

**OTOLARYNGOLOGY OF JOPLIN DBA JOPLIN EAR NOSE & THROAT
DR. RENEE WALKER and DR. SUZANNE LONG
1920 E 32ND STREET, JOPLIN MO 64804
417-781-4613**

REGISTRATION INFORMATION

Patient's legal name _____ Date of birth _____

Race _____ Ethnicity _____ Sex _____

Social security # _____ Marital status _____

Mailing address _____ City & State _____ Zip _____

Email address _____ Cell phone _____ Home phone _____

Preferred method of contact: Phone call Email Letter

Can we leave a detailed message: Yes No

IF PATIENT UNDER AGE 18 OR DISABLED:

Legal guardian name _____ Relationship to patient _____

Address _____ City & State _____ Zip _____

Phone _____ Date of birth _____ Social security # _____

PLEASE LIST AN EMERGENCY CONTACT *OTHER THAN GUARDIAN*

Name _____ Relationship to patient _____

Address _____ Phone _____

PHYSICIAN INFORMATION

Primary care physician name & phone# _____

Primary care physician address _____

Referring physician name and phone # _____

Referring physician address _____

How did you hear about our office? Radio Internet
Recommended by someone Insurance Other
Referred by physician TV

OTOLARYNGOLOGY OF JOPLIN DBA JOPLIN EAR NOSE & THROAT
DR. RENEE WALKER and DR. SUZANNE LONG
1920 E 32ND STREET, JOPLIN MO 64804
417-781-4613

INSURANCE INFORMATION

Patient's name _____ Date of birth _____

*IF AN INSURANCE CARD WAS GIVEN TO THE RECEPTIONIST - just sign at the bottom of the form

PRIMARY INSURANCE

Name of insurance _____

Policy or member ID number _____ Group number _____

Insured's name _____ Date of birth _____

Relationship to patient _____ SSN _____

SECONDARY INSURANCE

Name of insurance _____

Policy or member ID number _____ Group number _____

Insured's name _____ Date of birth _____

Relationship to patient _____ SSN _____

Our office will file all reimbursable services to the primary and secondary carriers.
Please remember that you are responsible for all deductibles, copays, and non-covered
service amounts, as indicated by the remit we receive from your insurance company.

You are also responsible to provide all information for any insurance updates to our
office in a timely manner.

I authorize the release of any medical information necessary to process my claim.
I authorize payment of medical and surgical benefits to Joplin Ear Nose and Throat.

By signing below, you acknowledge that you have read the above statements and agree to
all stated conditions.

Patient / Responsible party _____ Date _____

**OTOLARYNGOLOGY OF JOPLIN DBA JOPLIN EAR NOSE & THROAT
DR. RENEE WALKER and DR. SUZANNE LONG
1920 E 32ND STREET, JOPLIN MO 64804
417-781-4613**

**NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT
AUTHORIZATION FOR RELEASE OF INFORMATION**

In the course of providing service to you or your dependent, we receive health information. We may use and disclose this health information to other medical professionals for use in the following: 1) to ensure proper treatment of the patient's symptoms and conditions; 2) submission to the insurance company for claims review, determination of benefits and to receive payment for our services rendered to the patient.

In signing this document, you agree that we may use and disclose the patient's health information as indicated above.

I have read this document and understand it. I consent to the use and disclosure of mine / my dependent's health information for the purpose of treatment, administrative functions and service reimbursement. I acknowledge that a copy of the 'Notice of privacy practices' from Joplin Ear Nose & Throat was made available to me for review.

Patient / legal guardian

Date

Printed name

**OTOLARYNGOLOGY OF JOPLIN DBA JOPLIN EAR NOSE & THROAT
DR. RENEE WALKER and DR. SUZANNE LONG
1920 E 32ND STREET, JOPLIN MO 64804
417-781-4613**

PERMISSIONS

Patient name _____ Date of birth _____

I authorize the following people to be able to **receive patient's medical information:**

- | | | |
|----------|-------------------------------|---------------|
| 1. _____ | Relationship to patient _____ | Phone # _____ |
| 2. _____ | Relationship to patient _____ | Phone # _____ |
| 3. _____ | Relationship to patient _____ | Phone # _____ |

IF PATIENT UNDER AGE 18 OR DISABLED:

I authorize the following people to **bring the patient to their scheduled appointment:**

- | | | |
|----------|-------------------------------|---------------|
| 1. _____ | Relationship to patient _____ | Phone # _____ |
| 2. _____ | Relationship to patient _____ | Phone # _____ |
| 3. _____ | Relationship to patient _____ | Phone # _____ |

Patient / Legal guardian _____ Date _____

SURGERY CONSENT

Patient name _____ Date of birth _____

If Dr. Walker recommends surgery for the above patient, the patient will be taken to the surgery coordinator for scheduling. Surgery specifics will be explained, paperwork reviewed and your questions answered.

Our office will contact the insurance company to obtain the patient's policy benefits, determine prepay reimbursement (if any), and to obtain pre-certification for the surgery (if required).

**Please be aware that the amount of money collected for pre-payment of the surgery is only an estimate, determined by benefits given by the insurance company and the current allowable rate for the procedure(s) to be performed. If the insurance reimburses a different amount than the estimate, you may receive a bill for the balance due or a refund if an overpayment was made.

I agree that I have read and understand the surgery consent information noted above.

Patient / Legal guardian _____ Date _____

OTOLARYNGOLOGY OF JOPLIN DBA JOPLIN EAR NOSE & THROAT
DR. RENEE WALKER and DR. SUZANNE LONG
1920 E 32ND STREET, JOPLIN MO 64804
417-781-4613

NO SHOW, CANCELLATION AND LATE ARRIVAL POLICY

It is the goal of Joplin Ear Nose & Throat to provide excellent care to each patient in a timely manner. We schedule appointments so that each patient will have the appropriate amount of time to be seen and treated by our providers according to their individual symptoms and issues. That is why it is very important that each and every patient keep their scheduled appointment and arrive promptly at their scheduled time (15 minutes prior to appointment time for new patients).

As a courtesy to our patients, our office will make a reminder call prior to the scheduled appointment. If we are unable to reach the patient/guardian, we will leave a voicemail message.

Late arrival means any patient who arrives at the clinic 15 or more minutes after the scheduled appointment time. If this occurs, the patient will not be seen and the appointment will need to be re-scheduled.

Same day cancellation means cancellation of an appointment or surgery less than 24 hours before the scheduled appointment/surgery time. If you are unable to keep your appointment or scheduled surgery, please contact our office with at least a 24 hour notice so that we can reschedule, so that we can attempt to fill that spot from with someone on our waiting list.

No show means failure to arrive for a scheduled appointment or surgery without prior notification to our office. See further information on no shows below.

Established patients - if you fail to show up for an appointment without prior notification, you will be charged a \$25 no show fee. This charge is not reimbursable by your insurance company and will be billed directly to you. **After three no shows for office appointments, the patient will be dismissed as a patient of Joplin Ear Nose & Throat.

New patient - if you fail to show up for an appointment without notification, you will not be allowed to re-schedule your appointment.

Surgery no shows - if any patient fails to show up for a scheduled surgery without prior notification to our office, you will be dismissed as a patient of Joplin Ear Nose & Throat.

I understand the no show, cancellation and late arrival policy of Joplin ear Nose & Throat as indicated above and agree to its provisions. I understand that failure to comply may result in dismissal as a patient of Joplin Ear Nose & Throat.

Patient name (print)	Date	Signature
----------------------	------	-----------

Guarantor name (print)	Date	Signature
------------------------	------	-----------

** If patient is under age 18 or disabled.