PATIENT INFORMATION

Date of Visit: ______________

First: ______________________________ Middle: __________ Last: ______________________________
Date of Birth: __/__/__ Age:____ Social Security #:___-__-____ Gender: M F Marital Status: S M D W
Mailing Address: _________________________________ City: _______________ State: ______ Zip:______
Best Phone #: _________________Cell Phone #: _________________ Work Phone #: _________________
OK to leave a detailed message, including results? ☐Y ☐N
Email Address: ____
Primary Care Doctor: _______________________________ Referring Doctor: _________________________
Pharmacy: (Please include City) ____
How did you hear about our office? ____
Preferred language: ☐ English ☐ Spanish ☐ Other _______________________________________
Preferred Contact: ☐ Email ☐ Text ☐Phone ☐ Other ____________________
Race: ☐ Caucasian ☐ Asian ☐ African-American ☐ Other ____________________
Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐Other _____________________

PRIMARY INSURANCE

Insurance Company Name ____
Policy Holder ________________________________ Policy Holder's Date of Birth _____________________
Policy Number _______________________________ Group/Plan Number ____________________________
Policy Holder's Phone _________________________ Alternate Phone ________________________________
Insured's Employer ____________________________ Relationship to patient _________________________

SECONDARY INSURANCE

Insurance Company Name ____
Policy Holder ________________________________ Policy Holder's Date of Birth _____________________
Policy Number _______________________________ Group/Plan Number ____________________________
Policy Holder's Phone _________________________ Alternate Phone ________________________________
Insured's Employer ____________________________ Relationship to patient _________________________

MINORS *(under 18 years of age)* Minors must be accompanied by a legal guardian.
Father's Name ______________________________ Employer ____________________ DOB _______________
Address ___________________________________ Best Phone ___________________ SS# _______________
Mother's Name ______________________________ Employer ____________________ DOB _______________
Address ___________________________________ Best Phone ___________________ SS# _______________
May we discuss the patient's care with both parents? ☐Y ☐N

Emergency Contact: _________________**Relationship:** ________________ **Best Phone:** ______________

I consent to the release of medical information to my insurance company and to such other organizations as may be permitted under the Health Insurance Portability and Accountability Act (HIPAA). I acknowledge that I have received the Notice of Privacy Policy. I authorize and request that any insurance benefits be paid directly to Bridger Ear, Nose & Throat, PLLC. I understand the financial policies of this practice and agree that I am responsible for the balance on my account. If it becomes necessary to send my account to collection for non-payment, I will be responsible for all collection and legal fees incurred.

Signature: ______________________________ Printed Name: _______________________ Date: _______________
Relationship to Patient: __________________

Brennan T. Dodson, MD

CHIEF COMPLAINT: What is the reason for your visit? ____

CURRENT MEDICATIONS, HERBALS, OR SUPPLEMENTS: *(Doses & Schedule)*

Drug	Dose & Schedule	Drug	Dose & Schedule

MEDICAL HISTORY: *(i.e. Diabetes, High Blood Pressure, Cancer)*

MEDICATION ALLERGIES:

Drug	Reaction	Drug	Reaction

OTHER ALLERGIES: *(Food, Etc.)*

Substance	Reaction	Substance	Reaction

SURGERY HISTORY: *(Year and Surgery)*

FAMILY MEDICAL HISTORY: *(Please check √ all that apply)*

	Allergies	Asthma	Autoimmune Disorder	Blood Disorder	Cancer *(type)*	Diabetes *(type I or II)*	Heart Disease	Stroke	Thyroid Disease	Other
Father										
Mother										
Sibling(s)										
Children										
Maternal Relatives										
Paternal Relatives										

Bridger
EAR, NOSE & THROAT
Brennan T. Dodson, MD

SOCIAL HISTORY:

Y	N	Tobacco	Type	Quantity/Past Use
Y	N	Caffeine	Type	Quantity
Y	N	Alcohol	Type	Quantity
Y	N	Illegal Drugs	Type	Quantity

STUDENTS/CHILDREN:

Y	N	Poor grades
Y	N	Trouble concentrating in school
Y	N	Hyperactivity
Y	N	Violent behavior
Y	N	Daycare

REVIEW OF SYSTEMS: *(Please circle any symptom that applies to you)*

General	Fever	Chills	Night Sweats	Loss of Appetite	Fatigue	Weight Loss/Gain
Eyes	Blurred Vision	Eye Pain	Tearing			
Ears	Hearing Loss	Ear Discharge	Ear Pain	Ringing in the Ears		
Nose	Nose Bleeds	Congestion	Sinus Pain	Seasonal Allergies		
Throat	Hoarseness	Sore Throat	Voice Changes	Difficulty Swallowing		
Cardiovascular	Heart Attack	Chest Pain	Palpitations	Leg Swelling	Heart Murmur	
Respiratory	Sleep Apnea	Wheezing	Chronic Cough	Tuberculosis		
Gastrointestinal	Heartburn	Constipation	Frequent Diarrhea	Nausea/Vomiting	Blood in Stool	
Genitourinary	Kidney Stones	Painful Urination	Frequent Urination	Blood in Urine		
Musculoskeletal	Joint Swelling	Back Pain	Weakness			
Skin	Color Change	Cellulitis	Psoriasis	Rash		
Neurologic	Dizziness	Headaches	Poor Balance	Numbness/Tingling		
Hematologic	Enlarged Glands	Anemia	Bleeding Disorders			
Psychological	Depression	Anxiety	Trouble Sleeping	Memory Loss		

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Surgery Financial Policy

Our surgeon fees are based on the level of professional skill required and severity and complexity of your/your child's condition. **You will receive an estimate of our charges but an exact quote is not possible.** In order to provide the best treatment, it may be necessary to perform different or additional procedures than listed on the original estimate. This is not only to provide the best surgical results for your condition, but also to prevent undergoing two operations. Some surgery procedures require a surgical assistant. Should that occur in your surgery, you may incur a separate billing for the assistant's services.

It is the policy of Bridger Ear, Nose & Throat that any remaining applicable insurance deductibles and co-insurances must be paid prior to any surgery. This payment is based on information we receive from your insurance company and our estimated charges. If payment is not submitted in full prior to surgery, your surgery will be cancelled and will not be rescheduled until payment is received.

<u>**It is your responsibility to contact your insurance company.**</u> We will obtain prior authorization from your insurance company for the physician fees only. **Pre-Certification of a surgery does not guarantee payment by your insurance company.** It is the patient's responsibility to contact their insurance company prior to surgery to verify eligibility, benefits, coverage, and preauthorization requirements. It is also the patient's responsibility to check with their insurance to inquire if the condition could be considered pre-existing.

Some insurance companies use the phrase "usual and customary" when discussing professional and facility fees. Insurance companies set their own "usual and customary" rates based on a wide geographical area and the fees we charge may differ. We ask that you realize that services are rendered to a person, not an insurance company. Hence, the insurance company is responsible to the patient and the patient is responsible to us. **If we are not contracted with your insurance company, you will be billed for all charges they deem over "usual and customary". Determination of benefits is determined after a claim is received by your insurance company.** If your insurance company denies your claim, you will be responsible for the entire cost of surgery. If we are not contracted with your insurance company, you will be responsible for the difference between our fees and your insurance companies' fee. We are contracted with the following insurance companies: Blue Cross Blue Shield, Allegiance, New West, Medicare, Medicaid and TriCare.

A global period is a time period in which additional procedures related to the original pre-operative diagnosis are included in the initial surgeon's fee. Not all procedure codes have a global period. For more information on global periods please contact our billing office.

Separate statements will be sent to you for each provider of services: physician, anesthesiologist, Bozeman Deaconess Hospital and/or pathology/lab. If you are unable to meet our payment requirements or have financial questions, please contact our billing department at (406)556-9798. If it becomes necessary to send your account to collections for non-payment, you will be responsible for all collection and legal fees incurred. We accept the following forms of payment: Cash, Check, Care Credit, VISA and MasterCard.

_______________________________________   _______________

Patient Signature   Date

_______________________________________   _______________

Surgery Coordinator   Date

Surgery Estimate Worksheet

Contracted Insurance Companies: Blue Cross/Blue Shield, New West, Allegiance, Tricare, Medicare & Medicaid

It is YOUR responsibility to contact your insurance to verify benefits, coverage, exclusions and deductibles.

Your Insurance Company's Phone #: ____________________

CPT Codes								
Physician Fees								Total
Allowed Amount								
	x 100%	x 50%	x 50%	x 50%	x 50%	x 50%	x 50%	Total

Estimated Financial Responsibilities

Estimate of Surgeon Fee Only $______________________________

Allowable (If Applicable) $______________________________

Deductible $______________________________

Out of Pocket $______________________________

Coinsurance $______________________________

Estimated Patient Responsibility $______________________________

The surgeon's fee is due **PRIOR** to surgery. You may receive a bill from the following: physician, anesthesiologist, Bozeman Deaconess Hospital and pathology/lab. If you wish to obtain estimates of these charges please call the following numbers:

Bozeman Deaconess Hospital
Dottie – (406) 522-1711

Gallatin Valley Anesthesia
Janice – (406) 582-4963

FINANCIAL POLICY

We are committed to providing the best treatment possible for our patients. Our charges are usual and customary for our specialty. Your insurance is a contract between you and your insurance company. You will be billed for any applicable copayments, deductibles, and/or exclusions of your insurance contract and it is your responsibility to know your plan's coverage, restrictions and requirements. Full payment is collected at the time of service for all co-pays, co-insurance or any deductible amounts. We accept cash, check, Visa, MasterCard and Care Credit. You are encouraged to inquire about the cost of any procedure before it is performed.

• Contracted insurance companies: BlueCross/BlueShield, Allegiance, New West, Medicare, Medicaid & Tricare.

• If your insurance determines a service non-covered, you will be responsible for the balance. If your insurance company has not settled a claim within 60 days, the responsibility for the balance will transfer to the patient.

• Montana Medicaid requires authorization from your primary care physician. Without this information, your appointment will be rescheduled or you will be required to sign a waiver and pay in full at the time of service.

• Patients without insurance coverage will be required to pay in full at the time of service. A 10% discount is available to self-pay patients when visits are paid in full at the time of service.

• If you require surgery, a patient representative will provide you with the estimated fee and explain your expected financial obligation. We require payment of your expected financial obligation prior to the procedure.

• When a patient is late, or does not arrive for an appointment, it prevents us from seeing and treating other patients in a timely manner. If you are running late, or are unable to make the appointment, please notify the office. If you do not inform our office that you will be unable to keep your appointment, you may be discharged from our practice.

MINOR PATIENTS: (under the age of 18) We assign all financial responsibility to the parent/guardian that completes and signs the patient registration forms. Any amount due at the time of service is expected from the parent/guardian accompanying the minor at the visit. Minors without a parent/guardian will be rescheduled.

PLEASE NOTE: Our office will charge $15.00 on returned checks. Unpaid patient balances ≥60 days are subject to a yearly 9.5% interest rate of outstanding balances. If it becomes necessary to send your account to collection for non-payment, you will be responsible for all collection and legal fees incurred.

We feel it is important for our relationship that you understand our financial policies.
Please read this carefully, and ASK IF YOU HAVE ANY QUESTIONS.

By signing the acknowledgement in the office, you are indicating that you have read and understand the above policies and had all your questions answered.

Signature: ______________________________ Printed Name: ______________________ Date: _______________
Relationship to Patient: __________________

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PRIVACY POLICY: CONSENT FOR COMMUNICATION WITH FAMILY AND OTHERS INVOLVED IN YOUR CARE

Note: We will not discuss your care with anyone other than those listed below, with the exception of your primary care and/or referring physician.

Bridger Ear, Nose & Throat may discuss information regarding your care and treatment with the following individuals.

If we may ONLY speak with you, check here: ☐ and sign below.

Name	Relationship to Patient	Type of Information Allowed (Circle)
		ALL MEDICAL BILLING
		ALL MEDICAL BILLING
		ALL MEDICAL BILLING

SPECIFIC INSTRUCTIONS OR LIMITATIONS: ____

We will continue to rely on the information on this form when communicating with family members or others involved in your care unless you request changes. Please promptly notify our office if you wish to alter the designations above.

Signature: ____________________________ Printed Name: _____________________ Date: ______________

Relationship to Patient: _________________

To revoke this authorization, please submit a written request to Bridger Ear, Nose & Throat, PLLC.

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		ALL MEDICAL BILLING
		ALL MEDICAL BILLING
		ALL MEDICAL BILLING

SPECIFIC INSTRUCTIONS OR LIMITATIONS: ______________________________

We will continue to rely on the information on this form when communicating with family members or others involved in your care unless you request changes. Please promptly notify our office if you wish to alter the designations above.

______________________________ Date:
Patient or Guardian Signature

____
Printed Patient Name

____
Relationship to Patient

To revoke this authorization, please submit a written request to Bridger Ear, Nose & Throat, PLLC.

Authorization for Use and Disclosure of Protected Health Information (PHI)

Patient Legal Name: ______________________________ Date of Birth: ____________
Address: ______________________________ Phone: ____________
City: ______________________________ State: ________ Zip: ______

I authorize: ______________________________
Address: ______________________________ Phone: ____________
City: ______________________________ State: ________ Zip: ______
Fax: ______________

To disclose/release the Protected Health Information (PHI) of the patient listed above to:

Person/Organization: ______________________________
Address: ______________________________ Phone: ____________
City: ______________________________ State: ________ Zip: ______
Fax: ______________

Purpose: ☐Continuation of Care ☐Personal ☐Insurance ☐Litigation ☐Other: ________

Dates of Treatment: ____________________ Date Needed: ____________________

Pertinent PHI Information: ☐ Entire record ☐ Specific Item: ____________

ACKNOWLEDGEMENT: I request and authorize the above-named doctor or health care provider to release the information specified above to the organization, agency, or individual named on this request. I understand that the information to be released may include information regarding drug and alcohol abuse, communicable/infectious diseases, Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS) and psychological or psychiatric conditions, if any. I understand that if the receiver is not a health plan or health care provider, the released information may no longer be protected by Federal Privacy regulations and may be redisclosed.
EXPIRATION: Without my express revocation, this authorization will automatically expire one year from the date hereof, unless otherwise specified: ______________________________
REVOCATION: I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. To revoke this authorization, I must submit a letter to the Director of Health Information Management.
OTHER CONDITIONS: A copy of this authorization with my signature may be used with the same effectiveness as an original. I understand that:
• If I do not sign this authorization, Bridger Ear, Nose, and Throat will still provide treatment and seek payment for services provided.
• Fees/charges will comply with all laws and regulations applicable to release of information.

I authorize: ______________________________to pick up my Protected Health Information.

Signature of Patient/Patient Representative: ______________________________Date________

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