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**Head and Neck**  
S U R G E R Y  
A S S O C I A T E S , P S C

*Pediatric and Adult Diseases of  
the Ear, Nose and Throat*

*Allergy*

Joseph F. Haas, M.D., FACS  
Steven M. Woodruff, M.D., FACS  
W. Mark Gutowski, M.D., F.A.A.P., FACS  
Todd M. Kirchhoff, M.D.  
Steven P. Magary, M.D.  
Bryan J. Krol, M.D., FACS  
Michael A. Domet, M.D.  
James J. Kempiners, M.D.  
Theodore H. Miller, M.D., Ph.D.  
Michelle A. Veazey, M.D.

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Dear patient of Head and Neck Surgery Associates,

Enclosed please find forms to be filled out **prior to your visit** with Head and Neck Surgery Associates. Please complete the forms and **bring them with you along with your insurance card to your visit.**

If you have had any recent tests, x-rays or lab work that may be pertinent to your visit, call us and let us know so we may call for your results. You may have the results of your tests, x-rays or lab work faxed to us at (859) 572-3044.

If you have had a CT scan please bring the film in with you.

Our offices are open Monday through Friday, 9 am to 5 pm should you have any questions concerning your visit.

Thank you,

Head and Neck Surgery Associates, PSC

www.headandnecksurgeryassociates.com

40 North Grand Ave.  
Fort Thomas, Kentucky 41075-1765  
859 / 781-4900

20 Medical Village Drive Suite 268  
Edgewood, Kentucky 41017-3454  
859 / 341-1100

7575 U.S. 42  
Florence, Kentucky 41042-1939  
859 / 283-9100

Ludlow Hill Professional Building Suite 140  
368 Bielby Road  
Lawrenceburg, Indiana 47025-1004  
812 / 537-5510

# Head and Neck Surgery Associates, PSC

# Center for Surgical Care

Joseph F Haas, MD  
Bryan J Krol, MD

Steven M Woodruff, MD  
Michael A Domet, MD

W Mark Gutowski, MD  
James J Kempiners, MD

Todd M Kirchoff, MD  
Theodore H Miller, MD

Steven P Magary, MD  
Michelle A Veazey, MD

## Registration Form

## Welcome!

**Patient** Legal Last Name \_\_\_\_\_ Legal First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Prefers to be Called \_\_\_\_\_ Email for Practice Education/Follow-up Only \_\_\_\_\_

How did you hear about our practice? \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Name of Referring Physician \_\_\_\_\_

Gender \_\_\_\_\_ Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_ Marital Status \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Pharmacy \_\_\_\_\_ Pharmacy Phone \_\_\_\_\_

Name and phone number of a local friend or relative that does not live with you in case of emergency.

\_\_\_\_\_  
\_\_\_\_\_

**Responsible Party** Legal Last Name \_\_\_\_\_ Legal First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Gender \_\_\_\_\_ Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_ Marital Status \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Pharmacy \_\_\_\_\_ Pharmacy Phone \_\_\_\_\_

**Primary Insurance** Company Name \_\_\_\_\_

ID Number \_\_\_\_\_ Group Number \_\_\_\_\_

Policyholder's Legal Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_ Insurance Phone Number \_\_\_\_\_

Insurance Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Employer Name \_\_\_\_\_ Employer Phone Number \_\_\_\_\_

Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Secondary Insurance** Company Name \_\_\_\_\_

ID Number \_\_\_\_\_ Group Number \_\_\_\_\_

Policyholder's Legal Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_ Insurance Phone Number \_\_\_\_\_

Insurance Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Employer Name \_\_\_\_\_ Employer Phone Number \_\_\_\_\_

Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Online Payment Processing Available [www.NKYENT.com](http://www.NKYENT.com)



## AUTHORIZATION

Head and Neck Surgery Associates, PSC is hereby authorized to give my insurance company or its representative, any and all information they may have regarding my or my dependent's condition when under observation or treatment by them, including history obtained, diagnosis and treatment.

A photocopy of my signature may be used. I hereby assign the benefits payable under my insurance to Head and Neck Surgery Associates, PSC and Center for Surgical Care for any services provided. I authorize all medical information about me to be released to the Health Care Financing Administration and its agents to determine these benefits or the benefits payable for related services.



Print Name

Signature

Date

**Your insurance card & driver's license or government issued ID with residential address are required.**

### RACE AND ETHNICITY

State law requires Health Policy Boards to report at least every two years on the health of minority citizens. The reports must identify minority health status and special health needs, and recommend ways to meet the health needs of minorities. These things cannot be known unless each patient's race and ethnicity is known. The Board has asked health care providers to ask every patient's race so that the health needs of each ethnic population group can be determined. You are therefore asked to state your race and ethnicity.

**Race** Please circle one:

**Ethnicity** Please circle one:

A Asian

J Native Hawaiian or Pacific Islander

H Hispanic or Latino

I American Indian or Alaskan Native

W White

N Non Hispanic or Latino

B Black or African American

N Other

### ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have reviewed and/or received a copy of the Notice of Privacy Practices. This notice describes the use and disclosure of my protected health information and rights I have regarding my protected health information.

Print Name

Signature

Date

Relationship if Patient is Under Age 18

***If a parent is not accompanying a patient under age 18 for an appointment, before that patient can be seen, we must be provided with a guardianship order, a custody decree or written permission from the parent/guardian authorizing the non-parent adult to present the child for treatment.***

According to the Notice of Privacy Practices, we may not disclose your protected health information to family members or friends who may be involved with your treatment or care without your written permission. Please note the name and relationship to the patient of those you give us permission to disclose medical information:

Legal Last Name

First Name

Relationship to Patient

Legal Last Name

First Name

Relationship to Patient

Legal Last Name

First Name

Relationship to Patient



Name \_\_\_\_\_ DOB \_\_\_\_\_ Today's Date \_\_\_\_\_

Please indicate if you have experienced any of these symptoms recently Circle Y for Yes and N for No.

General	Fevers	Y	N	Respiratory	Shortness of breath at rest	Y	N
	Chills	Y	N		Cough	Y	N
	Sweats	Y	N	Gastrointestinal	Heartburn	Y	N
	Fatigue	Y	N	Genitourinary	Kidney stones	Y	N
	Recent and expected weight loss	Y	N	Musculoskeletal	Jaw pain	Y	N
Eyes	Blurred vision	Y	N		Joint pain	Y	N
	Double vision	Y	N		Skin	Rash	Y
	Vision loss	Y	N	Suspicious lesions	Y	N	
Ears/Nose/Throat	Decreased hearing	Y	N	Neurologic	Headache	Y	N
	Difficulty swallowing	Y	N		Weakness	Y	N
	Ear drainage	Y	N		Dizziness	Y	N
	Earache	Y	N	Psychological	Anxiety	Y	N
	Ringing in the ears	Y	N		Depression	Y	N
	Facial pain	Y	N	Endocrine	Heat intolerance	Y	N
	Headaches	Y	N		Cold intolerance	Y	N
	Hoarseness	Y	N	Hematologic/ Lymphatic	Abnormal or easy bruising	Y	N
	Mouth ulcers/sores	Y	N		Abnormal bleeding	Y	N
	Nasal congestion	Y	N	Allergic / Immunologic	Swollen glands in neck	Y	N
	Runny nose	Y	N		Hay fever	Y	N
	Nosebleeds	Y	N	Women	HIV exposure	Y	N
	Postnasal drainage	Y	N		Currently pregnant	Y	N
	Sinus pain	Y	N		Last menstrual period		
	Cardiovascular	Sore throat	Y	N	month      day      year		
Sneezing		Y	N				
Chest pain		Y	N				
	Shortness of breath with exertion	Y	N				

**LIST ALL SURGERIES YOU HAVE HAD**

<input type="checkbox"/> Check box if you have not had any surgeries.	Date

If yes did you have any problems with anesthesia?  Y  N  
 If yes describe problems: \_\_\_\_\_

Have you or any member of your family had malignant hyperthermia? (high fever caused by anesthesia)  
 If yes please explain details (who, when, result)  Y  N

To the best of my knowledge, my information on this form is accurate and complete.

Signature of patient, parent or guardian: \_\_\_\_\_ Date: \_\_\_\_\_  
 Relationship to patient: \_\_\_\_\_

<b>FOR OFFICE USE ONLY</b>		<b>MD / CRNA COMMENTS AND NOTES</b>	
Initial when reviewed		Surgery scheduled:	
Date	Staff initials	Date:	Physician:
		Anesthesia Plan:	P.S. I II III
		Signature:	

# NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEAD & NECK SURGERY ASSOCIATES, PSC MAY USE AND DISCLOSE YOUR HEALTHCARE INFORMATION AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION  
PLEASE REVIEW IT CAREFULLY

HEAD AND NECK SURGERY ASSOCIATES, PSC is required by law to maintain the privacy of your protected health information. This information consists of all records related to your health, including demographic information, either created by HEAD AND NECK SURGERY ASSOCIATES, PSC or received by HEAD AND NECK SURGERY ASSOCIATES, PSC from other healthcare providers.

We are required to provide you with notice of our legal duties and privacy practices with respect to your protected health information. These legal duties and privacy practices are described in this notice. HEAD AND NECK SURGERY ASSOCIATES, PSC will abide by the terms of this Notice, or the Notice currently in effect at the time of the use or disclosure of your protected health information.

HEAD AND NECK SURGERY ASSOCIATES, PSC reserves the right to change the terms of this notice and to make any new provisions effective for all protected health information we maintain. Patients will be provided a copy of any revised Notices upon request. An individual may obtain a copy of the current Notice from our office at any time.

## Uses and Disclosures of Your Protected Health Information not Requiring Your Consent

HEAD AND NECK SURGERY ASSOCIATES, PSC may use and disclose your protected health information, without your written consent or authorization, for certain treatment, payment and healthcare operations. There are certain restrictions on uses and disclosures of treatment records, which include registration and all other records concerning individuals who are receiving, or who at any time have received services for mental illness, developmental disabilities, alcoholism, or drug dependence. There are also restrictions on disclosing HIV test results.

### Treatment may include:

- Providing, coordinating, or managing healthcare and related services by one or more healthcare providers;
- Consultations between healthcare providers concerning a patient;
- Referrals to other providers for treatment;
- Referrals to nursing homes, foster care homes, or home health agencies.

For example, HEAD AND NECK SURGERY ASSOCIATES, PSC may determine that you require the services of a specialist. In referring you to another doctor, HEAD AND NECK SURGERY ASSOCIATES, PSC may share or transfer your healthcare information to that doctor.

### Payment activities may include:

- Activities undertaken by HEAD AND NECK SURGERY ASSOCIATES, PSC to obtain reimbursement for services provided to you;
- Determining your eligibility for benefits or health insurance coverage;
- Managing claims and contacting your insurance company regarding payment;
- Collection activities to obtain payment for services provided to you;
- Reviewing healthcare services and discussing with your insurance company the medical necessity of certain services or procedures, coverage under your health plan, appropriateness of care, or justification of charges;
- Obtaining pre-certification and pre-authorization of services to be provided to you.

For example, HEAD AND NECK SURGERY ASSOCIATES, PSC will submit claims to your insurance company on your behalf. This claim identifies you, your diagnosis, and the services provided to you.

### Healthcare operations may include:

- Contacting healthcare providers and patients with information about treatment alternatives;
- Conducting quality assessment and improvement activities;
- Conducting outcomes evaluation and development of clinical guidelines;
- Protocol development, case management, or care coordination;
- Conducting or arranging for medical review, legal services, and auditing functions.

For example, HEAD AND NECK SURGERY ASSOCIATES, PSC may use your diagnosis, treatment, and outcome information to measure the quality of the services that we provide, or assess the effectiveness of your treatment when compared to patients with similar situations.

HEAD AND NECK SURGERY ASSOCIATES, PSC may contact you, by telephone or mail, to provide appointment reminders. You must notify us if you do not wish to receive appointment reminders. We may not disclose your protected health information to family members or friends who may be involved with your treatment or care without your written permission. Health information may be released without written permission to a parent; guardian, or legal custodian of a child; the guardian of an incompetent adult; the healthcare agent designated in an incapacitated patient's healthcare power of attorney; or the personal representative or spouse of a deceased patient.

There are additional situations when HEAD AND NECK SURGERY ASSOCIATES, PSC is permitted or required to use or disclose your protected health information without your consent or authorization. Examples include the following:

- As permitted or required by law. In certain circumstances we may be required to report individual health information to legal authorities, such as law enforcement officials, court officials, or government agencies. For example, we may have to report abuse, neglect, domestic violence or certain physical injuries. We are required to report gunshot wounds or any other wound to law enforcement officials if there is reasonable cause to believe that the wound

occurred as a result of a crime. Mental health records may be disclosed to law enforcement authorities for the purpose of reporting an apparent crime on our premises.

- For public health activities. We may release healthcare records, with the exception of treatment records, to certain government agencies or public health authority authorized by law, upon receipt of written request from that agency. We are required to report positive HIV test results to the state epidemiologist. We may also disclose HIV test results to other providers or persons when there has been or will be risk or exposure. We may report to the state epidemiologist the name of any person known to have been significantly exposed to a patient who tests positive for HIV. We are required by law to report suspected child abuse and neglect and suspected abuse of an unborn child, but cannot disclose HIV test results in connection with the reporting or prosecution of alleged abuse or neglect. We may release healthcare records, including treatment records and HIV test results, to the Food and Drug Administration when required by federal law. We may disclose healthcare records, except for HIV test results, for the purpose of reporting elder abuse or neglect, provided the subject of the abuse or neglect agrees, or if necessary to prevent serious harm. Records may be released for the reporting of domestic violence if necessary to protect the patient or community from imminent and substantial danger.
- For health oversight activities. We may disclose healthcare records, including treatment records, in response to a written request by any federal or state governmental agency to perform legally authorized functions, such as management audits, financial audits, program monitoring and evaluation, and facility or individual licensure or certification. HIV test results may not be released to federal or state governmental agencies, without written permission, except to the state epidemiologist for surveillance, investigation, or to control communicable diseases.
- Judicial and administrative proceedings. Patient healthcare records, including treatment records and HIV test results, may be disclosed pursuant to a lawful court order. A subpoena signed by a judge is sufficient to permit disclosure of all healthcare records except for HIV test results.
- For activities related to death. We may disclose patient healthcare records, except for treatment records, to a coroner or medical examiner for the purpose of completing a medical certificate or investigating a death. HIV test results may be disclosed under certain circumstances.
- For research. Under certain circumstances, and only after a special approval process, we may use and disclose your health information to help conduct research.
- To avoid a serious threat to health or safety. We may report a patient's name and other relevant data to the Department of Transportation if it is believed the patient's vision or physical or mental condition affects the patient's ability to exercise reasonable or ordinary control over a motor vehicle. Healthcare information, including treatment records and HIV test results, may be disclosed where disclosure is necessary to protect the patient or community from imminent and substantial danger.
- For workers' compensation. We may disclose your health information to the extent such records are reasonably related to any injury for which workers compensation is claimed.

HEAD AND NECK SURGERY ASSOCIATES, PSC will not make any other use or disclosure of your protected health information without your written authorization. You may revoke such authorization at any time, except to the extent HEAD AND NECK SURGERY ASSOCIATES, PSC has taken action in reliance thereon. Any revocation must be in writing.

#### Your Rights Regarding Your Protected Health Information

You are permitted to request that restrictions be placed on certain uses or disclosures of your protected health information by HEAD AND NECK SURGERY ASSOCIATES, PSC to carry out treatment, payment, or healthcare operations. You must request such restriction in writing. We are not required to agree to your request, but if we do agree, we must adhere to the restriction, except when your protected health information is needed in an emergency treatment situation. In this event, information may be disclosed only to healthcare providers treating you. Also, a restriction would not apply when we are required by law to disclose certain healthcare information.

You have the right to review and/or obtain a copy of your healthcare records, with the exception of psychotherapy notes, or information compiled for use (or in anticipation for use) in a civil, criminal, or administrative action or proceeding. HEAD AND NECK SURGERY ASSOCIATES, PSC may deny an access under other circumstances, in which case you have the right to have such a denial reviewed. We may charge a reasonable fee for copying your records.

You may request that HEAD AND NECK SURGERY ASSOCIATES, PSC send protected health information, including billing information, to you by alternative means or to alternative locations. You may also request that HEAD AND NECK SURGERY ASSOCIATES, PSC not send information to a particular address or location or contact you at a specific location, perhaps your place of employment. This request must be submitted in writing. We will accommodate all reasonable requests by you.

You have the right to request that HEAD AND NECK SURGERY ASSOCIATES, PSC amend portions of your health records, as long as such information is maintained by us. You must submit this request in writing, and under certain circumstances the request may be denied.

You may request to receive an accounting of the disclosures of your protected health information made by HEAD AND NECK SURGERY ASSOCIATES, PSC for the six years prior to the date of the request, beginning with the disclosures made after April 14, 2003. We are not required, however, to record disclosures we made pursuant to a signed consent or authorization.

You may request and receive a paper copy of this Notice, if you had previously received or agreed to receive the Notice electronically.

Any person or patient may file a complaint with HEAD AND NECK SURGERY ASSOCIATES, PSC and/or Secretary of Health and Human Services if they believe their privacy rights have been violated. To file a complaint with HEAD AND NECK SURGERY ASSOCIATES, PSC, please contact the Privacy Officer at the following:

CEO, HEAD AND NECK SURGERY ASSOCIATES, PSC, 40 N Grand Ave, Suite 101, Ft Thomas, KY 41075

It is the policy of HEAD AND NECK SURGERY ASSOCIATES, PSC that no retaliatory action will be made against any individual who submits or conveys a complaint of suspected or actual non-compliance or violation of the privacy standards.

This notice of Privacy Practices is effective April 14, 2003,



## Financial Policy

Online Payment Processing  
Available  
[www.nkyent.com](http://www.nkyent.com)



Thank you for choosing us as one of your health care providers. We are dedicated to providing you with quality care and efficient service. Your understanding of our financial policy is essential. If you have any questions regarding any aspect of our policy, please ask us.

We accept Visa, MasterCard, Discover, American Express, Health Savings Accounts, cash or check.

### Insurance

Though we file insurance claims as a courtesy to our patients, all charges are ultimately the responsibility of the patient/guarantor as of the date the services are rendered. Please understand that not all services are covered by all insurance carriers. It is thus highly recommended that patients communicate with their insurance companies to understand their benefits and limitations to their benefits. When services are not covered by insurance, full responsibility remains with the patient/guarantor.

### Referrals

Some insurance companies may require a referral. It is the patient/guarantor's responsibility to obtain the referral prior to the time of service. When required, the patient/guarantor will be responsible for payment in full at time of service if a required referral is not provided.

### Co-pays and Past-Balances

All co-pays and all past-balances are due at the time of service. Self-pay patients are required to pay a \$50 deposit at the time of service and any remaining balance is due upon receipt of a statement.

### Deductibles & Coinsurance

If you have a deductible and/or coinsurance, you are required to pay 50% of your estimated charges at your office appointment or 24 hours prior to surgery. Any remaining balance is due upon receipt of a statement.

If your balance is not paid, it will be automatically placed with a professional collection agency and reported to the credit bureau. If this occurs, you will be responsible for collection fees, interest and attorney costs.

I have read and fully understand the financial policy set forth by Head and Neck Surgery Associates, P.S.C and Center for Surgical Care. I agree to the terms of this financial policy. I also understand and agree that the terms of this financial policy may be amended by the practice at any time.

Print Name	Signature	Date
If Patient is a Minor Under Age 18: Print Patient Name		Relationship to Patient of
Person Signing		



*Electronic Charge/Debit Authorization*  
**Direct Payment Enrollment for Bill Payment**

Online Payment Processing Available [www.nkyent.com](http://www.nkyent.com)

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Name of Financial Institution \_\_\_\_\_

Account Number \_\_\_\_\_

Expiration Date \_\_\_\_\_ 3 Digit Security Code \_\_\_\_\_





Name as it appears on card \_\_\_\_\_

Card Billing Address \_\_\_\_\_

Daytime Phone Number \_\_\_\_\_

Cardholder phone \_\_\_\_\_

**Please charge my credit/debit account as follows:**

<input type="checkbox"/> 	<input type="checkbox"/> 	<input type="checkbox"/> 	<input type="checkbox"/> 
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By my signature below, I authorize Head and Neck Surgery Associates, PSC or Center for Surgical Care to process my credit/debit card the following payment indicated below. I understand that if I decide to discontinue this payment plan I will send notification in writing to HNSA, 40 N Grand Ave, Suite 101, Fort Thomas, Kentucky 41075.

- One time charge in the amount of \$ \_\_\_\_\_
- My balance due after my insurance processes a claim for date of service
- Monthly charge in the amount of \$ \_\_\_\_\_
- This authorization is not to exceed \$ \_\_\_\_\_ (maximum)

Print Name	Signature	Date
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Mail 40 N Grand Ave, Suite 101, Fort Thomas KY 41075, Fax (859) 572-3039, Email Billing [@nkyent.com](mailto:@nkyent.com) or Drop Off