North Florida Center for Otolaryngology
head & neck surgery
facial plastic surgery, pa

FACIAL rejuvenation CENTRE
PLASTIC SURGERY & MEDICAL SPA
NORTH FLORIDA CENTER FOR FACIAL PLASTIC SURGERY

Towne Centre
FOR DERMATOLOGY

CORT TALIAFERRO, MD DEIRDRE LEAKE, MD SEAN MILLER, MD CHRISTINA BRENNAN, MD IVETTE SOSA, MD

PATIENT INFORMATION			
Patient Name	Date	Sex	Age
Guardian (If patient is a minor)	Date of Birth	Marital Status	
Patient (or Guardian) Social Security Number	Email Address		
Home Phone Number	Cell Phone Number		
Home Address	Mailing Address if Different		
City State Zip	City State Zip		
NOTIFY IN CASE OF EMERGENCY			
Name	Relationship		
Home Phone	Cell Phone		

Please initial: _____ I have received the "Notice of Privacy Practices" for this office

PATIENT RECORD OF DISCLOSURE

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means

I wish to be contacted in the following manner (check all that apply):

Home Telephone: _____
☐ O.K. to leave a message with detailed information
☐ Leave a message with call back number only

Cell phone/other: _____
☐ O.K. to leave a message with detailed information
☐ Leave a message with call back number only

Please complete the following to give your authorization for our office to speak with anyone other than yourself regarding your medical care. If left blank, "I understand that no one other than me (patient) will have the authority to speak with our offices regarding my medical care."

Print Name: _____ Relationship: _____

Print Name: _____ Relationship: _____

Print Name: _____ Relationship: _____

ASSIGNMENT OF INSURANCE BENEFITS

Lifetime Authorization
Medicare: I certify that the information provided by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other pertinent information about me to release to the Social Security Administration or its intermediaries or carriers any information or documentation needed for this or a related Medicare claim. I authorize the physician organization to submit a claim to Medicare on my behalf. I request the payment for services provided be made directly to the physician organization.

I request this authorization to apply to all insurance plans.

Patient Name: _____ Date: _____

Signature: _____

If signed by other than beneficiary, state the reason the patient was unable to sign: _____

_____

FINANCIAL AGREEMENT

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy or your financial responsibility.

A current government-issued photo ID and current insurance card (if requesting us to bill your insurance) must be present at initial visit. Failure to provide either of these may require us to reschedule your appointment. It is our practice policy to photocopy your insurance card(s) and ID for our files.

APPOINTMENTS
24 hour notice must be provided in the event you cannot keep an appointment. Should you not provide this notice, a cancellation fee of $25 will be added to your account at the discretion of each office.

REFERRALS
If your plan requires a referral from your primary care physician, it is your responsibility to obtain it prior to your appointment and have it with you at the time of your visit. If you do not have your referral we will reschedule your appointment.

EXPECTED AMOUNT DUE
By law we must collect your carrier designated co-pay, co-insurance, and/or deductible. This payment is expected at the time of service. Please be prepared to pay the expected amount due at each visit. We bill primary and secondary insurances only, as a courtesy. If we are unable to verify your benefits, then you will be responsible for following up with your insurance.

MEDICARE
We will submit claims to Medicare. You will be responsible for the deductible and the 20% co-insurance, which can be billed to a secondary insurance if you have one.

OUT OF NETWORK PLANS
You will be responsible for any balance your plan indicates as due on their explanation of benefits form. We will adjust the charges to coincide with your plan's UCR (Usual, Customary, and Reasonable) charges. You will be responsible for your co-pay, co-insurance, and deductible. If we do not participate with your plan, we will send a courtesy claim to that carrier on your behalf. However, should they not pay your claim within 45 days; you will be responsible for the full amount due.

SELF PAY PATIENTS
Payment is expected at the time of service unless other financial arrangements have been made prior to your visit.

ENT PROCEDURES
Your insurance company requires that we bill our services to you using a coding system known as CPT (Current Procedural Terminology). Many codes that Otolaryngologists use to describe the services performed are found in the surgery section of the CPT code book. Your insurance may cover the care rendered for these codes differently than for office visits. Therefore, your insurance explanation of benefits may reflect that the service was paid with additional co-insurance or deductible. The nasal endoscopy or scope is an example and is separately payable from the office visit. We encourage every patient to check with your insurance company and verify your benefits.

YOU ARE RESPONSIBLE FOR THE TIMELY PAYMENT OF YOUR ACCOUNT. SHOULD IT BECOME NECESSARY FOR US TO USE AN OUTSIDE AGENCY TO COLLECT PAYMENT FROM YOU, YOU WILL BE ADDITIONALLY RESPONSIBLE FOR WHATEVER CHARGES WE INCUR AS A RESULT OF THIS. WE ACCEPT CASH, CHECKS, AND ALL MAJOR CREDIT CARDS.

INSURANCE INFORMATION		
Insurance Company		Subscriber Name
Insurance ID #	Group #	Subscriber Date of Birth
Secondary Insurance		Subscriber Name
Insurance ID #	Group #	Subscriber Date of Birth

Patient Name: _____ Date of Birth: _____

Patient/Responsible party Signature: _____ Date: _____

Responsible Party Name: _____ Relationship: _____