COASTAL CAROLINA ENT
PATIENT REGISTRATION SHEET

Cell#

Patient Information

ACCOUNT #	SOCIAL SECURITY #	TITLE	LAST NAME	FIRST NAME	MI
MAILING ADDRESS	CITY	STATE / ZIP CODE	HOME PHONE	PATIENT DATA (Office Use)	
BIRTHDAY (M/D/YY)	SEX (M,F)	RACE Black ❑ White ❑ Hispanic ❑ Other ❑	PRIMARY DOCTOR (Office Use)	MARITAL STATUS Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated ❑	
EMPLOYMENT Retired ❑ Full ❑ Part ❑ None ❑	STUDENT Part ❑ Full ❑ None ❑	REL. TO INSURED Self ❑ Spouse ❑ Child ❑ Other ❑	EMPLOYER CODE (Office Use)	EMPLOYER / SCHOOL NAME	
OCCUPATION	STREET ADDRESS	CITY	STATE / ZIP CODE	BUSINESS PHONE	

Financially Responsible Party (if other than Patient)

ACCOUNT #	SOCIAL SECURITY #	TITLE	LAST NAME	FIRST NAME	MI
MAILING ADDRESS	CITY	STATE / ZIP CODE	HOME PHONE	PATIENT DATA (Office Use)	
BIRTHDAY (M/D/YY)	SEX (M,F)	RACE Black ❑ White ❑ Hispanic ❑ Other ❑	PRIMARY DOCTOR (Office Use)	MARITAL STATUS Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated ❑	
EMPLOYMENT Retired ❑ Full ❑ Part ❑ None ❑	STUDENT Part ❑ Full ❑ None ❑	REL. TO INSURED Self ❑ Spouse ❑ Child ❑ Other ❑	EMPLOYER CODE (Office Use)	EMPLOYER / SCHOOL NAME	
OCCUPATION	STREET ADDRESS	CITY	STATE / ZIP CODE	BUSINESS PHONE	

Insurance Information

ACCOUNT DATA	BILLING CYCLE	LOCATION	ACCOUNT CONTROL	
PRIMARY INSURANCE COMPANY	POLICY #	INSURED'S NAME	DATE OF BIRTH	RELATIONSHIP TO PATIENT
SECONDARY INSURANCE COMPANY	POLICY #	INSURED'S NAME	DATE OF BIRTH	RELATIONSHIP TO PATIENT

Emergency Contacts

NAME	ADDRESS	PHONE
NAME	ADDRESS	PHONE
NAME	ADDRESS	PHONE

Other Personal Information

MEDICATIONS CURRENTLY TAKING | DRUG ALLERGIES

CURRENT MEDICAL CONDITIONS (Diabetes, High Blood Pressure, Pregnant, AIDS/HIV, Etc.)

METHOD OF PAYMENT (Credit Card, Cash, Etc.) | REFERRED BY (Doctor's Name, TV Ad, Newspaper, Radio, Friend's Name, Other-indicate)

Please Read and Sign Below

I authorize the release of any medical information necessary to process health insurance claims. I request payment of the benefits to be made directly to *Coastal Carolina ENT.* Any unexpected balance left after insurance payment has been received will be due in full within 90 days of notification from this office. I further understand that any sums due me, if less than $100.00, will be credited to my medical account. This authorization is valid unless rescinded in writing. A photocopy is as valid as the original.

I HAVE READ AND UNDERSTOOD ALL OF THE ABOVE AND HAVE GIVEN TRUTHFUL INFORMATION TO THE BEST OF MY KNOWLEDGE.

Signature ______________________ Date ____________

COASTAL CAROLINA ENT, P.A.

Patient Privacy Notice Form

Erik L. Kenyon, DO James DiMuzio, Jr., DO Jeffrey Coury, DO

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient authorization.

You may refuse to authorize the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). At any time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Signature: ______________________________ Print Name: ______________________________ Date: ____________

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

COASTAL CAROLINA ENT, P.A.

Erik L. Kenyon, DO James DiMuzio, Jr., DO Jeffrey Coury, DO

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule." We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate use of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

Thank your for being one of our highly valued patients.