HNA Allergy & Asthma

PATIENT INFORMATION

NAME: ____________________________ ______________________ _________ __________________________ SEX: M ☐ F ☐
Last First MI Nickname

ADDRESS: _______________________________ ___________________________ ______________ _______________________
Street City State Zip Code

BIRTHDATE: _____ /_____ /_______ SS#: ______ - _____ - ______ MARITAL STATUS: S ☐ M ☐ D ☐ W ☐ O ☐

PREFERRED CONTACT
PHONE NUMBERS: 1. (_____) ____________ Phone type: ________ 2. (_____) ____________ Phone type: ________

E- MAIL ADDRESS: ____ PRIMARY LANGUAGE: ______________________________

RACE: ☐AFRICAN AMERICAN ☐ AMERICAN INDIAN ☐ ASIAN
☐CAUCASIAN ☐PACIFIC ISLANDER ☐ OTHER ___________

ETHNICITY: ☐HISPANIC/LATINO ☐ OTHER
☐NON-HISPANIC/LATINO

REFERRING PHYSICIAN: ___________________________ ______________________ _OFFICE NUMBER: (_____) _____________
Last First OFFICE LOCATION:___________________

EMERGENCY CONTACT: ___________________________ PHONE: (_____) _____________ RELATIONSHIP: ________________

Please print the name and relationship of the persons you authorize to receive protected health care information:

NAME: ____ RELATIONSHIP: _________________________

NAME: ____ RELATIONSHIP: _________________________

INSURANCE POLICY INFORMATION

POLICY HOLDER'S NAME: ____
Last First MI

BIRTHDATE: _____ /_____ /_______ SS#: ______ - _____ - ______ RELATIONSHIP TO PATIENT: _________________

ADDRESS: ________________________________ _________________________ _____________ _________________________
Street City State Zip Code

PRIMARY INSURANCE CO: _________________________________ POLICY HOLDER'S EMPLOYER: _________________________

POLICY HOLDER'S NAME: ____________________________________ POLICY HOLDER'S BIRTHDATE: _____ /_____ /_______

POLICY #: _________________________ GROUP #: _______________________ RELATIONSHIP TO PATIENT: ________________

SECONDARY INSURANCE CO: ______________________________ POLICY HOLDER'S EMPLOYER: _________________________

POLICY HOLDER'S NAME: ____________________________________ POLICY HOLDER'S BIRTHDATE: _____ /_____ /_______

POLICY #: _________________________ GROUP #: _______________________ RELATIONSHIP TO PATIENT: ________________

ASSIGNMENT OF BENEFITS / RELEASE OF INFORMATION

I assign and request payment of medical benefits be made to **HEAD AND NECK ASSOCIATES OF ORANGE COUNTY, INC**. for medical services rendered. I authorize the release of medical information necessary to process my claim. I also authorize that I may be contacted via any of the above contact information I have provided. **I have read the Financial Policies and understand that I am financially responsible for any non-covered services.**

____ _____ /_____ /_______
Patient Signature **Date**

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FINANCIAL POLICIES

Head and Neck Associates will submit claims to your insurance company for all medical services rendered. We will attempt to verify eligibility and benefits with your insurance company; however, this verification is not a guarantee of payment. Any expenses deemed not covered by your insurance company will be your financial responsibility.

All monies owed by the patient, i.e., office visit copayments and non-covered services or supplies are due at the time of service. Also, when applicable, coinsurance percentages and/or deductibles may be collected at the time of service. Please be aware that this office will bill only for the physicians' services. Any other services related to your office visits, i.e., laboratory, radiology or pathology will be billed by the facility providing these services.

It is your responsibility to provide Head and Neck Associates with proof of insurance and an authorization number or referral when applicable. If these items are not provided we ask that you pay in full at the time of service.

The contract between Head and Neck Associates and your health plan, as well as the contract between you and your health plan requires that you make payment in full of all co-payments and deductible amounts deemed to be your responsibility upon claims processing. Additional discounts are forbidden by contract unless financial hardship is documented in writing by the patient.

Our office accepts the following forms of payment: most major credit cards, cash, and personal checks. A $20 service charge will be assessed to your account for any check returned by your bank.

ACKNOWLEDGEMENT OF RECEIPT
NOTICE OF PRIVACY PRACTICES

I hereby acknowledge receipt of the **Notice of Privacy Practices** being adhered to by Head and Neck Associates of Orange County. The Notice of Privacy Practices is supplied in accordance with the Privacy rule that is an integral part of the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

A physical copy of the HIPAA Acknowledgement can be provided upon request.

______________________________	______________________________	______________________________
Printed Patient Name	**Patient Birthdate**	**Date Signed**

______________________________	______________________________
Signature of Patient (Parent if Patient is Minor)	**Relationship to Patient** (If Patient is Minor)