



VITALE ENT NEW PATIENT REGISTRATION

Patient Name	Date of Birth	How did you hear about our office?
Patient Address	Patient Phone Number	Preferred Language
Ethnicity/Race	Marital Status: Married Single Divorced Widowed	
Email Address	Primary Care Physician	Pharmacy & Phone Number
EMERGENCY CONTACT (NAME, RELATION, PHONE NUMBER)		

CONSENT TO TREAT

I hereby give my consent to all physicians and healthcare staff of Vitale Institute P.L. to provide medical treatment as deemed necessary.

Release of Information:

I hereby authorize Vitale Institute P.L. and staff to obtain all necessary medical records from other doctors' offices, hospitals, clinics, surgery centers, and laboratories. I hereby give my consent to use my individual identifiable information as needed in the course of routine healthcare operations. I hereby authorize Vitale ENT to release any and all information to secure reimbursement from any insurance company to which I have subscribed.

Assignment of Benefits:

I hereby consent to allow a photocopy of my signature to be valid as the original, in order to process my current and any future Insurance claims. I hereby assign insurance benefits to be paid directly to Vitale Institute P.L.

Signature of Patient or Guarantor: _____ DATE: _____

ASSIGNMENT OF INSURANCE BENEFITS

Your insurance policy is a contract between you and your insurance company. Vitale ENT cannot guarantee payment of your claims. You alone are responsible for negotiating claims with your insurance agency. As a courtesy we will be happy to help you determine coverage you have available. In addition, Vitale ENT will be happy to request referrals/authorizations as needed, but ultimately, is the responsibility of the patient. I hereby assign all medical benefits, to include major medical benefits which I am entitled, private insurance, and any other health plans to Vitale ENT. A photocopy of my insurance card is considered valid and original. I am financially responsible for all charges not paid by insurance or for any charges relating to self-pay. I hereby authorize Vitale ENT to release all information necessary to secure payment. If the insurance pays only a portion of the bill or fails to make payment to Vitale ENT within 120 days, I will be responsible for the balance in full at this time.

Signature of Patient or Guarantor: _____ DATE: _____



NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

As part of your healthcare, this practice originates and maintains paper and/or electronic records describing your health history, symptoms, examinations, test results, diagnosis, and treatment, any plans for future care or treatment and payment for the services we provided. We use this information to:

- Plan your care and treatment
- Communicate with other health professionals or entities who contribute to your healthcare
- Submit your diagnosis and treatment information for payment for the services or treatment provided to you

“ONLY AS PERMITTED OR REQUIRED BY FEDERAL OR STATE LAW”, MAY WE USE YOUR PROTECTED HEALTHCARE INFORMATION TO DO THE FOLLOWING:

- To disclose, as may be necessary, your health information (including HIV+/AIDS status, drug/alcohol abuse notes and qualified mental health notes) to other healthcare providers and healthcare entities (such as: referrals to or consultations with, other healthcare professionals, laboratories, hospitals, etc.) or to others as may be required by law or court order concerning your treatment, payment and/or health care.
- To request from other healthcare entities and/or healthcare providers (i.e. doctors, dentists, hospitals, labs, imaging centers, etc.) specific healthcare information we may need for planning your healthcare and treatment.
- To submit the necessary information to your insurance company(s) for coverage verification as well as the diagnosis and treatment information to your insurance company(s), other agencies and/or individual(s) for payment of our services or treatment provided to you.
- To leave appointment reminders or other minimal necessary information related to your healthcare or healthcare payments on your answering machine, your mobile voicemail or with a household family member.
 - Please check**, if you do NOT want us to leave messages on your answering machine or with household family members.
 - Please check**, if you do NOT want us to leave messages on your cell phone voice mail.
- To discuss your health or payment information (only the minimal necessary in our judgment) with family members or other persons who are or may be involved with your healthcare treatment or payments.
- You may request a copy of our “Notices of Patient Privacy Practices”, at any time that provides a more complete description of health information uses and disclosures as required by the HIPAA standard.
- You have read or have had the right to read the “Notices of Patient Privacy Practices” prior to signing this authorization.

If you choose, please list by name and relationship the persons with whom we may share your healthcare or financial information with (SPOUSE, PARENT, CHILD, ECT):

- **Name:** _____ **Relationship:** _____
- **Name:** _____ **Relationship:** _____

I fully understand and agree to this authorization and acknowledge the above rights and disclosures.

Signature of Patient or Guarantor: _____ **DATE:** _____

APPOINTMENT NO SHOWS

Vitale ENT request that if you need to cancel or reschedule your appointment, you do within the same day as your scheduled appointment. Failure to cancel may result in a **\$50 dollar no show fee**. Office procedures, surgeries, and allergy testing must be cancelled **24 hours prior to appointment**. Failure to do so will result in a **\$100-dollar fee**. *****This fee is not covered by your insurance.*****

Signature of Patient or Guarantor: _____ **DATE:** _____



ARBITRATION AGREEMENT FOR CLAIMS ARISING OUT OF OR RELATED TO MEDICAL CARE AND TREATMENT

ARBITRATION PROCEDURES: The parties agree and recognize that the provisions of Florida Statutes, Chapter 766, governing medical malpractice claims shall apply to the parties and/or claimant(s) in all respects except that at the conclusion of the pre-suit screening period and provided there is no mutual agreement to arbitrate under Florida Statutes, 766.106 or 766.207, the parties and/or claimant(s) shall resolve any claim through arbitration pursuant to this Agreement. Accordingly, any demand for arbitration shall not be made until the conclusion of the pre-suit screening period under Florida Statutes, Chapter 766. Within (20) twenty days after a party to this Agreement has given written notice to the other of a demand for arbitration of said dispute or controversy, the parties to the dispute or controversy shall each have an absolute and unfettered right to appoint an arbitrator of its choice and give notice of such appointment to the other. Within a reasonable time after such notices have been given the two arbitrators so selected shall select a neutral arbitrator and give notice of the selection of the neutral arbitrator. The arbitrators shall hold a hearing within a reasonable time from the date of notice of selection of the neutral arbitrator. The parties agree that the arbitration proceedings are private, not public, and the privacy of the parties and of the arbitration proceedings shall be preserved.

BY SIGNING THIS AGREEMENT, YOU ARE AGREEING TO SETTLE ANY AND ALL DISPUTES OUTSIDE OF COURT WITHOUT A JURY TRIAL. YOU ARE AGREEING TO ARBITRATE CLAIMS ARISING OUT OF OR RELATED TO YOUR MEDICAL CARE AND TREATMENT.

Please see a staff member for further explanation of arbitration agreement

Signature of Patient or Guarantor: _____ **DATE:** _____

OFFICE USE ONLY: Witness: _____ **DATE:** _____

NASAL AND THROAT SCOPE PROCEDURE

A patient presenting to our office with sinus, allergy, throat, or voice complaints requires a thorough examination of that specific area. In some cases, this can only be accomplished through the use of an endoscope. This examination is essentially painless and can be performed quickly.



A procedural fee will be submitted to your insurance carrier for this procedure. We will accept your insurance company's allowance for this procedure. You will be obligated to pay any deductible and/or copayments or coinsurances that are applied to this procedure on the claim. PLEASE NOTE: Some insurance companies may list this diagnostic procedure as "SURGERY" on the remittance advice you receive. Please understand all fees are determined by your insurance company and all patient responsibility fees are based on the contract between you and your insurance company.

By signing below, you acknowledge that you have read the above, agree to the procedure, and understand and accept all charges regarding this procedure

Signature of Patient or Guarantor: _____ **DATE:** _____



MINOR PATIENT CONSENT FORM

INSTRUCTIONS: This form must accompany the patient registration form if the patient is a minor (under the age of 18 years of age). If legal guardian is other than the parent, please provide legal documentation.

Patient Name: _____ **DOB:** _____

Parent/Guardian: _____ **DOB:** _____

Cell: _____ Home: _____ Work: _____

Parent/Guardian: _____ **DOB:** _____

Cell: _____ Home: _____ Work: _____

DECLARATION OF PERSON TO BRING MINOR TO APPOINTMENTS

Vitale ENT requires a parent or legal guardian to be present at the new patient appointment. We feel it is also important for a parent of a minor to attend all follow-up visits but realize this may not be possible. This form may be used to allow a minor patient to receive treatment at our facility without a legal guardian present or an adult other than a parent to serve as a proxy decision maker for routine medical care and services at Vitale ENT. For some families, it may be more convenient to have prior authorization in place that allows routine medical care to be delivered to minors without their legal guardian present. This is important, in that, routine medical care will not be provided to a minor without approval by the parent or legal guardian, unless there is a written consent. This authorization is valid for 1 year or unless written termination from the legal guardian.

Limitations: Identify any specific limitations on the kinds of medical services for which this authorization is given (if none, state "none"). _____

Person authorized to bring minor to appointment:

NAME: _____ **DOB:** _____ **RELATIONSHIP:** _____

PHONE: _____

By signing below, I am authorizing the person above to serve as a proxy decision maker for routine medical care and services. If none, List none in the name section and sign below:

Parent/Legal Guardian Name

Signature

Date

