are prepared. If your records are voluminous, however, this fee may be higher. Please allow a minimum of FIFTEEN business days to obtain copies of records. A signed authorization is required to release all records.

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Financial and Billing Policy Continued

Completion of Additional Forms, Reports, and Letters: Documents/forms that require the physician's input and attestation, such as FMLA, disability papers, letters to attorneys, etc., require a prepayment of $25.00 for **each set** of forms. The fee is due upon submission of the forms to the physician, and prior to their preparation. Such forms require a **minimum of SEVEN business days for completion.**

Surgical Deposit/Cancellation: Based upon your insurance benefits, a deposit is due prior to surgery. The deposit amount is based on the anticipated surgical procedures, and is **only an estimate.** The fee is due the Friday before the procedure, or the procedure may be rescheduled. You may receive an additional bill from this office after the claim is processed**.** Please **MAKE SURE** to call the surgery center to get you're pricing in addition to Dr. James Liu's portion. ***We charge a $150.00 fee for all patients who fail to provide a 48 hour advance notice for surgery cancellations.***

Returned Checks: There is a $30.00 fee for each returned check. Unpaid checks will be prosecuted.

Collections: An unpaid account may be turned over to a third party collection agency that will report the information to all three major credit reporting agencies. All collection expenses and taxes, and all accrued statement fees will be added to the account balance when it is transferred to an outside collection agency.

Refunds: Refunds for deposits made with a credit card on an electively cancelled surgery/procedure will be issued by check. Refunds for services delivered are made only after your insurance company has fully processed the claim. Refund checks will be issued to the party who paid the overage (payer), not necessarily the guarantor on the account, unless written instructions from the original payer are received before the refund check is issued.

Complaints: Billing complaints may be made to the practice manager, preferably in writing, who will make every attempt to promptly resolve the issue in accordance with the policies stated herein.

**I have reviewed these policies and agree to the terms as stated above. A copy is available upon my request.

***Print Patient Full Name:**_____

***Patient or Legal Guardian Signature:**_____ ***Date:**_____

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www.entwoodlands.com
James H. Liu, M.D., F.A.A.P.

Disclosure Form

Dear Patients:

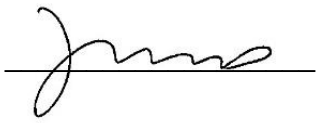
When it comes to your medical care, you always have a choice in terms of doctors, testing facilities and medications. Your insurance company will always have preferred medications and testing facilities (which usually cost them less) which may or may not be better for you from a medical or financial standpoint. You have the right to choose.

For complete disclosure I would like to state that I have either stocks, directorship, partnership, speaker bureau or other forms of financial interests in the following healthcare companies:

- Cy Fair Outpatient Care, LLC
- Conroe Premier Imaging Center, LP
- Memorial Hermann Specialty Hospital Kingwood, LLC

Sincerely,

James H. Liu, MD



***Patient or Legal Guardian Signature:** _____

***Date:** _____

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