Presbyterian ear Institute

PRESBYTERIAN EAR INSTITUTE
415 CEDAR ST SE
ALBUQUERQUE, NM 87106
(505) 224-7020 OFFICE

Patient Registration (Please Print Clearly) TODAY'S DATE ______________

Patient Name ____ Birth date ______________
Last Name First Name Middle Initial

Mailing Address: ________________________________ Phone ( ) ______________

City: ______________________________ State __________ Zip Code ______________

Physical Address (if different) ____

Sex ☐ Male ☐ Female SS# _____/_____/_____ Age_____ ☐ Married ☐ Single ☐ Widowed ☐ Divorced

Ethnicity (***Select all that apply***) ☐ Hispanic ☐ Black ☐ White ☐ Native American ☐ Asian ☐ Other

Email: ________________________________ Alternate Phone ( ) ______________

Employer________________________________ Employer Phone ( ) ______________

Who referred you? ______________________ Primary Care Physician ______________________

In case of emergency who should be notified? ______________________Phone______________

Person Responsible for Account ____

Parent/Guardian/Personal Representative Information (Please Print)

Name **(Parent 1)** ______________ DOB: __________ Name **(Parent 2)** ______________ DOB: __________

Relation to Patient________________________________ Phone ( ) ______________

Address if different from above______________________ Email______________________

City ______________________________ State__________ Zip Code ______________

Employer______________________ Employer Phone __________ Occupation______________

Primary Insurance (Please Print Clearly)

Insurance Company Name________________________________ Phone ( ) ______________

Member ID# ________________________________ Group # ______________

Insured's Name ______________________DOB__________SS#_____/_____/_____

City ______________________________State______________Zip______________

Secondary Insurance Is Patient covered by Additional Insurance? ☐ Yes ☐ No

Insurance Company Name________________________________ Phone ( ) ______________

Member ID# ________________________________ Group # ______________

Insured's Name ______________________DOB__________SS#______________

City ______________________________State______________Zip______________

Signature, I consent to treatment and have supplied all information to the best of my knowledge.

____ ______________________
Signature of Patient, Parent, Guardian, or Personal Representative Date

PRESBYTERIAN EAR INSTITUTE
415 CEDAR ST SE
ALBUQUERQUE, NM 87106
OFFICE ~ (505) 224-7020
FAX ~ (505) 224-7023

MEDICAL RECORDS RELEASE / REQUEST FORM

THIS FORM ALLOWS PRESBYTERIAN EAR INSTITUTE TO SEND MEDICAL RECORDS TO THE REFERRING DOCTOR, AUDIOLOGIST, AS WELL AS OTHER PROFESSIONALS AS INDICATED BELOW.

PATIENT INFORMATION

PATIENT NAME: ______________________ DATE OF BIRTH: ____/____/____

ADDRESS: ______________________

CITY: ______________ STATE: ________ ZIP: __________

INFORMATION TO BE RELEASED

** PLEASE INDICATE SPECIFIC RECORDS TO BE RELEASED.*

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PARTY RELEASING INFORMATION

FACILITY NAME: ______________________

FAX NUMBER: ______________ ADDRESS: ______________________

AUTHORIZATION

BY SIGNING BELOW, I HEREBY AUTHORIZE THE ABOVE FACILITY TO OBTAIN PERTINENT INFORMATION, INCLUDING MEDICAL, SOCIAL AND EDUCATIONAL AS NEEDED. IN ADDITION, I AUTHORIZE THAT A PHOTO COPY OF THIS AUTHORIZATION BE ACCEPTED WITH THE SAME AUTHENTICITY AS THIS ORIGINAL. ANY PERSON OR AGENCY RECEIVING THIS INFORMATION IS DIRECTED TO TREAT IT AS CONFIDENTIAL. THIS AUTHORIZATION MAY BE REVOKED IN WRITING AT ANY TIME. THE DISCLOSED INFORMATION MAY BE SUBJECT TO REDISCLOSURE BY THE RECIPIENT. THIS AUTHORIZATION WILL EXPIRE ONE YEAR FROM THE DATE IT WAS SIGNED.

______________________ ____/____/____

SIGNATURE OF PATIENT, GUARDIAN, OR PERSONAL REPRESENTATIVE — DATE

PRESBYTERIAN EAR INSTITUTE
415 CEDAR ST SE
ALBUQUERQUE, NM 87106

Welcome to PEI. Our goal is to provide you with quality medical care in a friendly, safe and caring environment. Although we take pride in the quality of our services, we know there is always room for improvement. If you have any suggestions or concerns related to your care of the service you receive, please request to speak with our office manager. PEI is committed to maintaining the very highest standards of ethics and integrity. We are committed to ensuring that all affairs are conducted in accordance with all applicable laws, rules, regulations policies and procedures.

FINANCIAL AGREEMENT

I, the undersigned patient/guardian/parent, assign directly to Presbyterian Ear Institute all benefits otherwise payable to me for services rendered. I also authorize this office to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions whether manual or electronic. I acknowledge that co-pays and deductibles are due at the time of treatment. I accept full financial responsibility for all charges not covered by insurance.

APPOINTMENT NON-COMPLIANCE CONTRACT

PEI understands that not showing and late cancellations for appointments sometimes cannot be helped. As soon as you are aware that you will be unable to keep your appointment, please notify the office immediately. Patients who no show or cancel with less than 24 hours notice of their scheduled appointment will be charged a $25.00 fee for which the patient, not the insurance company, is responsible. This fee must be paid in full before PEI will allow another appointment to be scheduled.

FACILITY AGREEMENT

Presbyterian ear institute (PEI) will make every attempt to make the wait comfortable, but we do insist that clients who are coming to Presbyterian Ear Institute for audiology testing (hearing tests), speech and language evaluation or therapy visits remain in the lobby while waiting for their provider. The provider will come to the lobby to accompany their client(s) to their office. **Guardians of minor clients must remain on Presbyterian Ear Institute property while the patient is being seen. No exceptions will be made.**

All patients/visitors to PEI must sign in at the front desk prior to any appointments.

Presbyterian ear institute (PEI) has several programs including a ***parent infant program***, ***speech and language therapy program***, and ***Presbyterian Ear Institute Oral School***. The school has a playground on site, as well as classrooms and a learning center. Due to insurance liability these areas are for enrolled students of Presbyterian Ear Institute and their families upon staff supervision only.

By signing below it is understood that all the above policies of Presbyterian Ear Institute will be followed.

______________________________	______________________________
PATIENT OR GUARDIAN (IF PATIENT IS MINOR)	DATE
______________________________	______________________________
PEI RECEPTIONIST	DATE

HIPAA PRIVACY POLICY

THIS NOTICE DESCRIBES HOW YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED BY THE STUDENT HEALTH CENTER AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

UNDERSTANDING YOUR PROTECTED HEALTH INFORMATION (PHI):
Understanding what is in your health record and how your health information is used will help you to ensure its accuracy, allow you to better understand who, what, when, where and why others may access your health information, and assist you in making more informed decisions when authorizing disclosure to others. When you visit us, we keep a record of your symptoms, examination, test results, diagnoses, treatment plan, and other medical information. We also may obtain health records from other providers. In using and disclosing this protected health information (PHI), it is our objective to follow the Privacy Standards of the federal Health Insurance Portability and Accountability Act, 45 CFR Part 464, even if this is not required in order to treat students. The law allows us to use and disclose PHI without your specific authorization for treatment, payment, operations and other specific purposes explained on the next page. It also includes contacting you for appointment reminders and follow-up care. All other uses and disclosures require your specific authorization.

YOUR HEALTH INFORMATION RIGHTS ALLOW YOU TO:
- Request a restriction on the uses and disclosures of PHI as described in this notice, although we are not required to agree to the restriction you request. You should address your request in writing to the Privacy Officer. We will notify you within 30 days if we cannot agree to the restriction.
- Obtain a paper copy of this Notice and upon written request, inspect and obtain a copy of your health record for a fee of $.60 per page and the actual cost of postage per NRS 629.061, except that you are not entitled to access, or to obtain a copy of, information compiled for legal proceedings.
- Amend your health record by submitting a written request with the reasons supporting the request to the Privacy Officer. In most cases, we will respond within 30 days. We are not required to agree to the requested amendment.
- Obtain an accounting of disclosures of your health information, except that we are not required to account for disclosures for treatment, payment, operations, or pursuant to authorization, among other exceptions.
- Request in writing to the Privacy Officer that we communicate with you by a specific method and at a specific location. We will typically communicate with you in person; or by letter, e-mail, fax, and/or telephone.
- Revoke an authorization to use or disclose PHI at any time except where action has already been taken.

OUR RESPONSIBILITIES AS REQUIRED BY LAW:
- Maintain the privacy of PHI and provide you with notice of our legal duties and privacy practices with respect to PHI.
- Abide by the terms of the notice currently in effect. We have the right to change our notice of privacy practices and we will apply the change to your entire PHI, including information obtained prior to the change.
- Post notice of any changes to our Privacy Policy in the lobby and make a copy available to you upon request.
- Use or disclose your PHI only with your authorization except as described in this notice.
- Follow the more stringent law in any circumstance where other state or federal law may further restrict the disclosure of your PHI.

FOR MORE INFORMATION OR TO REPORT A PROBLEM, CONTACT THE PRIVACY OFFICER AT:
Presbyterian Ear Institute
415 Cedar Street SE, Albuquerque, NM 87106
(505) 224-7020

If you feel your rights have been violated, you may file a complaint in writing with the Privacy Officer. If you are not satisfied with the resolution of the complaint, you may also file a complaint with the Secretary of Health and Human Services. Filing a complaint will not result in retaliation.

We may use or disclose your PHI for treatment, payment and operations, and for purposes described below:

TREATMENT:
We will use and exchange information obtained by a physician, nurse practitioner, nurse or other medical professionals, staff, trainees and volunteers in our office to determine your best course of treatment. The information obtained from you or from other providers will become part of your medical records. We may also disclose your PHI to other outside treating medical professionals and staff as deemed necessary for your care. For example, we may disclose your PHI to an outside doctor for referral. We will also provide your health care providers with copies of various reports to assist them in your treatment

PAYMENT:
We may send a bill to you or to your insurance carrier. Also, the disbursement office may receive PHI as necessary to pay a claim. The information on or accompanying the bill may include information that identifies you, as well as that portion of your PHI necessary to obtain payment.

HEALTH CARE OPERATIONS:
Members of the medical staff, trainees, medical students, a Risk or Quality Improvement team, or similar internal personnel may use your information to assess the care and outcomes of your care in an effort to improve the quality of the healthcare and service we provide.

OTHER USES AND DISCLOSURES NOT REQUIRING AUTHORIZATION:
• **Notification:** We may disclose limited health information to friends or family members identified by you as being involved in your care or assisting you in payment. We may also notify a family member, or another person responsible for your care, about your location and general condition.
• **Legally Required Disclosures & Public Health:** We may disclose PHI as required by law, or in a variety of circumstances authorized by federal or state law. For example, we may disclose PHI to government officials to avert a serious threat to health or safety or for public health purposes, such as to prevent or control communicable disease (which may include notifying individuals that may have been exposed to the disease, although in such circumstance you will not be personally identified), federal or state health oversight agencies, child abuse or neglect, domestic violence, to an employer to evaluate work related injuries, and to public officials to report births and deaths.
• **Law Enforcement & Subpoenas:** We may disclose PHI to law enforcement such as limited information for identification and location purposes, or information regarding suspected victims of crime, including crimes committed on our premises. We may also disclose PHI to others as required by court or administrative order, or in response to a valid summons or subpoena.
• **Information Regarding Decedents:** We may disclose health information regarding a deceased person to: 1) coroners and medical examiners to identify cause of death or other duties, 2) funeral directors for their required duties and 3) to procurement organizations for purposes of organ and tissue donation.

DISCLOSURES REQUIRING AUTHORIZATION:
The release of health information to other treating professionals outside Presbyterian Ear Institute will be made with written authorization from the patient, which you have the right to revoke at any time, except to the extent we have already relied upon the authorization or in the event of an emergency.

ACKNOWLEDGEMENT OF RECEIPT:
Federal law requires that we seek your acknowledgment of receipt of this Notice of Privacy Practices. Please sign below.

I acknowledge that I have received this Notice of Privacy Practices with an effective date of July 31, 2008, and that I understand that if I have any questions regarding this Notice, I may contact the Privacy Officer.

Signature: ______________________________ Date: ______________

Printed Name: ____________________________

Signature of Parent/Guardian(specify which):

______________________________________ Date: ______________

For Office Use Only

Signed Acknowledgment of Receipt received on ____________________.
Initials _______

Notice of Privacy Practices sent/delivered on ____________________.
Initials _______

Patient Refused or Failed to Acknowledge Receipt on _________________.
Initials _______