ENTAA Care Johns Hopkins Regional Physicians **Personal Information**

Patient's Name: Last, First, Middle Initial				Marital Status (Circle One) Single / Married / Divorced / Separated / Widowed
Date Of Birth: / /	Age:	Sex: ❑ M ❑ F	Email:	Home Phone Number:
Mailing Address:				Cell Phone Number:
City:	State:	Zip Code:		Pharmacy:
Employer:	Employer Phone Number:			Pharmacy Phone Number:

Primary Care Physician: _____ Contact Number: _____

Referred To Us By (Please Check One Box): ❑ Dr. _____ ❑ Insurance Plan ❑ Hospital
❑ Emergency Room ❑ Family ❑ Friend ❑ Internet ❑ Yellow Pages ❑ Other _____

Primary Insurance Information

Name of Insurance:	Subscribers Name:	Policy/Member ID:
Subscriber's Date Of Birth: / /	Employer:	Employer Phone Number:
Subscriber's Social Security Number:	Patient's Relationship To Subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other	Co-Payment: $ _____

Secondary Insurance Information

Name of Insurance:	Subscribers Name:	Policy/Member ID:
Subscriber's Date Of Birth: / /	Employer:	Employer Phone Number:
Subscriber's Social Security Number:	Patient's Relationship To Subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other	Co-Payment: $ _____

Financial Guarantor If Other Than The Patient

Name:		Patient's Relationship to Person: ❑Spouse ❑Child ❑Other _____
Mailing Address:		Primary Phone Number:
City:	State: Zip Code:	Secondary Phone Number:

IN CASE OF EMERGENCY

Name of Parent, Relative or Friend:	Relationship To Patient:	Primary Phone Number:	Secondary Phone Number:

Patient/Guardian Signature _____ *Date* _____

Witness Signature _____ *Date* _____

I acknowledge that I have received a copy of the Johns Hopkins Medicine Notice of Privacy Practices for Health Care Providers.

_____ _____ _____/_____/_____

Signature of Patient or Legal Representative & Title **Witness** **Date**

ENTAA Care

A member of Johns Hopkins Regional Physicians

PAYMENT TERMS

Patient Name: _____ **Date:** _____

I authorize Johns Hopkins Regional Physicians LLC, dba ENTAA Care, to submit charges to my insurance company on my behalf. I further understand that I will be financially responsible for all allowed charges not covered by my insurance benefits and personally guarantee all amounts owed to ENTAA Care. These amounts may include (but are not limited to):

- Copays/Co-Insurance/Deductibles
- "Non-Covered" services when agreed to in advance by the guarantor
- $37 fee for returned checks from your bank
- Cancellation fee up to $50 for appointments not cancelled within 24 hours of the appointment time

"Should you choose to use a credit card to pay for services at our practice, ENTAA Care acknowledges that we, as the service provider, are responsible for the security of your credit card information in any and all forms".

Agreement to Procedures Performed with Office Visits: I have been made aware and understand that certain conditions may require the use of a diagnostic endoscope for a more thorough examination of a specific area, such as the nose, sinus, or throat. In addition to a regular office visit, a procedural fee may be submitted to my insurance carrier if this type of service is performed during my visit. I agree to these charges and understand that they will be subject to my "surgical" benefits and I will be obligated to pay any additional copay, deductible, and/or coinsurance that may be applied by my insurance carrier. Other "surgical" services that may be performed during your visit include, but are not limited to, ear wax removal, biopsies, nasal cautery, removal of foreign bodies, etc.

_____ _____ _____

Signature of Patient (if over 18 years of age) Witness Date

_____ _____ _____

Signature of Guarantor Witness Date

_____

Guarantor's Relationship to Patient

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Surgery Letter and Ownership Disclosure

Print Patients Name: _____

Surgery Letter to our Patients:

If your provider should recommend that you be scheduled for a surgical procedure. You should hear from our office within approximately five (5) business days from your appointment.

We will be sending you your surgery information through our patient portal. If you have not yet signed up for our patient portal, please sign up immediately so that you can receive your surgery information. If you need your pin number, please contact our office at (410) 760-8840.

If we have not contacted you within **5 business days from your appointment**, please call our office at (410) 760-8840 ext. 225 or 247 to check on the status of scheduling your surgery. During this time, we will be verifying your insurance benefits and obtaining any necessary authorizations. Please note that if your physician has recommended an uvulopalatopharyngoplasty (UPPP), the authorization process may take 4-8 weeks to complete. In addition, if your procedure is not covered in full (100%) by your insurance plan, your out-of-pocket cost will be due prior to the surgery as a deposit.

If your schedule changes or if you find that there is a time when you cannot have your surgery, please call to inform us of the scheduling issue.

Ownership Disclosure:

The following providers have a business interest as owners of the Piney Orchard Surgery Center located at 1132 Annapolis Road, Odenton, MD 21113. This form serves as notification that you are not required to utilize this facility, but may elect to have your health care services provided at another facility at your request.

- Warren Buchalter, MD
- Alec Beningfield, MD
- Marc Hamburger, MD
- Thomas Lee, MD
- Robert Lisk, MD
- Avron Marcus, MD
- Jeffrey Pacheco, MD
- Nancy Solowski, MD

Surgeries are scheduled at the following facilities based on your provider's privileges and by availability given from the facility. Our Surgery Department will call you to schedule a date.

- Howard County General Hospital
- Anne Arundel Medical Center
- Baltimore Washington Medical Center
- Piney Orchard Surgery Center

I have read and reviewed this document and execute it with full understanding of its contents.

_____ _____ _____
Signature of Patient or Legal Representative & Title Witness Date

JOHNS HOPKINS REGIONAL PHYSICIANS

☐ Cardiovascular Specialists of Central Maryland
☐ ENTAA Care

STANDING AUTHORIZATION TO DISCUSS HEALTH INFORMATION WITH DESIGNATED PERSONS

Complete all sections of this Authorization as appropriate to your request.

Patient Name: _____ **Birth Date:** _____
(first) (m. initial) (last)

Address: _____
(street address) **Phone #:** _____

_____ **Medical Record #:** _____
(city) (state) (zip code) (if known)

For this Authorization, "**My Health Care Provider**" means _____
(name of health care provider)

For this Authorization, "**My Health Information**" means any and all information relating to my course of examination and treatment.

If I have initialed here (_____), "My Health Information" includes Substance Abuse Records/Information.

If I have initialed here (_____), "My Health Information" includes Mental Health Records/Information.

I authorize My Health Care Provider to discuss My Health Information with the person(s) or entity identified below for general information and inquiries, arranging appointments, identifying medications, discussing billing and payment and any other related matter.

Name: _____ Name: _____

Relationship: _____ Relationship: _____

Phone #: _____ Phone #: _____

I understand that:

- This Authorization is voluntary. My treatment will not be impacted, no matter if I sign this Authorization or not.
- If I do not sign this Authorization, My Health Care Provider will not disclose My Health Information as requested.
- This Authorization is valid for one year from date signed, unless I revoke/withdraw this Authorization or unless an earlier date is specified here: _____. I may revoke/withdraw this Authorization, except to the extent that action has been taken prior to receipt of the revocation/withdrawal, by mailing or faxing my written request along with a copy of the original Authorization to the clinic or department where my Authorization was made or given.
- Once My Health Information is disclosed as requested, it may no longer be protected by federal and state privacy laws, and could be re-disclosed by the person(s) receiving it.
- The medical information released may contain information related to HIV status, AIDS, sexually transmitted diseases, mental health, drug and alcohol abuse, etc.

Signature of Patient Only: _____ **Date**: _____/_____/_____
(Required)

If you are NOT the patient but are signing on behalf of the patient, complete the following:

I, _____, am the (check which applies)
(print your name)

- ☐ **Parent with Parental Rights** *(not sufficient for substance abuse records)*
- ☐ **Registered Kinship Care Relative** *(not sufficient for substance abuse records)*
- ☐ **Court Appointed Guardian**
- ☐ **Legally Appointed Healthcare Agent** *(not sufficient for substance abuse records)*
- ☐ **Medical Power of Attorney** *(not sufficient for substance abuse records)*
- ☐ **Power of Attorney with Right to See Medical Records** *(not sufficient for substance abuse records)*
- ☐ **Surrogate Decision Maker** *(not sufficient for substance abuse records or mental health records)*
- ☐ **Court Appointed Personal Representative of Deceased**

Representative's Signature: _____ **Date**: _____/_____/_____
(Required)

Address: _____ **Phone**: _____

You MUST attach proof of your authority to act on behalf of the patient as checked above (other than parent).