ENT and Allergy Associates of Florida
Caring For Our Patients Since 1963

Dr. Sanford Dolgin
Dr. Warren Goldstein

Excellence in Specialty Care for the Head and Neck ~ A Division of ENT and Allergy Associates of Florida

_____
(Print Patient Name)
D.O.B: _____

Thank you for choosing us for your health care needs. Please complete this patient information packet prior to your arrival. Plan to arrive 30 minutes prior to your appointment time to finalize paperwork and the registration process

- ✓ Bring Healthcare Insurance ID Cards and a picture ID
- ✓ Complete and sign **all** documents, failure to do so will delay your appointment or may need to reschedule.
- ✓ Have your referring physician's office fax pertinent medical records, CT/MRI scan reports and lab testing at least 2 days in advance or bring them with you at time of visit. Bring any CD of your most recent MRI and/or CT scan (if applicable)
- ✓ Your insurance policy may require an authorization and/or referral in order to see us. Make sure your Primary Care Physician faxed the authorization and/or referral information to our office **PRIOR to your appointment date**. Not doing so will require rescheduling your appointment.

While it is our desire to provide you with the best care possible, there are some limitations and restrictions that your managed care or insurance plan may impose which we cannot control. Because of this, there are certain policies and guidelines that we want you to be aware of and agree when dealing with our office as outlined below:

1. Payment is due at time of service: You are responsible for any co-pay, deductible, as well as any unpaid balance on your account prior to receiving medical services. This is part of the contract we (and you) have with your health insurance carrier. If you are not prepared to prepay for co-pays, deductibles, co-insurance, etc., we may ask you to reschedule your appointment. Any balance on your account should be paid within 30 days of receiving treatment.
2. Cancellation policy: We require that you give our office at least 48-hour notice if you need to cancel or reschedule an appointment. For office visits you will be subject to a $35.00 charge, and for all in office procedures and Audiology Testing you will be subject to a $100.00 charge. All surgery cancellations also require at least 5 days notice or you will be subject to a $200.0 charge.
3. We expect that any lab test, x-rays, surgery or other diagnostic exams that we order will be done prior to your follow up appointment. We are not party to or agree with your insurer or managed care plan if they deny authorization or coverage. If your plan denies authorization for our recommendations we ask that you initiate an appeal with them immediately and notify us in writing. If they require a letter from us, we will provide it.
4. Make a follow-up appointment within one week (or next available) after you have done any testing to discuss the results and recommendations. Do not wait for us to call you.
5. Self-pay patients: Discounted rates will be offered for all services paid at time of service.

Brooksville
11373 Cortez Blvd, Suite 408
(Hernando Medical office – Building C)
Brooksville, FL 34613
Phone: 352-688-0800
Fax: 352-462-3277

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Suite 103
Trinity, FL 34655
Phone: 352-593-3277
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6. There will be a charge for any and all medical forms (FMLA, Disability) filled out by this office. As a courtesy, a one-page progress report will be furnished upon request.
7. **"Abuse Free Zone"** – We appreciate and respect our staff. It is our belief that our staff should have a work environment free from verbal and physical abuse. We expect each one of you to treat each one of our staff members as you would like to be treated. Outbursts against our staff will not be tolerated and may result in discharge from the practice.

Signature of Patient, Parent or guarantor:_____Date:_____

Medicare Consent (applies to Medicare beneficiaries ONLY)

I certify that the information given by me in applying for payment under Title XVIII and/or Title XIX, of the Social Security Act, is correct. I authorize any holder of medical or other information about me to release to the social Security Administration or its intermediary carriers, any information needed for this or a related Medicare or Medicaid claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician/audiology services. I understand that I am responsible for my health insurance deductibles and co-insurance.

Patient/ Guardian Signature:_____ Date:_____

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Financial Consent

I hereby authorize said assignee to release all information necessary to secure payment.

I certify that the information given by me for payment by my insurance plan(s) is correct. I authorize any holder of medical or other information about me to release to the above plan or its intermediaries or carriers any information needed for this or any related insurance claim. I request that the payments of authorized benefits be made to ENT and Allergy Associates of Florida, P.A. on my behalf. I assign the benefits payable for medical services to the physician or organization furnishing the services and authorize such physician/organization to submit a claim to the above insurance on my behalf.

I understand that I am financially responsible for all charges whether or not paid by my insurance, including any deductibles, co-pays, and co-insurance, and that payments are due at the time services rendered.

I understand and agree that if I fail to make payment for services rendered to me, my name and account may be turned over to an attorney and/or a 3rd party collection agency and I agree to pay the additional collection fee of 30% of the outstanding amount owed, including any court cost, and/or reasonable attorney fees that may be incurred in the collection of any outstanding balance.

Privacy Consent

I have been provided a copy or access to a copy of the Practice's Notice of Privacy Practices.

Consent for Treatment

I hereby voluntarily consent to outpatient care at ENT and Allergy Associates of Florida, P.A., encompassing routine diagnostic procedures, examination, and medical treatment including, but not limited to, routine laboratory work (such as blood, urine and other studies), endoscopes, CT's, audiology testing, allergy testing and treatment, and administration of medications prescribed by the physician. I understand that the above diagnostic procedures and testing are separate from my office visit and may be subject to deductible and co-insurance.

I further consent to the performance of those diagnostic procedures, examinations and rendering of medical treatment by the physicians and their mid-level providers, including audiologist, medical assistants, or their designees as is necessary in the physician' judgment.

Message Consent

It is our policy to verbally notify you, the patient, of all test results ordered by your care provider and to confirm scheduled appointments. By indicating a response below, you are authorizing our staff to leave a detailed message on your voicemail and/or answering machine. **Please check response: □ Yes □ No**

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PBM Consent

By signing this consent form I am authorizing ENT and Allergy Associates of Florida, P.A. to request and use my prescription medication history from other health care providers and/or third-party pharmacy payors for treatment purposes.

Pharmacy Benefits Managers (PBM) are third party administrators, prescriptions programs, whose primary responsibility is processing and paying prescription drug claims. They also develop and maintain formularies which are lists of dispensable drugs covered by a particular benefit plan.

Appointment Reminders

ENT and Allergy Associates of Florida, P.A. uses a third-party appointment reminder system, to notify patients of their upcoming appointment via email, text message and phone.

Consent Forms Acknowledgement

I, the patient, hereby have read and understand the following:

- Financial Consent
- Privacy Consent
- Consent for Treatment
- PBM Consent
- Message Consent
- Appointment Reminders

Furthermore, I acknowledge I have been given the opportunity to ask questions regarding these Consents.

Patient/ Guardian Signature:_____ Date:_____

I also authorize my Physician and ENT and Allergy Associates of Florida, P.A. to photograph me for medically related documentation purposes. Yes_____ No_____

Signature:_____Date:_____

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Scope Procedure

Please be aware that depending on the nature of your specific medical condition and treatment, your healthcare provider may perform certain in-office procedures (e.g. nasal endoscopy, laryngoscopy) that are not included in the standard office visit.

This is because, as a highly trained specialist, your provider wants to ensure that all appropriate steps are taken to provide you with the absolute best medical care possible. These procedures will be billed separately from your visit charges. Depending on your individual insurance policy and carrier, these procedures may be classified as "surgery" and applied to an in-network deductible. In those cases, the amount allowed for the procedure by your insurer will be due from you.

Please be assured that the physicians of ENT and Allergy Associates of Florida always follow strict billing and coding guidelines, and that all procedures are performed in the best interest of you, our valued patient.

By signing below, you acknowledge that you have read the above and agree and understand.

Patient Name Printed: _____ Date: _____

Patient Signature: _____

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