Mat-Su Ear, Nose, Throat
& Facial Plastics

(907) 745-9200
www.matsuent.com

2490 S. Woodworth Loop
Suite 201
Palmer, Alaska 99645

OFFICE GUIDELINES

Thank you for choosing Mat-Su Ear, Nose, Throat & Facial Plastics, Inc. for your care. While it is our desire to provide you with the best care possible, there are some limitations and restrictions that your managed care or insurance plan may impose which we cannot control. Because of this, there are certain polices and guidelines that we want you to be aware of and agree to dealing with our office as outlined below:

1. Payment is due at the time of service
2. Cancellation Policy: We require that you give our office at least 24-hour notice if you need to cancel or reschedule an appointment.
3. Obtain any authorizations that you may need prior to your visit to avoid delays or rescheduling.
4. We expect that any lab test, x-rays, surgery, or other diagnostic exams that we order will be done within 7-10 days unless otherwise specified by our physician. We are not party to or agree with your insurer or managed care plan if they deny authorization or coverage. If your plan denies authorization for our recommendations we ask that you initiate an appeal with them immediately and notify us in writing. If they require a letter from us, we will provide it.
5. **Make a follow-up appointment within one week after you have done any diagnostic test (i.e. lab, x-ray, CT scans, biopsies, etc.) to discuss the results and recommendations. Do not wait for us to call you.**
6. You are responsible to contact the physician or his staff for an appointment if your condition does not improve within two weeks.
7. Your condition may require further procedures and examinations as part of the workup for your medical problem; however, most insurance carriers require prior approval. You will be financially responsible for all fees that your healthcare insurance deems as non-covered services or not medically necessary and services must be paid at the time at service.
8. Self-pay patients initial payment is for the consultation only. You will be responsible for in-office procedures. The patient, child's parents, or responsible person will be made aware of any additional out-of-pocket expenses prior to the provider performing the procedure and services must be paid at the time of service.
9. Managed care, with its multiplicity of rules that govern the practice of medicine, make it difficult for even us to be sure they are being followed. It is not our intention to bill contrary to your plan. If you discover any errors in billings, please inform us so that we can correct or help you to correct them.

You can expect to be treated with respect and professionalism at all times. If you have a problem with any of our staff, please notify our office manager.

Signature _____ Date _____

(Patient, Parent, Guardian or Guarantor)

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FINANCIAL POLICIES

Welcome to Mat-Su Ear, Nose, Throat & Facial Plastics, Inc. Our goal is to provide you excellent medical care and our financial policies have been developed to help keep your cost of medicine down. You can help by paying in a timely manner. Thank you!

Payment at the time of service is expected. Payment may be made by cash, personal check or credit card.

Mat-Su Ear, Nose, Throat & Facial Plastics Inc. will bill your insurance carrier. **We submit claims to your primary and secondary insurance carrier only, as a courtesy for our patients. We currently participate with Aetna, Blue Cross and Multiplan medical insurance plans. As part of our contract with the insurance companies, we are legally required to collect any co-pays or deductibles from you at the time of service.** Surgical patients are expected to pay their surgical co-pay at the time of their Pre-Operative appointment. We expect payment in full within 60 days for services billed to insurance. It is your responsibility to pay any balance older than 60 days and to follow up with your insurance carrier. Labs and pathology will be billed separately.

Veterans Administration patients must pre-authorize their treatment with the VA, prior to any medical visit.

Mat-Su Ear, Nose, Throat & Facial Plastics, Inc. does not accept third party liability claims.

Our Medicaid patients are expected to bring their current card and $3.00 co-pay. Our Denali Kid Care patients need to bring their cards with them for each visit.

We will need to see your insurance card(s) at the first appointment along with photo identification (driver's license) to confirm identification. We will verify insurance eligibility prior to your first appointment and if we can not verify your insurance you will be expected to pay in full. Demographic information will be updated at least annually thereafter.

Our cash patients are expected to pay for their office visits at each appointment. If surgery is indicated we will accept one half of the surgical fee at the "Pre-Operative" appointment with the balance due by the "Post-Operative" visit.

Mat-Su Ear, Nose, Throat & Facial Plastics, Inc. does not carry balances and we send no more than two statements.

If payments are defaulted all unpaid balances will be forwarded to Cornerstone Credit Services; (907) 770-8100. FAX (907) 770-8147)

ALL COLLECTION AGENCY FEES AND LEGAL FEES WILL BE ADDITIONAL AND THE GUARANTOR/PATIENT'S RESPONSIBILITY.

I have read, understand and agree to the provisions of this Financial Policy.

Signature _____ Date _____

(Patient, Parent, Guardian or Guarantor)

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MEDICAL HISTORY

Name _____ **Age** _____

Primary Care Provider _____

Chief Complaint _____

Drug Allergies? YES / NO Penicillin Sulfa Morphine Erythromycin Cephalosporin
Codeine Latex Other _____

Do you have any food allergies or other allergies, other than medication? YES / NO Please list:

_____

Please list your current medications, dosage, and how often you take them.

_____

_____

_____

Have you ever been operated on? Yes / No

Year _____ Surgery _____
Year _____ Surgery _____
Year _____ Surgery _____

Have you been hospitalized for medical problems, not including surgery? YES / NO

Year _____ Problem _____
Year _____ Problem _____

Review of Systems —Please circle any that may apply to you

Double vision	Unexplained weight loss	Fever /Chills	Hoarseness	Cough with blood
Nosebleeds	Loss of smell/taste	Anemia	Easy bruising	Muscular weakness
Chest pain	Trouble swallowing	Numbness	Skin rash	Blood urine/stool
Tingling	Shortness of breath	Dizziness	Moles	Tinnitus
Paralysis	Frequent Sore Throats	Sore Tongue	Skin Lesions	Ear Infections
Sinus disease	Gland Enlargement	Oral lesions	Snoring	Ear Pain/ Discharge
Headaches	Neck pain or lumps	Indigestion	Sleep Apnea	Hearing Loss
Congestion	Trouble breathing	Cancer (type) _____		

Medical Illness: Do you have any of the following diseases? Please circle all that apply.

High Blood Pressure	Diabetes	Asthma	HIV/AIDS	Cardiac Disease	MRSA
Thyroid Disease	Hepatitis	Cirrhosis	Seizures	Cancer	Tuberculosis

Bleeding tendency? YES / NO Have you EVER RECEIVED a blood transfusion? YES / NO
Have you ever had a head injury? YES / NO Year _____ Was there a loss of consciousness? _____

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MEDICAL SOCIAL HISTORY

Marital Status _____

Hobbies _____

Job History: (Please list all occupations especially those where there is risk of exposure to toxic chemicals or gases)

_____

_____

If student what school do you attend? _____

Do you smoke? Never Have No Date quit _____ Yes If yes, _____pack/day for how long?

Do you drink alcohol? No Date quit _____ Yes Amount _____

Highest grade completed: High School _____ College _____ Graduate school _____

Family History: Please list significant medical illness of your parents and siblings. If deceased, indicate age at death and cause of death.

Father _____

Mother _____

Sibling _____

Sibling _____

Is there anything else you wish Dr. Pulliam to know about your health or medical history?

I give permission for Dr. Pulliam to examine me or the child for whom I am legal guardian as would be necessary in the course of my/our treatment.

Signature _____ **Date** _____ **Relationship** _____

Reviewed by _____ **Date** _____ **Relationship** _____

Updated _____ **Date** _____

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AUTHORIZATION

Primary Insurance Name _____

Policy Holders Name

_____

Last First MI

Relationship to Patient _____ **Insured's Birth Date** ___/___/___ M D Y

Policy Holders Address _____
(If different from patients)

Insured's ID# _____ **Group# (Plan, Local or Policy#)** _____

Secondary Insurance Name _____

Policy Holders Name

_____

Last First MI

Relationship to Patient _____ **Insured's Birth Date** ___/___/___ M D Y

Policy Holders Address _____
(If different from patients)

Insured's ID# _____ **Group# (Plan, Local or Policy#)** _____

I HEREBY AUTHORIZE ANDREW R. PULLIAM, M.D. AND WHOMEVER HE MAY DESIGNATE AS HIS ASSISTANTS TO PERFORM MEDICAL TREATMENTS AS HE DEEMS ADVISABLE IN HIS OFFICE. I AUTHORIZE THIS OFFICE TO COMMUNICATE MY MEDICAL HISTORY TO THOSE HEALTHCARE PROFESSIONALS WHO ARE INVOLVED IN MY CARE AND RELEASE ANY MEDICAL OR OTHER INFORMATION NEEDED REGARDING MY TREATMENT.

I HEREBY ASSIGN ALL INSURANCE BENEFITS TO BE PAID DIRECTLY TO THE PHYSICIAN. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES. I HEREBY AUTHORIZE SAID ASSIGNEE TO RELEASE ANY AND ALL INFORMATION WHICH MAY BE FOUND IN THE RECORD AND IS NECESSARY TO SECURE PAYMENT.

THE INFORMATION I HAVE GIVEN HERE IS CORRECT AND TRUE TO THE BEST OF MY KNOWLEDGE.

Signature _____ **Date** _____

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PARENTS AND GUARDIANS

MINORS, 17 years and younger, will NOT be treated without a parent or legal guardian present. Grandparents, aunts and uncles and anyone else must bring a letter from the minor patient's parent or legal guardian to have a minor treated in this office.

The parent or legal guardian must be present at a pre-operative appointment. We will be obtaining signatures for the operative treatment and only the parent or legal guardian's signature is accepted.

THERE ARE NO EXCEPTIONS.

Signature _____ **Date** _____

(Signature of patient or legal guardian)

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PATIENT CONSENT

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Mat-Su ENT Associates, Inc. to use and disclose protected health Information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

I have the right to review the Notice of Privacy Practices prior to signing this consent. I have received a copy of Mat-Su ENT Associates, Inc. Notice of Privacy Practices. Mat-Su ENT Associates, Inc., reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Mat-Su ENT Associates, Inc. at 2490 South Woodworth Loop, Suite 201, Palmer, Alaska 99645.

With consent, Mat-Su ENT Associates, Inc. may call my home or other alternative locations and leave a message on voice mail or in person in reference to any Items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Mat-Su ENT Associates, Inc. may mail to my home or other alternative locations any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

I have the right to request that Mat-Su ENT Associates, Inc. restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my request restrictions, but if it does, it is bound by this agreement. By signing this form I am consenting to Mat-Su ENT Associates, Inc. use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Mat-Su ENT Associates, Inc. may decline to provide treatment to me.

Patient's Name (print) _____

Legal Guardian's Name (print) _____

Signature _____
(Signature of patient or legal guardian)

Date _____

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REFERRING PHYSICIAN: _____

PATIENT INFORMATION

In order to serve you properly we require the following information. All information provided will be strictly confidential. (PLEASE PRINT)

PATIENT INFORMATION

Circle: ADULT OR CHILD **Circle One:** FEMALE OR MALE

Name _____ **DOB** ____/____/____
Last First MI (Nickname) M D Y

SSN# _____ **Driver's License #** _____ **Marital Status:** S M D W

Mailing Address _____ **Phone Numbers**
Street/PO Box Apt/Ste City State Zip
Home _____

Physical Address _____
(*If different from mailing*) Street/PO Box Apt/Ste City State Zip Work _____

Employer _____ **Occupation** _____ Cell _____

Employer Address _____
Street/PO Box Apt/Ste/City State Zip

Email _____

Student? Y N If yes, what school does the patient attend? _____

RESPONSIBLE PARTY FOR MINORS: PARENT, GUARDIAN OR REPRESENTATIVE

Name _____ **Phone Numbers**
Last First MI (Nickname)
Home _____

Mailing Address _____
Street/PO Box Apt/Ste City State Zip Work _____

SSN# _____ **Driver's License #** _____ **DOB** ____/____/____ Cell _____
M D Y

Employer _____ **Occupation** _____

CONTACT INFORMATION: (With whom may we discuss your medical record or account)

Emergency: Name _____ Relation _____ Phone _____

Financial: Name _____ Relation _____ Phone _____

Medical: Name _____ Relation _____ Phone _____