Cleveland Nasal Sinus & Sleep Center

Howard L. Levine, MD
Hillcrest Hospital Physicians Atrium
6770 Mayfield Heights, OH 44124
Phone: 440-634-9980 Fax: 440-449-9279

REGISTRATION

(Please Print)

PATIENT INFORMATION

Name:_____ Soc. Sec.# _____

Address:_____

(Street Address) (City) (State) (Zip)

Sex ☐ Male ☐Female Age: _____ Date of Birth: _____/_____/_____ Home Phone: _____

Cell Phone: _____ Email: _____

Patient Employed By: _____ Occupation: _____

Employer Address: _____

(Street Address) (City) (State) (Zip)

Employer Phone#: _____ Whom may we thank for referring you? _____

Primary Care Physician: _____ Phone#: _____

In case of emergency who should be notified?: _____ Phone#:_____

Marital Status: ☐Single ☐Married ☐Widowed ☐Divorced ☐Separated

PRIMARY INSURANCE

Person Responsible for Account: _____

(Last Name) (First Name) (Middle Initial)

Relation to Patient_____ Insureds Date of Birth: _____/_____/_____ Soc Sec#: _____

Address (If different from patient) _____

(Street Address) (City) (State) (Zip)

Phone#:_____ Responsible Party Employer: _____

Employer Address: _____

(Street Address) (City) (State Zip Code

Insurance Company: _____ Customer Service Phone#: _____

(Please present card to receptionist)

Policy ID# _____ Group# _____

ADDITIONAL INSURANCE

Is patient covered by additional Insurance: ☐ Yes ☐ No Is this a Workers Compensation Claim? ☐ Yes ☐No

Subscribers Name: _____ Relation to Patient: _____ Date of Birth: _____

Address (if different from patient): _____

Street Address City State Zip Code

Policy Holder Employed By: _____ Employer Phone#:_____

Employer Address: _____

Street Address City State Zip Code

Insurance Company:_____ Customer Service Phone#:_____

Policy ID#: _____ Group#:_____

Workers Comp Claim#: _____ Do you have a C9 Authorization for your visit today? ☐Yes ☐No

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have Insurance coverage with _____

(Name of Insurance Company)

I authorize the physician office to submit any and all health care information to my health insurance program(s) for their review and payment. I understand that I am responsible for all services whether or not paid by insurance. I assign all insurance benefits for services rendered directly by Dr Levine, that would otherwise be payable to me. I further understand that with certain health care plans, I may be responsible for deductibles, co-payments, and varying rules concerning hospitals, labs and care. I authorize the use of this signature on all insurance submissions for consideration of payment.

_____ _____ _____

(Responsible Party Signature) (Relationship to Patient) (Date)

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Patient Records Disclosure

In general, the Health Insurance Portability and Accountability Act (HIPAA) rules gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individuals home.

I wish to be contacted in the following manner: (Check all that apply)

☐ Home Telephone: _____
- ☐ Okay to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Work Telephone: _____
- ☐ Okay to leave message with detailed information
- ☐ Leave message with call-back number only

☐ US Mail to: ☐ Ok to send mail to my home address ☐ OK to send mail to my work address
(Please be sure your work address is on the registration page)

☐ Ok to fax to this number: _____

☐ Ok to leave detailed information with the following family member(s):

Name_____ Relationship _____
Name _____ Relationship _____
Name _____ Relationship _____

☐ Ok to send email with detailed information to: _____

_____ _____
Patients Name (Please Print) Date of Birth

_____ _____
Signature of patient/parent/guardian Date

THE PATIENT IS RESPONSIBLE FOR PROVIDING ANY NECESSARY CHANGES TO THIS FORM.

The Notice of privacy Practices of Cleveland Nasal Sinus & Sleep Center provides information about how we may use and disclose confidential information about you. Please reed our notice before signing this consent. The terms of our notice may change at any time. If we change out notice, you may obtain a revised copy during your next visit.

By signing this authorization, you agree to let us use and disclose confidential medical information about you for treatment, payment and health care operations. This includes information about your physical and mental illness, substance abuse or HIV/AIDS. If applicable, you are also consenting to the release of medical information about you to any insurer, third party payer, the Social Security Administration, or any agents or consultants who help this office obtain payment for your treatment as well as other health care operations.

Date: _____ Patient Signature: _____

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Financial Policy

1. A photo ID may be requested upon checking in for your appointment
2. **We request you bring your current insurance card to each office visit**.
3. Co-Payments will be expected at the time of service.
4. If you do not have insurance, total payment is due at the time of service unless prior arrangements have been made.
5. Cosmetic procedures or other procedures not covered by insurance will require payment in full prior to the procedure being performed.
6. Our office accepts cash, checks, and all major cards (Visa, Mastercard, Discover, American Express). We also offer a payment assistance plan through Care Credit (12months same as cash)
7. There will be a charge of $30.00 for returned checks
8. **If you miss an appointment without providing a 24-hour notice, you will be charged a $25.00 No-Show fee.**
9. Account balances are due within 30 days of final payment by your insurance company. In the event your account is referred to our collection agency, your account will incur collection fees in addition to your account balance.
10. Balances or other account information will not be disclosed to anyone other than the patient.
11. Emergencies will be handled on a case by case basis
12. **It is the responsibility of the patient to secure a referral from their primary care physician. Patient will assume all financial responsibility for fees and charges incurred if a referral is required and not in place at the time of service.**
13. **WORKERS COMPENSATION:** It is your responsibility to have your physician of record (POR) obtain a C-9 authorization for consultation **BEFORE** you are seen. **(The C-9 request should include a consultation along with a diagnostic endoscopy, laryngoscopy or hearing test depending on the nature of your injury and allowed diagnosis).** New injured workers who do not yet have a POR should bring their employer information with BWC-MCO contact information, assigned claim number and date of injury. **Please bring a copy of the approved C-9, along with either your BWC ID card, or a statement with all pertinent BWC Claim information provided to you by your employer to your appointment.**

Name (Please Print): _____

Patient Signature: _____

Date: _____

****PLEASE NOTE****

As a courtesy we are informing you that certain hearing services such as hearing tests may not be covered by your insurance. Coverage for hearing services vary with each insurance plan.
Please check with your insurance company if you are unsure if you have coverage for hearing services.
We recommend verifying this information with your insurance plan prior to having these services provided.