Ear, Nose & Throat Specialists of Tulsa, L.L.P

William Hawkins M.D.

Referring Doctor: Name: _____ City: _____

Primary Care Physician: Name_____ City: _____

PATIENT INFORMATION

Name:_____ **DOB:** _____ **SS#:**_____

Address:_____ **City:**_____**State:**_____**Zipcode:**_____

Employer:_____

Race: (Please check all that apply) ☐ Caucasian ☐ Black or African American ☐Asian
☐American Indian or Alaska Native ☐ Other_____

Ethnicity: Hispanic or Latino ☐ Yes / ☐ No

Marital Status: S M D W

Parent /Guardian Info (if patient is a minor)

Name:_____ **DOB:** _____ **SS#:**_____

Name:_____ **DOB:** _____ **SS#:**_____

PRIMARY INSURANCE – POLICY HOLDERS INFORMATION (if other than the patient)

Name of Insurance:_____ **Relation to patient:** _____

Name:_____ **DOB:** _____ **SS#:**_____

Employer: _____

SECONDARY INSURANCE – POLICY HOLDERS INFORMATION (if other than the patient)

Name of Insurance:_____ **Relation to patient:** _____

Name:_____ **DOB:** _____ **SS#:**_____

Employer: _____

(For office Use Only)
Date Granted: _____ Initials: _____

Rev. 3-17

Confidential Communication Request

EAR, NOSE & THROAT SPECIALISTS OF TULSA, L.L.P.
6802 S OLYMPIA AVE, STE 200
TULSA, OKLAHOMA 74132

I hereby request the use of the following confidential channels for the communication of information related to my personal health, or payment for treatment. **This request replaces any prior request for confidential channel of communications I may have made.**

Contact Information:

Home #:_____ ☐ I prefer appointments to be confirmed at this number

Work#: _____

Cell# _____ ☐ I prefer appointments to be confirmed at this number

Email: _____

Please list other persons you authorize us talk to in regards to your treatment or appointment information:

Name: _____ Relationship to patient: _____ Phone#:_____

Name: _____ Relationship to patient: _____ Phone#:_____

Name: _____ Relationship to patient: _____ Phone#:_____

Signed: _____ **Date**:_____

Print Name: _____

If not signed by the patient, please indicate relationship to the patient: _____

EAR, NOSE & THROAT SPECIALISTS OF TULSA, L.L.P.
6802 S OLYMPIA AVE STE. 200 • TULSA, OKLAHOMA 74132-1826
(918) 749-8393 • FAX (918) 747-3112

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND PATIENT AGREEMENTS RELATED TO TREATMENT

CONSENT FOR ROUTINE MEDICAL TREATMENT

Ear, Nose and Throat Specialist of Tulsa, L.L.P. and its employees are hereby authorized to collect medical history information, obtain vital signs and perform other routine procedures for purposes of providing care to you. You have the right to consent or refuse consent to any proposed procedure or therapeutic course, absent emergency or extraordinary circumstances. Under emergency circumstances, we will take necessary and available actions to meet your medical needs.

CONSENT TO DISCLOSURE OF INFORMATION

Patient medical records and billing information are created and retained by Ear, Nose and Throat Specialist of Tulsa, L.L.P. and are accessible to its personnel and medical staff for use in my care. Ear, Nose and Throat Specialist of Tulsa, L.L.P. personnel and physicians may use and disclose medical information for its business operations and to any other physician or health care personnel involved in providing care. Safeguards are in place to discourage improper access. Ear, Nose and Throat Specialist of Tulsa, L.L.P. is authorized to disclose all or part of my medical record to any insurance carrier, workers compensation carrier, or administrator of a self-insured employer group which is responsible for any part of Ear, Nose and Throat Specialist of Tulsa, L.L.P. charges and to any health care provider who is or is expected to become involved with a patient's care. These disclosures are for treatment or payment purposes. Oklahoma law requires that we advise you that the information authorized for disclosure may include information which may be considered a communicable or venereal disease, including, but not limited to, Hepatitis, Syphilis, Gonorrhea, Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (AIDS). By signing this agreement, you are consenting to such disclosure. You may revoke this consent in writing addressed to Ear, Nose and Throat Specialist of Tulsa, L.L.P., except to the extent we have already acted in reliance on it.

ASSIGNMENT OF INSURANCE BENEFITS

You agree that insurance benefits for Ear, Nose and Throat Specialist of Tulsa, L.L.P. charges payable to the insured are to be made payable to Ear, Nose and Throat Specialist of Tulsa, L.L.P. and that insurance benefits for services provided by physicians in the hospital setting otherwise payable to the insured are to be made payable to the physicians(s) responsible for your care. Any payment received for this episode of care may be applied to any unpaid bills for which you are liable, subject to the rules of coordination of benefits.

PRECERTIFICATION POLICY

You understand that Ear, Nose and Throat Specialist of Tulsa, L.L.P. will assist with insurance precertification requirements which are the responsibility of the policyholder and/or hospital, but will not assume responsibility for precertification or any impact which it may have on insurance payment.

FINANCIAL RESPONSIBILITY

As consideration for the services provided to you, payment is guaranteed for any amount due for such services provided by Ear, Nose and Throat Specialist of Tulsa, L.L.P. Charges for services and goods shall be at Ear, Nose and Throat Specialist of Tulsa, L.L.P.'s billed charges rates unless otherwise agreed to in writing by Ear, Nose and Throat Specialist of Tulsa, L.L.P.

PATIENT'S CERTIFICATION

I hereby certify that I have read each of the above statements, have had each item explained to my satisfaction, and have received a copy of this Patient Agreement. I further certify that I am the patient or legally authorized by the patient to accept the terms of this Patient Agreement. A photocopy of this document has the same effect as an original.

X _____

Signature of Patient or Patient's Legally Authorized Representative (*Documentation Must Be Provided*)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

A complete description of how your medical information will be used and disclosed by Ear, Nose and Throat Specialist of Tulsa, L.L.P. is in our NOTICE OF PRIVACY PRACTICES, which you should read before signing this Acknowledgement. The Notice is posted throughout our office and you will be given a copy for your personal use.

I have received a copy of Ear, Nose and Throat Specialist of Tulsa, L.L.P. Notice of Privacy Practices dated_____

X _____ _____ _____

Patient or Representative | Legal Authority of Representative | Date Signed

Basis for refusal, if refused: _____

Ear, Nose & Throat Specialists of Tulsa, L.L.P

Diplomates American Board of Otolaryngology

William H. Hawkins, M.D.

SURGERY & DISEASE OF THE EAR, NOSE & THROAT

6802 S Olympia Ave Ste 200
TULSA, OKLAHOMA 74132
(918) 749-8393
(918) 747-3112 (FAX)

DISCLOSURE OF PHYSICIAN OWNERSHIP
NOTICE TO PATIENTS
Please carefully review the information contained in this notice.

I, William H. Hawkins M.D., am committed to providing the best quality healthcare to every patient I treat. I am pleased to inform you of the following:

1. I have ownership interest in Tulsa Spine & Specialty Hospital.

2. You have the right to choose the provider of your healthcare services. Therefore, you have the option to use a healthcare facility other than Tulsa Spine & Specialty Hospital.

3. You will **not** be treated differently by me if you choose to obtain healthcare services at a facility other than Tulsa Spine & Specialty Hospital.

There may be other physicians, including radiologists and anesthesiologists, involved in your care that have an ownership, or investment interest, in Tulsa Spine & Specialty Hospital. Physician owners are listed on our website and a list of owners can be provided to you on request. If you have questions concerning this notice, please feel free to ask your physician or any representative of Tulsa Spine & Specialty Hospital. We welcome you as a patient and value our relationship with you.

Acknowledgement of Disclosure

By signing this Disclosure of Physician Ownership, you acknowledge that you have read and understand the foregoing notice and hereby understand that your physician has an ownership interest in Tulsa Spine & Specialty Hospital.

_____

Signature of Patient/Guardian

_____

Print Name of Patient/Guardian

_____

Date

_____ Initials

I am fully aware some services such as nasal / throat endoscopies or in office procedures etc. may be subject to my deductible and coinsurance in addition to any copay I may have already paid.

_____ Initials

I am fully aware that I am responsible for any charges not paid by my insurance company such as copays, deductibles and/or coinsurance, and any non covered services.

_____ Initials

I am aware any audiology services performed at this office will be billed separately from any physician services. I understand these services may be subject to my deductible and/or coinsurance and I will be responsible for any charges not covered by my insurance company.

I HAVE READ AND FULLY UNDERSTAND THE FINANCIAL POLICY SET FORTH BY ENT SPECIALISTS OF TULSA.

Please Sign and Date to show that you understand and have received a copy:

_____
Patient Name and Date of Birth

_____
Print Name of Responsible Party/Patient

_____ _____
Signature of Responsible Party/Patient Date

Financial Policy

We are committed to providing you with the best possible care. If you have medical insurance, we are here to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our financial policy.
You must realize, however, that:

Payment is due at the time services are rendered unless payment arrangements have been approved in advance by our staff. We accept cash, checks, MasterCard, Visa, American Express or Discover. For patients with no insurance, we do allow a discount on self -pay patients if paid at the time of service.

A $35 fee will be charged for all returned checks plus if any bank fee and your account will be placed on a "cash only" basis.

Your insurance is a contract between you, your employer and the insurance company. If you have any questions regarding network providers, referrals, covered services, benefits and/or financial obligation please contact member services through your insurance company to best answer your questions.

While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. If we do not have your correct information, insurance cards or referral, then we will be unable to properly file a claim to your insurance company in a timely manner. All charges not covered by your insurance company will be your responsibility.

Should your account balance become uncollectable due to bankruptcy, we will allow 30 days of medical care after which you will be dismissed from our practice.

The accompanying parent or adult is responsible for full payment at the time of service. In case of divorce, we are not responsible for billing multiple parties. It is the responsibility of the parent/guardian whom brings the child in to work out the payment arrangements between custodial and non-custodial parents.

I AGREE THAT IF IT BECOMES NECESSARY TO FORWARD MY ACCOUNT TO A COLLECTION AGENCY, I WILL ALSO BE RESPONSIBLE FOR THE FEE CHARGED BY THE AGENCY FOR THE COSTS OF COLLECTION IN ADDITION TO THE ORIGINAL AMOUNT DUE.

We realize that financial problems may affect timely payment on your account. If such problems do arise, we encourage you to contact our Billing Office promptly to resolve any issues on your account at (918) 388-9090.

If you have any questions about the above information or any uncertainty regarding your insurance coverage, PLEASE don't hesitate to ask us. We are here to help you.
We will gladly discuss your proposed treatment and answer any questions relating to your insurance.

If the responsible party provides a wireless telephone number where he/she may be contacted, He/She consent to receive calls (including auto-dialed calls and prerecorded messages) at that wireless number from {hospital, doctor's office, collections agency}, its affiliates, agents, and independent contractors of each of them regarding the services rendered, or your related financial obligations.