PATIENT INFORMATION AND ACKNOWLEDGMENT OF RECEIPT & CONSENT

PATIENT'S NAME	SS#	MARITAL STATUS S M W D SEP	SEX M / F	BIRTHDATE	AGE	TODAY'S DATE
ADDRESS	CITY, STATE,ZIP CODE				HOME PHONE	
EMAIL	DRUG ALLERGIES, IF NONE, STATE "NO KNOWN ALLERGIES"		REFFERED BY			

PATIENT'S EMPLOYER (OR FATHER'S, IF MINOR)	OCCUPATION	HOW LONG	FATHER'S NAME AND SS#, IF MINOR
EMPLOYER'S ADDRESS		BUS. PHONE	FATHER'S BIRTHDAY, IF MINOR

SPOUSE'S EMPLOYER (OR MOTHER'S, IF MINOR)	OCCUPATION	HOW LONG	SPOUSE'S NAME AND SS# (OR MOTHER'S,IF MINOR)
EMPLOYER'S ADDRESS		BUS. PHONE	SPOUSE'S BIRTHDATE (OR MOTHER'S IF MINOR)

PERSON RESPONSIBLE FOR PAYMENT	ADDRESS, CITY, STATE, ZIP CODE	HOME PHONE
IN CASE OF EMERGENCY NOTIFY	RELATIONSHIP	HOME PHONE
HAS ANY MEMBER OF YOUR FAMILY BEEN TREATED BY OUR PHYSICIANS BEFORE? INCLUDE NAME OF FAMILY MEMBER.		

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE AND CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

Read before signing the Acknowledgement and Consent

This acknowledgement of notice and consent authorizes Ear, Nose & Throat Associates of Johnstown, Inc. to use and disclose health information about you for treatment, payment and health care operations purposes. With this consent, ENT Associates may call your home, cell phone or other alternative location and leave a message on voicemail or in person, in reference to any items that assist the practice in carrying out our healthcare operations, such as appointment reminders, insurance items and any calls pertaining to your clinical care, including laboratory or other results.

Notice of Privacy Practices- Ear Nose & Throat Associates has a Notice of Privacy Practices, which describes how we may use and disclose your protected health information. Please review our notice prior to signing this acknowledgement.

Amendments- We reserve the right to change our notice. You may obtain a revised notice by submitting a written request to:

Ear, Nose & Throat Associates, 348 Budfield Street, Johnstown, PA 15904 Attn: Privacy Officer

Acknowledgement and Consent

I have received the Notice of Privacy Practices for Ear, Nose & Throat Associates of Johnstown, Inc. and I authorize them to use and disclose health information about me for treatment, payment and healthcare operations purposes consistent with their Notice of Privacy Practices. I authorize payment of medical benefits to the physician. I authorize the physician to provide me with reasonable and proper medical care by today's standards.

Signature of patient or patient's personal representative ____________ Relationship to patient ____________ Date ____________

IF YOU HAVE MEDICARE COVERAGE, PLEASE SIGN BELOW SO WE MAY HAVE YOUR MEDICARE AUTHORIZATION ON FILE.

I authorize any holder of medical or other information about me to release to the social security administration and health care financing administration or its intermediaries, any information needed for this or related medical claims. I permit a copy of this authorization to be used in place of the original and request payment of medical benefits be made to the physician. Regulations pertaining to Medicare assignment of benefits apply. I authorize the physician to provide me with reasonable and proper medical care by today's standards.

Signature of patient or patient's personal representative ____________ Relationship to patient ____________ Date ____________

CO-PAYS DUE AT TIME OF SERVICE