Adult & Pediatric ENT & Allergy OF THE WOODLANDS

Tongue-Tie/Lip-Tie Registration Forms
Please Print Legibly

***Indicates Required Fields**

Demographics

***Patient Last Name**: _____ ***First Name**: _____ **Middle Initial**: _____

***Date of Birth**: _____/_____/_____ ***Gender**: ☐Male ☐Female ***Prefix**: ☐Mr. ☐Miss ☐Ms. ☐Mrs. ☐Dr. ***Suffix:** ☐II ☐III ☐IV ☐Jr ☐Sr

***Street Address**: _____ **Apt #**: _____ ***Marital Status**:_____

***City**: _____ ***State**: _____ ***Zip**: _____ ***Email**:_____

***Home Phone**: (_____)_____-_____ ***Cell Phone**: (_____)_____-_____ **Preferred**: ☐Home ☐Cell

SSN: ___ -____-_____ **Student Status**: ☐Full-Time ☐Part-Time ☐N/A

Employer Status: ☐Full-Time ☐Part-Time ☐Retired ☐N/A **Employer Name**:_____

***Primary Care Physician**: _____ ***Referring Doctor**: _____
(Print Full Name) **(Print Full Name)**

Address: _____ Address: _____

City: _____ State:_____ ZIP: _____ City: _____ State:_____ZIP:_____

***Phone** #:(_____)_____-_____ ***Phone** #:(_____)_____-_____

Emergency Contact

***Full Name**:_____ ***Relation to Patient**:_____

***Primary Contact Phone** #:(_____)_____-_____ ***Secondary Contact Phone** #:(_____)_____-_____

Preferred Pharmacy

***Pharmacy Name**:_____ ***Phone** #:(_____)_____-_____ **Address**:_____

DUE TO RECENT REFORMS MANDATED BY THE GOVERNMENT, DOCTORS ARE REQUIRED TO ASK *ALL* PATIENTS FOR THEIR RACE, ETHINICITY, AND PREFERRED LANGUAGE REGARDLESS OF YOUR INSURANCE TO MEET MEANINGFUL USE REQUIREMENTS.

***Race**: ❑American Indian/Alaskan Native ❑Asian ❑Native Hawaiian/Other Pacific Islander ❑Black/African American ❑White ❑Hispanic ❑ Other Pacific Islander ❑Other Race ❑Unreported/Refused to Report
***Ethnicity**: ❑Hispanic/Latino ❑Not Hispanic/Latino ❑Refused to Report
***Language**: ❑English ❑Other ❑Indian ❑Spanish

The above information is complete and accurate to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. If any changes occur I understand it is my responsibility to advise the office. I understand that I am financially responsible for any balance. I also authorize Woodlands ENT or insurance company to release any information required to process my claims.

***Print Parent or Legal Guardian Full Name:**_____

***Parent or Legal Guardian Signature:**_____ ***Date:**_____

***IF LEGAL GUARDIAN **COURT DOCUMENTS** MUST BE SUBMITTED TO OFFICE PRIOR TO VISIT (FAX: 936-271-2223)

17450 St. Luke's Way, Suite 200
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Adult & Pediatric ENT & Allergy OF THE WOODLANDS

Authorization to Release Information

PROTECTED HEALTH INFORMATION TO DESIGNATED REPRESENTATIVE(S)

I,_____, give my authorization to **release** my child's,
(Parent/Legal Guardian Full Name)

_____, information including results of laboratory tests, X-rays,
(Print Full Name of Patient)

protected health and/or other test results to the following designated representative(s).

***Parent/Guardian Initials**

_____ My Spouse (Name) _____

_____ My Child (Name) _____

_____ Other (Name) _____

_____ Personal Representative _____

_____ May leave a **detailed message** on answering machine at home.

_____ May be left on my answering machine at work.

_____ May leave a **detailed message** on cell#: _____

_____ MAY NOT BE GIVEN TO ANYONE OTHER THAN MYSELF.

***Print Parent or Legal Guardian Full Name:**_____

***Parent or Legal Guardian Signature:**_____ ***Date:**_____

As a patient, you have the right to revoke this authorization in writing at any time, except to the extent that action has been taken in reliance in this authorization or, if applicable, during contestability period. In order for the revocation of this authorization to be effective, Woodlands ENT must receive revocation in writing. The revocation must include, 1) The patients name, address, DOB, 2) The patient/legal guardians desire to revoke the authorization, 3) The date of the revocation and the patient/legal guardians signature. All revocations must be sent in writing to our office and will not be considered effective until receive by our office.

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Notice of Privacy Practices

1. **THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.** The notice is provided in two layers: This layer briefly summarizes how we handle your health information, and the attached bottom layer provides further details of our privacy policies and procedures.

2. **How we may use and disclose your health information.** We use health information about you for treatment, to get paid for treatment, for administrative purposes, and to evaluate the quality of care that you receive. For example, your health information may be shared with other providers to whom you are referred. Information may be shared by paper, mail, electronic mail, fax, or other methods. We may use or disclose your health information without your authorization for several reasons. If you sign an authorization to disclose information, you can later revoke it to stop any future disclosures.

3. **Your rights.** In most cases, you have the right to look at or get a copy of your health information that we use to make decisions about you. You may request that we limit disclosure to family members, other relatives, caregivers, or close personal friends who may or may not be involved in your care. If you request copies, we may charge you a cost-based fee. You also have the right to request a list of certain types of disclosures of your information that we have made. If you believe that your health information is incorrect or information is missing, you have the right to request that we correct the existing information or add the missing information.

*May we discuss your child's medical condition with any member of your family? **YES NO**

*If **YES**, please print the **full name** the members allowed:

_____

_____

4. **Our legal duty.** We are required by law to protect the privacy of your health information, provide this notice about our privacy practices, follow the privacy practices that are described in this notice, and see your acknowledgement of receipt of this notice. We may change our privacy policies any time. Before we make a significant change in our policies, we will change our notice. This notice will be prominently displayed at all ENT & Allergy of The Woodlands locations and on our website. You can also request a copy of our notice at any time. For more information about our privacy policies, contact our privacy officer.

5. **Privacy complaints.** If you are concerned that we have violated your privacy rights, our privacy policies, or if you disagree with a decision we made about access to your health information, you may contact our privacy officer. You may send a written complaint to the U.S. Department of Health and Human Services. Our privacy officer can provide you with the appropriate address upon request.

If you have any questions or complaints, please contact: Privacy Officer, 17450 St. Luke's Way, Suite 200, The Woodlands, Texas 77384. Phone number: (281) 203-5015.

Acknowledgement of receipt of Notice of Privacy Practices: Please sign and print your name and provide the date below to acknowledge that you have received both layers of the Notice of Privacy Practices.

***Print Parent or Legal Guardian Full Name:**_____

***Parent or Legal Guardian Signature:**_____ ***Date:**_____

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NOT A GUARANTEE Of Benefits: Deductibles, co-insurance, and co-payments are **due at the time of service**. Uncovered services are the patient's responsibility. Delays in processing due to pre-existing clauses or administrative delays become the patient's immediate responsibility. If the insurance premium has not been paid prior to the patients' appointment, the patient will be subject to self-pay pricing or the appointment will be cancelled. A statement will be sent if additional payment is owed after insurance processing. These procedures, including others may be subject to more than just your copay: *Nasal debridement, removal of cerumen, tongue-tie, lip-tie, allergy testing and treatment*. In accordance with Texas Admin Code 28 TAC 3.3703 (a) (28) you may be referred for non-emergency treatment to a facility that is out of network. Please ask our staff if you have questions about the above services mentioned. If we are contracted with your insurance carrier, we are required to follow our contract and their requirements. If you have a co-pay or deductible, you must pay that at the time of service. It is the insurance carrier that makes the final determination of your eligibility. Our surgery pre-certification staff will obtain the necessary authorization for the surgery procedure(s). Insurance is a contract between you and your insurance carrier. As a courtesy to you, we will file an insurance claim to your primary insurance carrier and your secondary, if applicable. It is the insurance company that makes the final determination of your eligibility. Estimates given by insurance specialist's are never a guarantee of eligibility. You agree to pay any portion of the charges not covered by your insurance carrier.

Appointment Cancellation: Failure to provide 2 business days/48 hours advance notice of the cancellation of your appointment for *Tongue-tie/lip tie and Lactation appointments w*ill result in a 'no-show' fee of $50 per provider appointment, which must be paid prior to rescheduling the next appointment. New patients who no-show their first appointment will not be rescheduled. Patients with 3 consecutive no show or rescheduled appointments will be asked to seek a new provider. **If a patient is in a grace period because their insurance premium has not been paid to date, or they have a term date their appointment may be cancelled.**

Referrals: If your insurance carrier requires an office referral and/or pre-authorization, **you are responsible for obtaining it**. Failure to obtain the referral and/or pre-authorization may result in the cancellation of you or your child's appointment. If your insurance plan requires a current referral, it is your responsibility to ensure that the referral is in this office before your visit. If you see the doctor without a referral, your claim may get denied by your insurance and you will be responsible for the cost of the visit.

Minors/Divorce: Responsibility for payment for treatment of minor children, regardless of the legal status between the parents, rests with the parent who seeks the treatment on that date of service. In the case of a divorce or separation, the party responsible for the child's account remains responsible for the account. After a divorce or separation, the parent authorizing treatment for the child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Copies of Medical Records: Texas law allows the provider to collect a $25.00 fee, with additional charges due if the records exceed 20 pages. However, we want to provide this service at a cost that simply covers the expense of record retrieval and duplication. This charge is $20.00, payable before the records are prepared. If your records are voluminous, however, this fee may be higher. Please allow a minimum of THIRTY business days to obtain copies of records. A signed authorization is required to release all records.

Financial and Billing Policy Continued

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Completion of Additional Forms, Reports, and Letters: Documents/forms that require the physician's input and attestation, such as FMLA, disability papers, letters to attorneys, etc., require a prepayment of $25.00 for **each set** of forms. The fee is due upon submission of the forms to the physician, and prior to their preparation. Such forms require a **minimum of SEVEN business days for completion.**

Surgical Deposit/Cancellation: Based upon your insurance benefits, a deposit is due prior to surgery. The deposit amount is based on the anticipated surgical procedures, and is **only an estimate.** The fee is due the Friday before the procedure, or the procedure may be rescheduled. You may receive an additional bill from this office after the claim is processed**.** Please **MAKE SURE** to call the surgery center to get you're pricing in addition to Dr. James Liu's portion. ***We charge a $150.00 fee for all patients who fail to provide a 48 hour advance notice for surgery cancellations.***

Returned Checks: There is a $30.00 fee for each returned check. Unpaid checks will be prosecuted.

Collections: An unpaid account may be turned over to a third party collection agency that will report the information to all three major credit reporting agencies. All collection expenses and taxes, and all accrued statement fees will be added to the account balance when it is transferred to an outside collection agency.

Refunds: Refunds for deposits made with a credit card on an electively cancelled surgery/procedure will be issued by check. Refunds for services delivered are made only after your insurance company has fully processed the claim. Refund checks will be issued to the party who paid the overage (payer), not necessarily the guarantor on the account, unless written instructions from the original payer are received before the refund check is issued.

Complaints: Billing complaints may be made to the practice manager, preferably in writing, who will make every attempt to promptly resolve the issue in accordance with the policies stated herein.

**I have reviewed these policies and agree to the terms as stated above. A copy is available upon my request.

***Print Parent or Legal Guardian Full Name:**_____

***Parent or Legal Guardian Signature:**_____ ***Date:**_____

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Lactation and Frenotomy Appointment Cancellation Policy

Our goal is to provide quality individualized medical care and lactation support in a timely manner. No-shows, late shows and cancellations inconvenience those individuals who need access to these services.

Cancellation of a Lactation or Tongue-Tie/Lip-Tie Appointment
Appointments are in high demand, and your early cancellation will allow another patient access to timely lactation support and medical care. In order to be respectful of the needs of other patients, please be courteous and call Dr. Liu's office promptly if you are unable to keep a scheduled appointment.

If it is necessary to reschedule or cancel your scheduled appointment, we require that you call at least ***2 business days/48 hours*** in advance. If the call is not made prior to this deadline each appointment will be subjected to the cancellation fee.

***A **$50.00 cancellation fee** will be charged for any appointments cancelled or rescheduled less than **2 business days/48 hours in advance** including any no-show appointments.

I acknowledge and accept the cancellation policy related to Lactation and Frenotomy appointments.

***Print Parent or Legal Guardian Full Name:**_____

***Parent or Legal Guardian Signature:**_____ ***Date:**_____

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Disclosure and Consent

Frenuloplasty Procedure

As a patient, you have the right to be informed about your medical condition and recommended surgical procedure(s) so that you may choose whether or not to undergo the surgical procedure(s) after learning the risks and hazards involved. The purpose of this disclosure is not meant to be alarming, but is simply our effort to ensure you are well-informed in making a decision for patient treatment and care.

I voluntarily request physician **Dr. James H. Liu, MD, FAAP** to treat my condition which has been explained to me as:

Ankyloglossia (tongue tie and lip tie)

It is to my understanding that the recommended surgical procedure is planned for my benefit and I voluntarily consent to and allow this procedure:

Frenuloplasty

I understand the possibility of my physician discovering other or different conditions during my office visit, which may require additional or different procedures for treatment. I give consent to my physician to perform the necessary procedure(s) for optimal treatment advisable in his best professional judgment.

While I understand possible risks and hazards in continuing without treatment of my present condition, I also understand possible risks and hazards relating to the surgical procedure recommended for me. Common risks and hazards include infection, blood clots, hemorrhage, allergic reactions, and even death. I also realize that the following risks and hazards may occur with this procedure:

1. Inadequate mobilization of the tongue with necessity for follow-up procedures.
2. Bleeding, scarring or infection.
3. Injury to salivary ducts.

My physician and his staff have allowed me the opportunity to ask questions regarding my condition, the surgical procedure, and risks and hazards involved with the procedure and with continuing without treatment. I have obtained sufficient information to make a well-informed decision and am willing to give my consent for this surgical procedure. This form has been fully explained to me, and I have read it or have had it read to me, and I understand all of its contents.

***Print Parent or Legal Guardian Full Name:**_____

***Parent or Legal Guardian Signature:**_____ ***Date:**_____

Advance Beneficiary Notice of Noncoverage (ABN)

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NOTE: Reading and understanding the following information is important for your decision whether or not to receive these health care items or services.

We expect that your health insurance company may or may not pay for the item or service described below. The fact that this is an expectation does not mean that you should not receive healthcare. Your doctor's professional recommendations are very important for patient health. Right now, in your case, your health insurance policy may not pay for:

Service: Lip-Tie

_____ _____

***Print Patient Full Name** ***DOB**

This form's purpose is to help you make the most informed decision regarding receiving healthcare services from Woodlands ENT with the knowledge that you may be fully responsible financially. Before you make a decision about your options, please read this entire notice carefully.

- Please ask us to explain information you do not understand about your health insurance benefits or why the recommended service(s) may not be paid by your health insurance company.
- **The estimated cost for this service is $250.00.**

PLEASE SELECT & CHECK **ONE** OPTION

☐ Option 1. **YES**. I want to receive the recommended service(s).
I understand that my health insurance company will not decide whether to pay for my service(s) unless I receive the service(s). Please submit my claim to my health insurance company. I understand that I may receive a bill from Woodlands ENT for my service(s) and I may be fully responsible for paying the bill while my health insurance company is processing claims or if they deny claims. If my health insurance company does make payment, I will receive a refund as necessary. I understand I may be able to appeal my health insurance company's decision not to pay.

☐ Option 2. **NO**. I DO NOT want to receive the recommended service(s).
I will not receive the service(s) recommended by my doctor. I understand that my doctor's staff will not be able to submit a claim to my health insurance company and that I will not be able to appeal a claim for the recommended service(s).

_____ _____

***Print Parent or Responsible Party Full Name** ***DOB**

_____ _____

***Parent or Responsible Party Signature** ***Date**

Note: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our office. If a claim is submitted, your health information may be shared with your insurance company. Your health information seen by your health insurance company will be kept confidential.

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