Anthony C Zamboni, MD
Charles E. Stewart, MD

Date: ______________________

Last Name, First Name, M.I., Date of Birth

Street Address, Apt. #, City, State, Zip Code

Home Phone Number Cell Phone Number Work Phone Number

Social Security Number Gender (Male/Female) Occupation

Responsible Party (if under 18) Responsible Party SS# Responsible Party DOB

Responsible Party Relationship to Patient Mother's Name Father's Name

Referring Physician if Any Family Physician

Person to Contact in Case of Emergency • Phone #'s • Relationship to Patient

In order for us to file a claim with your insurance company, you must completely fill out all insurance information. Your insurance company requires that we have this information.

PRIMARY INSURANCE

Insurance Company Name and Address

ID Number Group Name/Number Employer

Insured's Name Relationship to Patient Insured Social Security # Insured DOB

SECONDARY INSURANCE

Insurance Company Name and Address

ID Number Group Name/Number Employer

Insured's Name Relationship to Patient Insured Social Security # Insured DOB

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AUTHORIZATION TO USE & DISCLOSE HEALTH INFORMATION

I authorize Silver State to request/disclose a copy of the specific health and medical information described below regarding:

Name of Patient: ____Date of Birth:____________________

consisting of items such as; clinical notes, prescriptions, lab results, x-ray results, (please note if the family or friends listed below are able to bring in the patient w/o your presence)

etc.:____

____

Names of family or friends who can call and check on your well-being and/or who can pick-up prescriptions, records, etc. when you are unable to:

Name:____ Phone:________________________

Relationship to Patient:____

Name:____ Phone:________________________

Relationship to Patient:____

or the purpose of Medical Care: We are requesting this Authorization from you for our own use and disclosure to allow another health care provider or health plan to disclose information to us: We cannot condition our provision of services or treatment to you on the receipt of this signed authorization. You may inspect a copy of the protected health information to be used or disclosed. You may refuse to sign this Authorization. We will provide you with a copy of the signed authorization, if requested. You have the right to revoke the Authorization at any time, provided that you do so in writing and except to the extent that we have already used of disclosed the information in reliance on this Authorization. Unless revoked earlier or otherwise indicated, this Authorization will expire in 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

Signature of Patient:____Date:_____________

Signature of Guardian:____Date:_____________

PATIENTS FINANCIAL OFFICE AGREEMENT

Name:____ Date of Birth:____________________

Silver State ENT participates and is contracted on many insurance plans, but not all of them. It is your responsibility to know whether the doctor you are seeing is a participant on your plan. Charges for services rendered by Silver State ENT will be submitted directly to your insurance company for payment, as a courtesy to you. You will be responsible for any amount not paid by your insurance. Should you not have insurance coverage, you will be responsible for payment at the time of your visit. All copays are due at the time of service. If your insurance is subject to co-insurance or deductible, our office will collect a minimum of $20.00 at the time of service. ***Patients should note that not all medical and surgical services are covered by insurance. Patients are directly responsible for such fees. Including services billable in a post-op period. ***Please be aware that you may be subject to additional co-pay by your Insurance Company if you are seen by the Doctor and the Audiologist on the same day. You are responsible for any balance due after your insurance has processed and paid your claim.***It is your responsibility to notify this office of your preferred hospital, lab and radiological facilities, and if prior authorization is required. ***It is your responsibility to make sure your insurance processes and pays your claims in a timely manner. ***No Show and 24 Hour Cancellation policy effective October 1, 2019. A fee of $25.00 will be applied if you no show to your scheduled appointment or do not provide 24 hour notice for a cancellation. This fee must be paid before we will schedule another appointment. New patients will not be scheduled after two consecutive no shows.

I authorize Silver State ENT to release any information acquired during my examination and treatment for the purpose of claim payment. I further authorize payment directly to the physicians for benefits due me for this service. I recognize and accept personal responsibility for any balance remaining after payment of such benefits.

Signature: ____ Date:_____________________

Signature of Guardian:____ Date:_____________________

HIPAA INDIVIDUAL PATIENT AUTHORIZATION

I consent to the use or disclosure of my health information (PHI) by Silver State ENT for the purpose of diagnosing or providing treatment to me, obtaining payment of my healthcare bills or to conduct healthcare operations. I understand that diagnosis or treatment of me by Dr. Zamboni and Dr. Stewart may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations of the practice. Silver State ENT is not required to disclosed to carry out treatment, payment, or healthcare operations of the practice. Silver State ENT is not required to agree to the restrictions I may request; however, if Silver State ENT agrees to a restriction that I request, the restriction is binding on Silver State ENT.

I have the right to revoke this consent, in writing, at any time, except to the extent that Silver State ENT has already made disclosures of my protected health information in reliance upon my prior consent.

My "Protected Health Information" means health information, including my demographic information, collected from me and created or received by my physician, another healthcare provider, a health plan, my employer or healthcare clearinghouse. This protected health information relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Silver State ENT's Notice of Privacy Practices prior to signing this document. This notice will be made available to me in the office at my request. The notice describes the types of uses and disclosure of my protected health information that will occur in my treatment, payment, of my bills or in the performance of healthcare operation of Silver State ENT.

Silver State ENT reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practice by calling Silver State ENT and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

The agreement will remain in effect until the time in which I notify Silver State ENT otherwise.

______________________________ ____________________

Signature Date

Anthony C Zamboni, MD
Charles E. Stewart, MD

REASON FOR TODAY'S VISIT

Name:______________________________________ Date:________________

DOB:________________________ Sex: _______Female _______Male Height:__________

Weight: ________________ O2: ________________ Pulse: ________________

Pharmacy and Location:____

Reason for Today's Visit:____

Name of Medication:	Dosage:	How Often Taken:

ARE YOU ALLERGIC TO ANY MEDICATION? _______Yes _______NO
If Yes, please list below.

Drug Allergies:

Name of Medication:	Dosage:	How Often Taken:

Do you have a history of trouble with anesthesia? _______Yes _________No

Do you have a family history of easy bleeding? _________Yes _________No

Name of Medication Type of Reaction List any surgeries you have had (including dates):

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