Benke Ear, Nose & Throat Clinic, P.A.

Personal Information

Today's Date: _____ Account #: _____ SSN: _____

First Name: _____ MI: _____ Last Name: _____

Address: _____

Zip Code: _____ City: _____ State: _____

Date of Birth: _____ Age: _____ Marital Status: _____

Sex: _____ May we leave information on your answering machine or voicemail? ○ Yes ○ No

Primary Phone: (number you wish to be reached at) _____ Other #: _____

Occupation: _____ Work No: _____

Employer: _____ Full Time Student: ○ Yes ○ No

In the event of an emergency please contact:

Name: _____ Relationship: _____ Phone No: _____

Minor Patients: Name of Parent/Guardian _____

Who Referred you? ○Physician ○Family ○Friend ○Phone Book ○Insurance Co. ◉Other _____

Referring Physician's Name: _____ Phone No: _____

Address: _____

Insurance Information:

Please present your insurance card(s) to the receptionist. Please give complete information.

Primary Insurance: _____ Insured's Name: _____

Patient's Relationship to Insured: ○ Self ○Spouse ○Child ○Other

Policy #: _____ Group#: _____

Employer: _____ SSN: _____ DOB: _____

Secondary Insurance: _____ Insured's Name: _____

Patient's Relationship to Insured: ○ Self ○Spouse ○Child ○Other

Policy #: _____ Group #: _____

Employer: _____ SSN: _____ DOB: _____

NOTICE REGARDING INSURANCE CLAIMS/PAYMENTS:

If we are filing insurance for your visit, we must have complete information and any required referral at the time of the visit. If you cannot provide the information, we will be unable to file your insurance, and payment in full will be required.

Payment of your charges cannot be determined until the claim is submitted to your insurance company. Payment will be based on your individual health plan, and the amount applied to your plan deductible and/or coinsurance will be your responsibility. Procedures which are excluded from coverage, based on your plan's determination of medical necessity, will also by your responsibility. Your office visit co-pay is due at the time of the visit and, in many cases, covers only the office visit charge. Any procedures performed will be considered surgery by your insurance company, and deductibles and coinsurance may apply.

For all other patients, payment is required at the time of service. We will provide you with the necessary documentation to file for reimbursement upon your request.

I have read the above information and understand that I am responsible for payment for services I receive.

Patient/Guardian Signature: _____ **Date:** _____

In accordance with privacy policies Benke ENT clinic must have written authorization to release any medical information to any persons other than parent(s) or legal guardian(s) of minors. This includes appointment information, financial information, and medical info.

RELEASE OF MEDICAL INFORMATION

I, _____, authorize BENKE EAR NOSE & THROAT CLINIC, P. A. to release information regarding my medical care to the following persons

_____	_____
Name	Relationship
_____	_____
Name	Relationship
_____	_____
Name	Relationship

X

SIGNATURE OF PATIENT OR GUARDIAN **DATE**

OR sign below if you DO NOT want your medical information shared.

☐ I DO NOT authorize release of medical information to anyone other than myself.

X

SIGNATURE OF PATIENT OR GUARDIAN **DATE**

ACKNOWLEDGEMENT OF FINANCIAL POLICY

I HAVE READ AND UNDERSTAND THE FINANCIAL POLICY OF BENKE EAR, NOSE & THROAT CLINIC, P.A.

X

SIGNATURE OF PATIENT OR GUARDIAN **DATE**

CANCELLATION POLICY

Benke Ear, Nose & Throat Clinic will charge a patient $50.00 when the patient fails to cancel a scheduled appointment in LESS than 24 hours before the patient's scheduled appointment time.
There will be no exceptions to this policy unless an emergency has occurred. Thank you for abiding to our office policy.

X

SIGNATURE OF PATIENT OR GUARDIAN **DATE**

I authorize Benke ENT Clinic to send communications via electronic or direct mail regarding special events, products, or services relevant to me.

X

SIGNATURE OF PATIENT OR GUARDIAN/DATE **E-MAIL**

Benke Ear Nose and Throat
PATIENT HEALTH HISTORY

Please fill out every item:

Patient's Last Name _____ **First** _____ **MI** _____

Sex ◯Male ◯Female **Date of Birth:** _____ **Age:** _____

Name of Primary Care Physician and/or Referring: _____

Pharmacy Preference (include location): _____

REASON FOR TODAY'S VISIT: _____

Who is accompanying the patient to this appointment? _____

Do you currently wear or have you ever worn hearing aids? _____

Where did you purchase your devices: _____

Are your devices working well for you? If not, please explain:_____

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING INCLUDING ALL BLOOD THINNERS ie: Aspirin, Plavix, Coumadin and NSAIDS (USE BACK IF NECESSARY)

Name of Medication	Dosage	How Often Taken

ARE YOU ALLERGIC TO ANY MEDICATION? ◯ **Yes** ◯ **No.** If yes, please list below:

Name of Medication	Type of Reaction

DO YOU HAVE ANY NON-MED ALLERGIES? ie: Latex, Tape, Dye_____

Have you been to the ER or recently hospitalized for ASTHMA and/or allergic reaction related problems:

_____

Have you ever had any problems with general or local anesthesia? ◯ Yes ◯ No

If yes, please list type of problems: _____

CLINICAL STAFF USE ONLY: **Height**_____ **Weight**_____ **BP**_____/_____**Pulse:**_____

Past Medical Hx reviewed: yes____ no____

Past Hx surgical Hx:_____

_____

Last flu vaccine given: _____ patient declined: _____ (over 65) last pneumonia vaccine: _____

COVID Vaccine:_____ Booster:_____ patient declined:_____

Tobacco use:_____ Current/Previous:_____ Stopped:_____

ETOH use: _____ Frequency: _____ x day/week/month

BENKE EAR NOSE AND THROAT CLINIC
TELEMEDICINE INFORMED CONSENT

Telemedicine services involve the use of secure interactive videoconferencing equipment and devices that enable health care providers to deliver health care services to patients when located at different sites.

1. I understand that the same standard of care applies to a telemedicine visit as applies to an in-person visit.
2. I understand that I will not be physically in the same room as my health care provider. I will be notified of and my consent obtained for anyone other than my healthcare provider present in the room.
3. I understand that there are potential risks to using technology, including service interruptions, interception, and technical difficulties.
    a. If it is determined that the videoconferencing equipment and/or connection is not adequate, I understand that my health care provider or I may discontinue the telemedicine visit and make other arrangements to continue the visit.
4. I understand that I have the right to refuse to participate or decide to stop participating in a telemedicine visit, and that my refusal will be documented in my medical record. I also understand that my refusal will not affect my right to future care or treatment.
    a. I may revoke my right at any time by contacting Benke Ear, Nose and Throat Clinic at 817-641-3750.
5. I understand that the laws that protect privacy and the confidentiality of health care information apply to telemedicine services.
6. I understand that my health care information may be shared with other individuals for scheduling and billing purposes.
    a. I understand that my insurance carrier will have access to my medical records for quality review/audit.
    b. I understand that I will be responsible for any out-of-pocket costs such as copayments or coinsurances that apply to my telemedicine visit.
    c. I understand that health plan payment policies for telemedicine visits may be different from policies for in-person visits.
7. I understand that this document will become a part of my medical record.

By signing this form, I attest that I (1) have personally read this form (or had it explained to me) and fully understand and agree to its contents; (2) have had my questions answered to my satisfaction, and the risks, benefits, and alternatives to telemedicine visits shared with me in a language I understand; and (3) am located in the state of Texas and will be in Texas during my telemedicine visit(s).

_____ _____

Patient/Parent/Guardian Printed Name Patient/Parent/Guardian Signature

_____ _____

Witness Signature Date

BENKE
EAR NOSE & THROAT
CLINIC

FINANCIAL POLICY

Payment is due at the time services are rendered – this includes co-pays, co-insurance and deductibles. The patient will be responsible for non-covered services.

We accept payment by cash, personal check, MasterCard, Visa, and Discover. All returned checks will be subject to a $25.00 returned check fee due immediately from the patient or responsible party.

Self Pay: New patients should be prepared to pay $190.00 to $370.00 for the first visit. There will be an additional fee for any procedure or diagnostic testing. (example: hearing test, cerumen removal, etc.)

HMO and PPO: Patients covered by a Health Maintenance Organization (HMO) or Participating Provider Organization(PPO), of which Benke Ear, Nose & Throat Clinic is a participant, must bring the HMO/PPO card and be prepared to pay the CONTRACT CO-PAY AMOUNT at the time of service. Also, the patient is responsible for any referral required from the patient's PCP required by the insurance company.

MEDICARE: We accept assignment on all Medicare Claims. Patients covered by MEDICARE PART B must bring their Medicare card. We will also file MEDICARE SUPPLEMENT claims. We do not accept Medicare or any Medicare replacement with Medicaid as a supplement.

MEDICAID AND MANAGED CARE MEDICAID: We accept Medicaid for children up to 18 years of age only. We DO NOT accept Medicaid as a secondary insurance. The Medicaid managed care plans that we currently accept are the Cooks, Superior, and Molina Health plans.

WE WILL FILE PRIVATE INSURANCE CLAIMS AS A COURTESY TO OUR PATIENTS. If you wish us to file for you, please bring your insurance card and proper photo identification to your first visit so we may verify your coverage. Payment for the UNINSURED PORTION is due at the time services are rendered. This includes DEDUCTIBLE and COINSURANCE as verified by the insurance carrier. Due to the large amount of insurance policies we accept, it is the member's responsibility to ensure that Dr. Benke is a contracted **in-network** physician with your insurance. Any cost incurred due to out of network deductibles and/or coinsurance will be the member's responsibility. Your Insurance Policy is a contract between you and your Insurance carrier. We are not a party to the contract. As medical care providers, our relationship is with you not your Insurance Carrier. Not all services are a covered benefit in all policies. Some insurance carriers select services that will not be covered. We recommend you inform yourself of any policy exclusions. THE PATIENT WILL BE RESPONSIBLE FOR NON-COVERED SERVICES.

UNCOLLECTED/PAST DUE BALANCES AND FEES: We make every effort to **estimate** your patient portions according to your health plan. However, it is becoming increasingly difficult to ask enough questions to find out every limitation, exclusion and percentage on the many insurance plans we see. This can sometimes result in additional amounts due after your claim has been paid. You will receive a statement if there is any remaining balance after your insurance has paid. Any balances not paid after 60 days will acquire an additional "collections" fee and will be forwarded to a collection agency for further action.

*****OUR OFFICE POLICY REGARDING DIVORCED PARENTS – THE PARENT BRINGING THE CHILD TO OUR OFFICE IS RESPONSIBLE FOR PAYMENT AT THE TIME SERVICES ARE RENDERED. WE DO NOT COLLECT PAYMENTS FROM BOTH PARENTS. OUR OFFICE WILL PROVIDE THE PARENT A RECEIPT OF PAYMENT AT CHECKOUT*****

Our fees fall within the reasonable, usual and customary range considered by most carriers.
You may request a copy of this policy from the receptionist

BENKE EAR NOSE & THROAT CLINIC PA

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 09/23/2013, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law, and to make the new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care of Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

Required by Law. We may use or disclose your health information when we are required to do so by law.

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

National Security. We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody to protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPPA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit of a dispute, we may disclose your PHI in response to a court of administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

OTHER USES AND DISCLOSURES OF PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

YOUR HEALTH INFORMATION RIGHTS

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of our health information, you must submit your request in writing to the Privacy Official. If you request this accounting more than once in a 12-month period, we may charge you a reasonable cost-based fee for responding to the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. **We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment** or health care operations, and the information pertain solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location of your request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

Amendment. You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (email).

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or if you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you chose to file a complaint with us or with the U.S. Department of Health and Human Services.

Our Privacy Official: Sarah Wallace

Telephone: (817) 641-3750 Fax: (817) 641-3754

1317 Glenwood Drive, Cleburne, TX 76033