Date: ____________________

Patient Registration

Patient Name: ______________________________ Date of Birth ____________

Age ________ Male _____ Female _____

Address ______________________________ City ______________ St _____ Zip ______

Home/Cell Phone ______________________ Social Security # ____________________

Patient Employer ______________________ Employer Phone ____________________

Spouse Name ______________________ Date of Birth ____________________

Emergency Contact Name and Phone ______________________________________

Marital Status S M D W

Primary Insurance Information

Ins Co Name ______________________ ID # ______________________

Group # ______________________ Name & Address of **Policy Holder** ______________________

______________________ City ______________ St. _______ Zip _______

****Responsible Party or Policy Holder DOB** ______________________

Secondary Insurance Information

Ins Co Name ______________________ ID # ______________________

Group # ______________________ Name & Address of Policy Holder ______________________

______________________ City ______________ St. _______ Zip _______

****Responsible Party or Policy Holder DOB** ______________________

Medical Information

Primary Doctor ______________________ Phone ______________ Fax ______________

Current Medications ____

____

Drug Allergies ____

Have you been hospitalized in the past 5 yrs ______________________________

Recent Labs, Xray, CT or MRI ______________________ Smoke ________ Alcohol ________

Reason for today's visit ____

Patient Name ____ Date ____________________

Review of Systems - Circle All That Apply

Constitutional:

Good Health

Recent weight gain

Recent weight loss

Stroke/TIA

ENT:

Sinus issues

Sinus infections

Nasal Allergies

Nasal polyps

Hearing loss

Tinnitus

Difficulty Swallowing

Sore Throat

Cardiovascular:

HBP

Heart attack (s)

Pacemaker

CAD

A-Fib

High Cholesterol

CHF

Immunologic/Infectious Disease:

HIV/AIDS

TB

Hepatitis

RA/ Lupus

Autoimmune Disorder

History of MRSA

Gastrointestinal:

GERD

IBS/Colitis

Crohns Disease

Endocrine:

Diabetes 1/ 2

Thyroid Disease

Musculoskeletal:

Arthritis

Fibromyalgia

Back Pain

Gout

Neurological

Parkinson's disease

Migraine Syndrome

Seizure Disorder

Tremors

Respiratory:

Asthma

SOB

Chronic cough

Sleep Apnea

Eyes:

Dry eye

Glasses/Contacts

Thyroid eye disease

Double vision

Glaucoma

Macular degeneration

Psychological:

Bipolar Disorder

Depression

Anxiety

ADHD

ADD

Memory loss/confusion

Alfred N. Carr, M.D. & Colorado Hearing Tinnitus and Balance

Medical Information Distribution / Release

2030 Mountain View Avenue
Suite 500
Longmont, Colorado 80501

Kit Carson Memorial Hospital
286 16th Avenue
Burlington, Colorado 80807

Please list the family member or other person, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operations).

Name | Phone Number

Please list the family member, or significant others, if any, whom we may inform about your medical condition **only in an emergency**

Name | Phone Number

Please print the address of where you would like your billing statements and / or correspondence from our office sent if other than you home address.

Please print the telephone number where you want to receive calls about your appointments, and other health care information if other than your home. Phone Number

Please indicate if you want all correspondence from our office sent in a sealed envelope marked ' Confidential '. ○Yes ○No

Can confidential messages (i.e. appointment reminders) be left on your voice-mail ? ○Yes ○No

I consent to receiving direct mail updates including but not limited to: clinic service notifications, health notifications, marketing or promotional events (such as educational seminars, free battery giveaways, etc.), and any other service or product updates that could benefit me or help to improve my health. ○Yes ○No

Signature of Patient or Patient's Representative | Print Name | Date

Alfred N. Carr, M.D. : 303 - 772 - 3204

Colorado Hearing Tinnitus and Balance (Longmont) : 303 - 776 - 7770
Colorado Hearing Tinnitus and Balance (Burlington): 719 - 346 - 4722

Facsimile: 303 - 772 - 7043

Colorado Hearing
Tinnitus and Balance

Alfred N. Carr, M.D. & Colorado Hearing Tinnitus and Balance

2030 Mountain View Avenue
Suite 500
Longmont, Colorado 80501

Kit Carson Memorial Hospital
286 16th Avenue
Burlington, Colorado 80807

Patient Financial Responsibility Disclosure Statement.

Your signature below forms a binding agreement between Alfred N. Carr, M.D. (ANC) and Colorado Hearing Tinnitus and Balance (CHTB- as providers of medical services) to the Patient who is receiving medical services, or the Responsible Part for minor patients (those patients under 18 years old). Responsible Party is the individual who is financially responsible for payment of medical bills.

All charges for services rendered are due and payable at the time of service.

Medical Insurance: We have contracts with many insurance companies, and we will bill them as a service to you. As the responsible party you are responsible if your insurance company declines to pay them for any reason.

Therapeutic, Lab, and X-Ray Office Procedures may NOT be a benefit according to insurance coverage. The following are typically NOT covered:

- ☐ Canalith Repositioning exercises
- ☐ Hearing Aids
- ☐ Allergy Shots
- ☐ Tinnitus Management
- ☐ Dixhallpike
- ☐ Hearing Aid Batteries
- ☐ Acoustic protection (ear or swim molds)

The person signing on behalf of the Patient as the Responsible Party must:

* Inform ANC and CHTB of the current address and phone number for the patient and the responsible party.
* Present all current insurance cards prior to each office visit.
* Verify at each visit that the information is current when signing our data (sign-in) sheet.
* Pay any required co-pay at the time of the visit.
* Pay any additional amount owing within 30 days of receiving a statement from our office. *(When ANC or CHTB receives an explanation of benefits (EOB) from your insurance company, any amounts that you need to pay will be billed to you.)*

Returned Check Policy:

If a payment is made on an account by check, and the check is returned as Non-Sufficient Funds (NSF), Account Closed (AC), or Refer to Maker (RFM), the patient or the Patient's Responsible Party will be responsible for the original check amount in addition to a $50 Service Charge. Once notice is received of the returned check, ANC or CHTB, will send out a letter to notify the Responsible Party of the returned check. If a response is not made within 15 days from the letter date by the Patient or the Responsible Party, the account may be turned over to our collection agency and a collection fee will be added to the outstanding balance - in addition to the $50 Check Service Charge.

Non-Payment on Account:

Should collection proceeding or other legal action become necessary to collect an overdue account, the patient or the patient's Responsible Party, understands that ANC or CHTB has the right to disclose to an outside collection agency all relevant personal and account information necessary to collect payment for services rendered. The patient or the Responsible Party, understands that they are responsible for all costs of collection including, but not limited to, interest due at 18% APR, all court costs and Attorney fees, and a collection fee will be added to the outstanding balance.

By signing below, you agree to accept full financial responsibility as a patient who is receiving medical services, or as the responsible party for minor patients. Your signature verifies that you have read the above disclosure statement, understand your responsibilities, and agree to these terms.

Signature of Patient or Patient's Representative | Print Name | Date

Alfred N. Carr, M.D. : 303 - 772 -3204
Colorado Hearing Tinnitus and Balance (Longmont) : 303 - 776 - 7770
Colorado Hearing Tinnitus and Balance (Burlington): 719 - 346 - 4722
Facsimile : 303 - 772 - 7043

Colorado Hearing Tinnitus and Balance

Alfred N. Carr, M.D. & Colorado Hearing Tinnitus and Balance

Notice of Health Information Privacy Practices

Effective Date of this Notice: July 1, 2013

2030 Mountain View Avenue
Suite 500
Longmont, Colorado 80501

This notice describes how information about you may be used and disclosed within this organization and how you can obtain access to this information.

Please read this carefully.

"Alfred N. Carr, M.D. (ANC) and Colorado Hearing Tinnitus and Balance (CHTB) is required by law to maintain"
"the privacy of your personal/medical information and provide you with notice of its privacy policies."

Uses and Disclosures

Treatment: ANC and CHTB may use your information to provide or coordinate your care. We may disclose all or any of your medical information to any of our physicians, other consulting or referring physician, nurses, or nurse practitioners, physician assistants, and other employees who have legitimate need for such information.

Payment: We may release your information to determine coverage by an insurer for our services, billing, and claims processing. The information may be released to an insurance company, third party payer or other organization involved in the payment of your bill. This information may include copies or excerpts of your medical information that is necessary to receive payment.

Routine Operations: We may use and disclose your information during routine operation of the practice. An example of routine operation would be to contact you to remind you of an appointment or to disclose information to transcriptionists, attorney or consultant working for our practice. These entities are called 'Business Associates'. Out practice requires our Business Associates to treat your information in the same manner that we do.

Research: Under certain circumstances, we may use and disclose your information within approved clinical research studies. Most clinical research studies require specific patient consent; however, there may be some cases where a review of your information without patient contact may be conducted by the researchers.

Regulatory Agencies: We may disclose your information to state, local or federal agencies authorized by law to conduct inspection, audits, or investigation of the practice.

Law Enforcement / Litigation: We may disclose your information for valid law enforcement purposes as required by law or in response to a court order or subpoena.

Public Health: We may disclose your information to public health authorities as authorized by law and related to the prevention or control of certain diseases.

Workers' Compensation: We may release your information to Workers' Compensation agencies in the event your illness or injury may be related to your work.

Military / Veterans: If you are a member of the armed forces or a veteran, we may release your information as required by military command authorities.

As Otherwise Required: We may disclose your information in any situation in which such disclosure is required by law (for example, child or domestic abuse).

Prohibited Uses: We will not disclose your information to person outside the practice for purpose other than treatment, payment or healthcare operation without your authorization in writing. If you provide such an authorization to us, you may revoke it in writing at anytime in the future and we will honor that request.

Your Rights Related to Your Health Information

Although all records concerning your treatment at ANC or CHTB are the property of ANC or CHTB, you have certain rights concerning this information as follows:

Right to Confidentially: You have the right to receive confidential communication of your health information by alternative means or at alternative locations.

Right to Inspect and Copy: You generally have the right to inspect and receive a copy of your health information from ANC or CHTB, unless, the information is restricted by law or your physician. You will need to make payment for copies of any records we provide.

Right to Amend: You have the right to request an amended or correction to your health information. If we agree that information is appropriate, we will include that information in your health information.

Right to Accounting: You have the right to obtain a record of disclosures that we make of your health information for other than treatment, payment or routine operations of the practice.

Right to Request Restrictions: You have the right to request restrictions on certain uses and disclosures of your health information. We will abide by these requests to the extent that we are able.

Right to Revoke Authorization: You have the right to revoke your prior authorization to release your health information except to the extent action was taken in reliance of your original authorization.

<u>Changes to this notice:</u> ANC and CHTB will abide by the terms of this Notice currently in effect. However, ANC and CHTB reserve the right to change the terms of the Notice at any time. Any new notice provisions will be effective for all health information from the time that the changes are effective within ANC and CHTB.

X

Signature of Patient or Patient's Representative | Print Name | Date