St. Joseph's/Candler

Physician Network
Ear, Nose & Throat

Welcome to our practice. We appreciate the opportunity to take care of your healthcare needs, and we look forward to serving you. Your health is our primary concern. Our philosophy is to provide comprehensive care while treating every patient with dignity and respect. We offer a wide variety of services and preventive programs to address your physical wellbeing.

In order to expedite the new patient registration process, we ask that you complete the enclosed *New Patient Registration Forms* and bring with you to your appointment. Please do not mail forms to the practice. Completing this information ahead of time allows us to see you in a timely manner upon your arrival at our office and ensures we have the information necessary to fully address your healthcare needs.

In addition, please bring the following items with you:

- A photo ID,
- Your insurance card(s),
- Your copayment (if required by your plan), and
- A complete list of all medications you are currently taking.

Should you need to reschedule or cancel your appointment, please call us at least twenty-four hours in advance at to allow us the courtesy of offering your spot to another patient.

Thank you for choosing St. Joseph's/Candler Physician Network for your healthcare needs.

Patient Registration Form

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PATIENT INFORMATION

Last Name	First Name	M	Preferred Name

Mailing Address	City	State	Zip Code

Home Phone	Cell Phone	Work Phone	Birthdate	Gender at Birth ☐ Male ☐ Female

Preferred communication preference for appts, Rx refills, & test results ☐ Voice ☐ Text ☐ Both	Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed	Social Sec Number

Employer Name	Occupation/Job Title	☐ Full-time ☐ Part-time

Employer Address	City	State	Zip Code

GUARANTOR INFORMATION

Last Name	First Name	M	Relationship to Patient

Address	City	State	Zip Code

Home Phone	Cell Phone	Birthdate	Social Sec Number

EMERGENCY CONTACT

Patient Relationship to Insured: ☐ Spouse ☐ Parent ☐ Child ☐ Other_____	Last Name	First Name	M

Address	City	State	Zip Code

Home Phone	Cell Phone	Work Phone

PRIMARY INSURANCE ☐ SELF PAY (not insured)

Primary Insurance Company	Policy ID Number #

Coverage Start Date	Subscriber/Insured Name	Patient Relationship to Insured: ☐ Spouse ☐ Parent ☐ Child ☐ Other_____

Group Number #	Group Name	Subscriber Date of Birth	Subscriber Social Sec Number

SECONDARY INSURANCE

Secondary Insurance Company	Policy ID Number #

Coverage Start Date	Subscriber/Insured Name	Patient Relationship to Insured: ☐ Spouse ☐ Parent ☐ Child ☐ Other_____

Group Number #	Group Name	Subscriber Date of Birth	Subscriber Social Sec Number

RX HISTORY CONSENT AND ADVANCE DIRECTIVE

Indicate whether you consent for your provider to view your prescription history from external sources: ☐ Yes ☐ No	Advance Directive protects your right to refuse medical treatment: Do you have an Advance Directive? ☐ Yes ☐ No

Patient Registration Form (page 2 of 2)

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PATIENT PORTAL

You can access your health information via our secure patient portal. You can choose not to, but we strongly **recommend that you NOT opt out**. ☐ Opt Out	Email Address (Required for portal access):

ADDITIONAL INFORMATION

Race: ☐ Asian ☐ Black ☐ Hispanic ☐ White ☐ Decline ☐ Other	Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Decline	Language: ☐ English ☐ Spanish ☐ Sign Lang ☐ Decline ☐ Other

PRIMARY CARE PROVIDER INFORMATION

Primary Care "PCP" Name	Date of Last Visit	Referred By

IF A PREFERRED FACILITY IS NOT SELECTED BELOW, ALL TESTS WILL BE SENT TO AN AFFILIATE/ SUBSIDIARY OF ST JOSEPHS/CANDLER HEALTH SYSTEM. PATIENT MAY BE RESPONSIBLE FOR PAYMENT

Preferred Lab: ☐ St. Joseph's/Candler ☐ LabCorp ☐ Quest Diagnostics ☐ Other _____	Preferred X-ray/Imaging: ☐ St. Joseph's/Candler ☐ Other_____	Preferred Hospital: ☐ St. Joseph's Hospital ☐ Candler Hospital ☐ Other _____

PHARMACY INFORMATION

Pharmacy Name (Primary)	Phone	Fax	
Address	City	State	Zip Code

MAIL ORDER PHARMACY INFORMATION (If N/A check here ☐)

Mail Order Pharmacy Name	Phone	Fax	
Address	City	State	Zip Code

AUTHORIZATION TO TREAT, OBTAIN MEDICATION HISTORY, & ASSIGNMENT OF BENEFITS

I do hereby consent to and authorize the performance of all treatments, surgeries, and medical services deemed advisable by the health care providers and staff of Candler ENT Practice, LLC to me, or to the above-named minor, of whom I am the parent or legal guardian; this includes obtaining medication history. I hereby certify that, to the best of my knowledge, all statements contained hereon are true.

I request that payment of authorized benefits be made to Candler ENT Practice, LLC and authorize Candler ENT Practice, LLC to release any medical information to my insurance carrier or third-party payer to facilitate processing my insurance claims. I understand that failure to pay outstanding balances within 90 days of notification of the amount due will result in submission to an outside collection agency.

Patient's Initials _____

I acknowledge I have received and understand the Notice of Privacy Practices, which describes how the practice uses and discloses health information.

Patient's Initials _____

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HIPAA Authorization for Release of Health Information

I hereby authorize Candler ENT Practice, LLC to release information from the health records of:

Patient Name: _____ DOB: _____ SSN: _____

TO:

FIRST AND LAST NAME	RELATIONSHIP	DATE OF BIRTH	PHONE NUMBER

INFORMATION ABLE TO BE RELEASED

☐ Entire Record	☐ Lab Results	☐ Nursing Notes	☐ Demographics
☐ Emergency Room Notes	☐ Radiological Results	☐ Physician Orders	☐ Medication Records

FOR THE PURPOSE OF

- ☐ Anything on behalf of the patient
- ☐ Creating/Changing/Canceling appointments
- ☐ View or correct demographic information to include signing in on my behalf
- ☐ Receive documents containing my PHI (Protected Health Information) on my behalf with an authorization for release of information signed by me
- ☐ Picking up prescriptions/forms and or medications on my behalf.
- ☐ Speaking to Candler ENT Practice, LLC staff regarding my PHI including but not limited to billing and insurance information on my behalf.
- ☐ Other: _____

I understand that I can revoke this authorization by providing written notice to the Health Information Department of Candler ENT Practice, LLC or in a manner described in the Notice of Privacy Practices. I also understand that if the information has been released by relying upon this Authorization, that revocation will not be valid.

I PLACE NO LIMITATIONS ON HISTORY OF ILLNESS OR DIAGNOSTIC AND THERAPEUTIC INFORMATION, INCLUDING ANY TREATMENT FOR ALCOHOL, DRUG ABUSE OR DEPENDENCY, PSYCHIATRIC OR PSYCHOLOGICAL ILLNESS, MENTAL ILLNESS OR RETARDATION AND ACQUIRED IMMUNE DEFICIENCY (AIDS) SYNDROME.

The physician's office listed above may not condition treatment, payment, on the signing of this authorization, unless allowed by law. I understand that I am waiving my rights to privacy by releasing my medical information to the parties listed above and this information may be re-disclosed by the receiving party. I hereby authorize the entity listed above to release the said information described above. I understand that this Release of Information will expire within ONE (1) YEAR from the date listed below.

PLEASE PRINT YOUR NAME AND SIGN BELOW:

_____ _____

Printed Name **Date**

_____ _____

Signature of Patient or Personal Representative **Relationship**

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Financial Agreement and Office Policies

APPOINTMENTS

We believe that our patient's time is valuable and every effort is made to keep your waiting time to a minimum. If you are unable to keep your appointment, please notify the office as soon as possible. This courtesy allows us to give appointments to another patient. If you do not cancel your appointment 24 hours prior to the scheduled appointment time a No-Show fee will be charged to your account. If you have 3 or more No Shows within a 12-month period you could be discharged from the practice.

FINANCIAL POLICY

- Your Insurance Card(s) and a picture ID will need to be presented each time you visit our practice to assure we have the most recent information. If an insurance card is not provided, payment for services will be collected prior to being seen.
- Co-payments must be paid prior to seeing the health care provider on the date service is rendered. Self-pay and uninsured patients will be required to pay a deposit prior to being seen. Patients are responsible for their deductibles or charges not reimbursed by insurance.
- It is understood that returned checks made payable to this office for insufficient funds, stop payments or other reason for non-payment will be assessed a $30.00 NSF fee for which the patient will be held responsible.
- Patients with no financial ability to pay St. Joseph's/Candler charges will be screened for eligibility under Medicaid and other state programs and/or evaluated against established guidelines for financial assistance.

PATIENT PORTAL

The patient portal allows patients to manage their personal health information at their own convenience. You will be able to securely and confidentially exchange non-emergent messages with our practice, request prescription refills, request and keep track of appointments, view referrals to specialists, view lab and imaging results and update your contact information.

PRESCRIPTION REFILLS

Please contact your pharmacy directly for more expedient prescription refills. Please allow your pharmacy up to 48 hours to process your refill request. Note that prescriptions will not be refilled after hours, on weekends, or holidays. Some prescriptions cannot be refilled if you have not seen your health care provider within the last 3-6 months. If you have mail service prescriptions, please allow 7-10 business days for the necessary forms to be completed.

TEST RESULTS

You must have an appointment for lab tests and a lab order from your provider. Your health care provider will review your test results and notify you via voice message, letter, or message sent to your patient portal. If you have not heard from us within 7 days, please contact the office.

REFERRALS AND PRIOR AUTHORIZATIONS

Most insurance plans require a patient to be seen by their primary care provider prior to seeing a specialist. If your insurance plan requires a prior authorization you must verify your insurance has approved the visit before seeing the specialist. Otherwise, you will be responsible for any incurred charges.

CONSENT TO USE PHOTOGRAPH AND DOCUMENTATION AIDS

I understand and consent to photographs, video, digital media, and other images being made or recorded to document clinical notes and/or assist with my care. I further consent to the use of such materials for Candler ENT Practice, LLC **internal** purposes including, but not limited to, patient identification, treatment, training, performance improvement, and/or educational purposes. I understand that the Candler ENT Practice, LLC will retain ownership rights to these materials, but that I will be allowed to view them or obtain copies at a reasonable cost.

MEDICAL RECORDS

Please note that requests for any health information cannot be processed without a signed medical record release from the patient or legal representative. Please allow up to 7 business days for your request to be processed. A fee may be charged for this service.

PLEASE PRINT YOUR NAME AND SIGN BELOW:

_____	_____
Printed Name	**Date**
_____	_____
Signature of Patient or Personal Representative	**Relationship**

Joint Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. PLEASE REVIEW IT CAREFULLY.

St. Joseph's/Candler Health System is committed to protecting the privacy and safeguarding the security of your protected health information. This Joint Notice describes the privacy practices of SJ/C and each of the SJ/C entities that participate in our "organized health care arrangement" (collectively referred to herein as "SJ/C" or "We"), including without limitation St. Joseph's Hospital, Candler Hospital, each Hospital's Medical Staff, our affiliated physician practices and Hospital Based Physician Practices providing services in Anesthesiology, Radiology, Pathology, the Emergency Rooms and Hospitalists. Each of the SJ/C providers that comprise the organized health care arrangement are presenting this document as their joint Notice of Privacy Practices. SJ/C providers that participate in the organized health care arrangement may share medical information with each other for treatment, payment, or health care operations as described in this Notice.

SJ/C is committed to protecting the privacy of your identifiable health information, known as "protected health information" or "PHI." We are required by law to provide you with you with this joint Notice of our legal duties and privacy practices regarding PHI and to abide by the terms of the Notice currently in effect.

How we may use or disclose your health information

FOR TREATMENT. We may use and disclose your PHI for medical treatment or services. SJ/C uses or discloses your PHI to healthcare professionals, who require access to your PHI for treatment. For example, your PHI may be disclosed to facilities and providers not affiliated with SJ/C that are involved in your treatment.

FOR PAYMENT**.** We may use and disclose your health information to others for purposes of receiving payment for treatment and services that you receive. For example, a bill may be sent to you or a third-party payor, such as an insurance company or health plan. The information on the bill may contain information that identifies you, your diagnosis and treatment or supplies used in the course of treatment.

FOR HEALTH CARE OPERATIONS**.** We may use and disclose health information about you for operational purposes. For example, your health information may be disclosed to members of the medical staff, risk or quality improvement personnel and others to: evaluate the performance of our staff; assess the quality of care and outcomes in your case and similar cases; learn how to improve our facilities and services; and determine how to continually improve the quality and effectiveness of the healthcare we provide. This includes sending information to a third-party to conduct research on patient satisfaction and effectiveness of the services performed.

APPOINTMENTS**.** We may use your information to provide appointment reminders or information about treatment alternatives other health-related benefits and services that may be of interest to you.

FUNDRAISING. We may use limited PHI to contact you regarding charitable support or communications about SJ/C or its affiliates. All charitable support will be used to improve the healthcare services, expand patient programs and purchase state-of-the-art technology for SJ/C. You have the right to opt out of such fundraising communications at any time. If you sign an authorization form for any purpose, you may revoke it, in writing, at any time, except to the extent that action has been taken in reliance on the authorization.

REQUIRED BY LAW. We may use and disclose information about you as required by law. For example, SJ/C may disclose information for the following purposes: for judicial and administrative proceedings pursuant to legal authority; to report information related to victims of abuse, neglect or domestic violence; and to assist law enforcement officials in their law enforcement duties.

Public Health. Your health information may be used or disclosed for public health activities such as assisting public health authorities or other legal authorities to prevent or control disease, injury, or disability, or for other health oversight activities. These oversight activities include, for example, audits, investigations, inspections and licensure. These activities are necessary for the government to monitor the health care system, government programs and compliance with civil rights laws.

RESEARCH. We may use your health information for research purposes as allowed by law. The Institutional Review Board will review the research proposal and established protocols to ensure the privacy of your health information.

HEALTH AND SAFETY. Your health information may be disclosed if there is a potential serious threat to the health or safety of you or any other person as allowed by law.

HEALTH INFORMATION EXCHANGE (HIE). We may participate in certain HIEs in which your PHI is electronically shared in a secure and confidential manner with other health care providers involved in your care. Participation in the HIE is voluntary and you may elect to opt-out. If you choose to not participate in an HIE, your PHI will not be available for access through such HIE; however, it may remain available for access through other mechanisms if permitted or required by applicable law.

INDIVIDUALS INVOLVED IN YOUR CARE. We may release health information about you to a friend or family member who is involved in your medical care or payment for your care or to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

FACILITY DIRECTORY PURPOSES. We may include certain limited information about you in a facility directory while you are a patient, such as your name, location in the facility, general condition (e.g., fair) unless you object to us doing so.

ADDITIONAL USES AND DISCLOSURES. As permitted by law, we may disclose your PHI to organ and tissue donor organizations, correctional institutions, coroners, medical examiners and funeral directors, workers compensation agents, or military command or national security authorities.

OTHER USES. Other uses and disclosures will be made only with your written authorization and you may revoke the authorization except to the extent SJ/C has taken action in reliance on such.

YOUR RIGHTS TO PRIVACY:

- You have the right to request a restriction on certain uses and disclosures of your information. However, the organizations listed above are not required to agree to a requested restriction.
- You have the right to obtain a paper copy of the Notice of Privacy Practices upon request to the Privacy Official or a member of the organization.
- You have the right to inspect and obtain a copy of your health record as allowed by state and federal regulations.
- You may also request an amendment to your health record as allowed by state and federal regulations.
- You may also request communications of your health information by alternative means or at alternative locations. For example, by sending information to a P.O. Box instead of your home address.
- You may revoke your Authorization to use or disclose health information except to the extent that action has already been taken by providing written notice to the Health Information Management Department at SJ/C, 5353 Reynolds Street, Savannah, Georgia 31405.
- You may also receive an accounting of disclosures made of your health information as provided by federal regulations by sending a written request to the Health Information Management Department at the address listed above.
- If you have a concern or complaint about your privacy rights, you may direct the concern or complaint in writing
  to: *St. Joseph's/Candler Privacy Official*
  5353 Reynolds Street
  Savannah, Georgia 31405 (912) 819-5290

You may also contact the Department of Health and Human Services, if you believe your privacy rights have been violated. You will not be retaliated against for filing a complaint.

OUR OBLIGATIONS UNDER THIS JOINT NOTICE.
We are required by law to maintain the privacy of protected health information and to provide you with a Notice of our legal duties and privacy practices with respect to the protected health information.

CHANGES TO THIS NOTICE.
We reserve the right to change this Notice, and to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. If this notice is revised or changed, we will post the current Notice with its effective date. An up-to-date copy of this Notice is available electronically on our websites. You are entitled to a copy of the Notice currently in effect.

COMMUNICATIONS.
Please note that as communications over the internet can be intercepted, e-mail and text messaging may not be a secure method of transmitting information. By providing us with your email address or mobile phone number, you understand these risks and consent to us communicating with you via e-mail or text message about your treatment or payment for your care.

Effective Date: April 14, 2003
Last Revised: December 2023

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Patient Consent to Contact

By providing a telephone number, I expressly consent and authorize Candler ENT Practice, LLC , any practitioner or clinical provider as well as any of their related entities, agents, or contractors including but not limited to schedulers, marketers, advertisers, debt collectors, and other contracted staff (collectively referred to herein as "Provider") to contact me through the use of any dialing equipment (including a dialer, automatic telephone dialing system, and/or interactive voice recognition system) and/or artificial or prerecorded voice or message. I expressly agree that such automated calls may be made to any telephone number (including numbers assigned to any cellular or other service for which I may be charged for the call) used by or associated with me and obtained through any source including but not limited to any number I am providing today, have provided previously, or may provide in the future in connection with the medical goods and services and/or my account. By providing this express consent, I specifically waive any claim I may have to the making of such calls, including any claim under federal or state law and specifically any claim under the Telephone Consume, Protection Act, 47 U.S.C. § 227. By providing a telephone number, I represent that I am the subscriber or owner or have the authority to use and provide consent to call the number.

By providing a telephone number I expressly consent to the receipt of text messages from Provider at any telephone number (including numbers assigned to any cellular or other service for which I may be charged for the call) used by or associated with me and obtained through any source including but not limited to any number I have provided previously or may provide in the future in connection with my account. By providing this express consent, I specifically waive any claim I may have for the making of such calls, including any claim under federal or state law and specifically and claim under the Telephone Consumer Protection Act, 47 U.S.C. § 227. By providing a telephone number, I represent that I am the subscriber or owner or have the authority to use and provide consent to call the number.

By providing my email address now or at any time in the future in connection with the medical goods and services provided and/or my account, I expressly opt-in to the receipt of email communications from Provider for or related to the medical goods or services provided, my account, and other services such as financial, clinical, and education information including exchange news, changes to health care law, health care coverage, care follow-up, and other health care opportunities, goods, and services. By providing this express consent, I specifically waive any claim I may have for the sending of such emails, including any claim under federal or state, and specifically any claim under the CAN-SPAM Act. 15 U.S.C. § 7701, et seq. By providing an email address, I represent that I am the subscriber or owner or have the authority to use and provide consent to contact the email address.

I understand that providing a telephone number and/or email address is not a condition of receiving medical services. I also understand that I may revoke my consent to contact at any time by directly contacting Provider or using the opt-out method that will be identified in the applicable communication. I also understand that it is my responsibility to notify Provider immediately of any change in telephone number or email address.

PLEASE PRINT YOUR NAME AND SIGN BELOW:

_____	_____
Printed Name	**Date**
_____	_____
Signature of Patient or Personal Representative	**Relationship**