

Welcome

J. Michael King, MD
Jonathan C. Mills, MD
Michael Vidas, MD
Catherine C. Weng, MD

Personal Information

Patient's Name _____ Date _____
LAST FIRST

Date of Birth _____ Age _____ SS# _____ DL# _____

Male Female Single Married Divorced Widowed Other _____

Address _____ City _____ State _____ Zip Code _____

Home Phone _____ Work _____ Cell _____

At which phone number do you prefer we contact you? _____

Email Address _____

Occupation _____ Name of Employer _____

In case of emergency, whom should we contact? _____

Relationship to Patient _____ Phone Number _____

How did you hear about us? _____

Pharmacy Information

Preferred Pharmacy Location _____

Is it okay to download your medication history from your insurance company? Yes No

Person Responsible for Payment

Name _____ SS# _____

Address _____ City _____ State _____ Zip Code _____

Home Phone _____ Cell _____ Work _____ Ext _____

Occupation _____ Name of Employer _____

Insurance Information

Primary Health Insurance Company _____

Name of Insured _____ Relationship to Patient _____

Date of Birth _____

Other Health Insurance Company _____

Name of Insured _____ Relationship to Patient _____

Date of Birth _____



Privacy Practices Acknowledgement

I, _____, have received a copy of the Notice of Privacy Practices for Peak ENT and Voice Center. By signing below, I authorize Peak ENT and Voice Center to use or disclose my medical, financial and all other personal health information for the purposes of providing me with treatment, collecting payment for that treatment, consulting with other health care providers with respect to my care, and discussing my information with their staff to accomplish this.

Print Name of Patient or Legal Guardian

Patient's Name

Signature of Patient or Legal Guardian

Date

I authorize Peak ENT and Voice Center to share and discuss my information with the following person:

Name: _____

Relationship: Spouse Parent Child Caregiver Other

At what phone number may we leave a message if we are not able to reach you?

Which means of communication can we use to remind you of your appointments?

Phone

Text Message

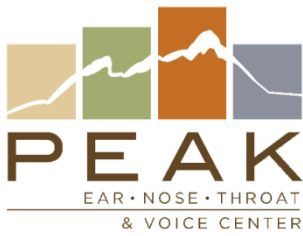
Email

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but this could not be obtained because:

the individual refused to sign communication barriers restricted attaining the written acknowledgement

Other: _____



Notice of Privacy Practices

This notice describes how health information about you (as a patient of Peak ENT and Voice Center) may be used and disclosed, and how you can get access to your personal health information. Please review this notice carefully.

Your Personal Health Information

Peak ENT and Voice Center collects personal health information from you through the application process with our practice, your treatment, and payment and related healthcare operations, as applicable. Your personal health information includes any information--oral, written or recorded--that is created or received by certain health care entities, including health care providers, as well as health insurance companies or plans.

Uses or Disclosures of Your Personal Health Information

In general, we may not use or disclose your personal health information without your permission. Further, once your permission has been obtained, we must use or disclose your personal health information in accordance with the specific terms of that permission. However, there are circumstances that permit us by law to use or disclose your personal health information. These include: providing you with treatment, collecting payment for that treatment, consulting with other health care providers with respect to your care, and discussing your information with our staff to accomplish this. You may revoke your permission to use or disclose any personal health information at any time, except to the extent that we have already taken action in reliance on your authorization.

You have the right to request restrictions on the use or disclosure of your personal health information to family members, relatives, or close personal friends directly relevant to your care or payment of such care. While we are not required to agree to any specified restriction, if we do agree to a restriction, we are required not to use or disclose your personal health information against the terms of your permission, except in certain emergency situations. We will not accept a request to restrict uses or disclosures that would otherwise be required by law.

You have the right to receive and to obtain a copy of confidential communications of your personal health information. We may require written requests and charge a reasonable cost-based fee. We reserve the right to deny you access to and copies of certain personal health information as required by law.

You have the right to request that we amend your personal health information or a record about you contained in your patient chart, for as long as the designated chart is maintained by us. We may require that you provide a written request to support the change in your information. We reserve the right to deny such requests if the information is not part of your patient chart maintained by us, or if it is accurate and complete.

We reserve the right to revise this Notice of Privacy Practices at any time and will provide a revised copy upon request. Please forward a written request to J. Michael King, Privacy Officer at Peak ENT and Voice Center, 403 Summit Blvd. Suite 204, Broomfield, CO 80021.



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PRACTICE POLICIES

1. Our office will file claims with insurance carriers with whom we have contracts; however, **the guarantor is responsible for all fees, regardless of insurance coverage.**
2. Insurance cards are required to bill. No card is no insurance, therefore non-emergency appointments must be rescheduled or the full amount due must be paid at the time of completed services.
3. It is the insured's responsibility to know your health plan and its benefits; some plans do not cover certain procedures. All in-office surgical procedures are not part of your office visit, these procedures are billed separately. Your insurance plan may apply these procedures towards your deductible or co-insurance. Examples of in-office surgical procedures are: ear wax removal, all endoscopy (scopes), biopsies.
4. Co-payments or coinsurance deductibles and payments for non-covered services are required at the time of service, per insurance regulations. A \$20 fee could be assessed if your co-pay is not collected at the time of the appointment.
5. Charges denied for any reason by the EXPLANATION OF BENEFITS of your insurance company are due upon receipt. If you are not in agreement with your insurance company, you must pay for the services rendered and wait for reimbursement from your insurance company. We will be glad to resubmit the claim for you or help you if we can.
6. We accept cash, check, Visa, MasterCard and Discover.
7. A \$25 charge is rendered for all returned checks.
8. Monthly service charge of 1.5% will be applied to accounts over 30 days, with a minimum service charge of \$5. ***New appointments cannot be made until all accounts are brought current.***
9. Accounts more than 90 days past due, may be turned over to a collection agency. Any costs or legal fees to recover due services are also the responsibility of the guarantor.
10. Our office will not become involved in any legal agreements between divorced or separated parents, unless legally required to recover due services. *The parent or guardian, who brings the child in, is responsible for the account.*
11. Patients are seen by appointment only. We will try to accommodate patients without appointments, but there may be long waits without guarantee that they can be seen that day. Patients with appointments will have priority for their time slot.
12. Patients arriving over 10 minutes late may be rescheduled for a later time.
13. Each patient has his or her own appointment. If a brother, sister or parent needs medical attention, a separate appointment (with appropriate co-pay) is required and must be made in advance.
14. Appointments may be rescheduled at any time, due to emergency or unforeseen events. Our office will try to inform you as soon as possible to avoid causing you any inconvenience.
15. **No-show appointments** or appointments cancelled with less than 24 hour notice could **be charged a \$50 fee. A \$100 fee could be assessed for no-show procedure appointments, and/or appointments scheduled for longer than 40 minutes.** Your insurance company will not pay for these charges. These charges must be paid before your next scheduled appointment.
16. Dr. King has financial and ownership interest in Red Rocks Surgery Center.

**Any deviation of the above policies may be altered or waived
with written approval of Peak ENT and Voice Center.**

Printed Name: _____

Signature: _____ Date: _____