EASLEY HEAD & NECK SURGERY, P.A.

PATIENT REGISTRATION SHEET

PATIENT INFORMATION:

Last Name: ______________________ First Name: ______________________ M.I. ______

Goes by: ____________________ D.O.B. ____________________ Sex: _______________

S.S. # _______________________ Race: ______________ Marital Status: _____________

Address: ____

Zip: ____________________ City: ________________________ State: _______________

Home Phone _____________________________ Cell Phone _________________________

Work Phone ________________________ Preferred Contact: Cell Text E-mail Home Work

E-mail address: ____

IF PATIENT IS A MINOR:

Parent/Guardian Name: ____

Relationship: __________________________ S.S.# _______________________________

D.O.B. ____________________ E-mail address: ___________________________________

Address (if different from patient): ______________________________________

INSURANCE INFORMATION:

PRIMARY INS: ____

Policyholder Name: __________________________________ D.O.B. ________________

S.S.# ____________________________ Policy # __________________________________

Group # ______________________ Employer ______________________________________

SECONDARY INS: ____

Policyholder Name: _________________________________ D.O.B. _________________

S.S.# ____________________________ Policy # __________________________________

Group # __________________________ Employer __________________________________

Easley Head & Neck Surgery, P.A.
PATIENT REGISTRATION SHEET

EMERGENCY CONTACT: ______________________________

PHONE #: ______________________ RELATIONSHIP: ______________

FAMILY DOCTOR: ______________________________

REFERRED BY: ______________________________

PHARMACY/ADDRESS/PHONE # ______________________________

I, the undersigned patient/legal guardian (for minor patient), give my consent for the physician and Easley Head & Neck Surgery, (EHNS) to administer medical treatment to the above named patient. I authorize the release of any medical information to the Physicians listed above or any entity necessary to process health insurance claims by mail, electronic submission or facsimile. I request payment of the benefits to be made directly to EHNS. Any unexpected balance left after the insurance payment has been received will be due in full within 90 days of notification from this office. I have also received and understand EHNS Information Policy regarding Privacy and the EHNS Financial Policy. **It is your responsibility, as the patient and policy holder, to know your insurance benefits and your responsibility to pay anything the insurance company rejects.**

This authorization is valid unless rescinded in writing. A photocopy is valid as the original. I have read and understand all of the above and given truthful information to the best of my knowledge.

____
Patient or Legal Guardian Date

Relationship: ______________________________

I authorize the Physician and staff to give information concerning the health and well being of above patient to the persons listed below. If the patient is a minor, the persons listed below are allowed to bring patient to appointment and have them treated. **I understand that I may revoke this consent form by giving written notice to any EHNS staff member.**

______________________ ______________________
NAME RELATIONSHIP

______________________ ______________________
NAME RELATIONSHIP

______________________ ______________________
SIGNATURE (Patient or Legal Guardian) DATE

WITNESS: ______________________ DATE: ______________

EASLEY HEAD AND NECK SURGERY, P.A. INFORMATION NOTICE POLICY

Easley Head and Neck Surgery, P.A.(EHNS) and its President, Phillip W. Saccogna, M.D., understand our patients' concerns about the privacy of their medical information and record. Our company is dedicated to protecting the confidentiality and security of nonpublic personal information we collect and keep in accordance with applicable laws and regulations. This notice describes our privacy policy and describes how we treat personal information about our patients that we receive or share. EHNS reserves the right to make changes to this notice. If you have any questions about this notice, please contact our designated privacy official in our office at 855-2411, 115 Whitmire Road Easley, SC 29640. We are required by law to give you this notice. This notice was adopted on 11/6/01. PLEASE REVIEW THIS INFORMATION CAREFULLY.

PATIENT ACCESS TO INFORMATION:

Copies of medical records are available to our patients. This request must be submitted in writing, using a request for medical records form available at the front desk . There is a charge for medical record copies, applicable with current law. Copies of records are usually available within 30 days of the written request, unless special circumstances exist, in which it may be up to 60 days. You also have the right to inspect your medical record. This request must also be made in writing and a mutually agreed upon time will be set up to complete this request. We may deny a request in certain limited circumstances. If you are denied access, you may ask for a review. Where required by law, this review will be conducted by a health care professional whom did not make the initial denial. We will comply with this outcome.

AMENDING THE MEDICAL RECORD:

Patients have the right to request an amendment to their medical record. This request must be made in writing, and may take up to 60 days to process. Forms are available at the front desk or by request to EHNS 115 Whitmire Road, Easley, SC 29640. EHNS will consider amending medical information that the company maintains, or in cases where the original creator is no longer available. If the request is denied, the patient may submit a written statement of disagreement to the EHNS Privacy Officer, or complain to the HHS Secreatary.

CONFIDENTIAL COMMUNICATION:

EHNS will accommodate all requests to keep communications with our patients confidential. It is our policy not to release any information to anyone other than the patient, unless the patient is a minor, without express written consent of the patient. We do not leave messages regarding medical information on answering machines, or with anyone who is not the patient. Should a patent desire medical information to be disclosed/discussed with someone such as a family member, a form is available at the front desk that gives us permission to do this. This consent can be revoked at any time by the patient by notifying the privacy officer in writing of this request.

ACCOUNTING OF DISCLOSURES:

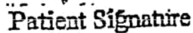
Patients have the right to have an accounting of disclosures of their medical information at no charge once per year. However, this disclosure does not include payments, other providers involved in the patient's medical care, or information given to law enforcement officials as required by law. EHNS has 60 days in which to respond to this request. Please note that EHNS very rarely is involved in any sharing of information, and would not do so without Patient consent. Forms for an accounting of disclosures are available at the front desk at EHNS.

(OVER)

OBTAINING PATIENT PERMISSION TO SHARE OR USE MEDICAL INFORMATION:
Patient consent is obtained in order to provide treatment. Once received, EHNS does not need additional consent to share medical information with other providers involved in the patient's care. For any other use of a patient's medical information, WRITTEN consent will be obtained. Exceptions to this include; where required by law (Ex. Audits), public health responsibilities (Ex., suspected abuse, medical recalls, etc.), worker's compensation, lawsuits (court orders); or to prevent a serious threat to health or safety. In the event of potential research projects, patients' involvement is only with permission in he event it requires any identifiable information. Patient consent can be revoked at any time by notifying the privacy officer in writing. However, if you revoke this consent we are not permitted to use or disclose information about you for treatment, payment, or healthcare operations, and we may choose to discontinue providing you with healthcare treatment and services.

CURB BUSINESS ASSOCIATES OVERUSE OF MEDICAL INFORMATION:
EHNS patient data is protected from Business Associates involved with ENHS. Business Associates are obligated to sign EHNS Privacy Policy Contracts. EHNS employees who may need access to medical information include; Clinical Assistants, Billing personnel, Receptionists, and the Office Manager.

PATIENT COMPLAINTS:
Patients have the right to file a complaint with the Privacy Officer if protections are violated. Complaints must be filed within 180 days after the patient is aware of the violation. A complaint may be sent to: Privacy Officer, Phillip W. Saccogna, M.D., EHNS, 115 Whitmire Rd., Easley, S.C. 29640. If complaints go unresolved after a reasonable amount of time, patients can complain directly to HHS.



Patient Signatire Date