GLACIER
ENT & Hearing

Intake Form

Patient Information: _____ Appt Date: _____
Account #: _____ Patient's SSN: _____
First Name: _____ MI: _____ Last Name: _____
Mailing Address: _____
City: _____ State: _____ Zip: _____
Date of Birth: _____ Age: _____ Sex: _____
Marital Status: _____ Spouse's Name: _____
Phone #: Home: _____ Cell: _____ Email: _____
Required Information for Minor Patients.

Mother/Guardian: _____ DOB: _____ SSN: _____
Address: _____ Phone #: _____

Father/Guardian: _____ DOB: _____ SSN: _____
Address: _____ Phone #: _____

If not parent, who is accompanying child at this visit: _____

Emergency Contact Name: _____ Phone #: _____ Relationship: _____
Referring Physician Name: _____ Referring Physician Phone #: _____

Insurance Information: _____
Please present your insurance card(s) to the receptionist and give complete information below.

Primary Insurance: _____ Insured's Name: _____
Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other
Policy #: _____ Group #: _____
Employer: _____ SSN: _____ DOB: _____

Secondary Insurance: _____ Insured's Name: _____
Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other
Policy #: _____ Group #: _____
Employer: _____ SSN: _____ DOB: _____

NOTICE REGARDING INSURANCE CLAIMS/PAYMENTS

If we are filing insurance for your visit, we must have complete information and any required referral at the time of the visit. If you cannot provide the information, we will be unable to file your insurance, and self-payment in full will be required at checkout.

Payment of your charges cannot be determined until the claim is submitted to your insurance company. Payment will be based on your individual health plan, and the amount applied to your plan deductible and/or coinsurance will be your responsibility. Procedures which are excluded from coverage, based on your plan's determination of medical necessity, will also be your responsibility. Your office visit co-pay is due at the time of the visit and, in many cases, covers only the office visit charge. Any procedures performed will be considered surgery by your insurance company, and deductibles and coinsurance may apply.

For all other patients, payment is required at the time of service. We will provide you with the necessary documentation to file for reimbursement upon your request.

I have read the above information and understand that I am responsible for payment for services I receive.

Print Patient Name: _____ Patient Date of Birth: _____
Print Guardian Name: _____
Signature of Patient/Guardian: _____ Date: _____

160 Heritage Way, Kalispell, MT 59901
ENT • P: (406) 752-8330 • F: (406) 752-8412
HEARING • P: (406) 752-1014 • F: (406) 756-1379
www.glacierentclinic.com

GLACIER
ENT & Hearing

HEALTH HISTORY FORM

Glacier Ear, Nose & Throat

To obtain a complete medical history, it is important to fill out this form. If the question does not apply, enter "n/a." This information is important for your doctor to review, and it will be entered into your medical record.

Last Name: _____ First Name: _____ MI: _____

Preferred Name: _____ Date of Birth: _____

Height: _____ Weight: _____ Occupation: _____

Reason for Visit: _____

Referring Physician: _____ Primary Care Physician: _____

Select your gender identity (select all that apply):

☐ Female ☐ Male ☐ Transgender Male-to-Female

☐ Transgender Female-to-Male ☐ Nonbinary ☐ Choose Not To Disclose ☐ Other

Pronouns:

☐ He/Him ☐ She/Her ☐ Them/Them ☐ Other: _____

Select your race (select all that apply):

☐ American ☐ Indian ☐ Alaskan Native ☐ Native Hawaiian ☐ Pacific Islander

☐ Black or African American ☐ White (Not Hispanic/Latino) ☐ Choose Not To Disclose ☐ Other: _____

Ethnicity:

☐ Hispanic or Latino ☐ Choose Not To Disclose ☐ Other: _____

Do you have a latex allergy? ☐ Yes ☐ No

Do you have any history or a diagnosis of the following? (check all that apply):

Any type of cancer? ☐ Yes ☐ No

What type of cancer and what is the status? _____

High Blood Pressure: ☐ Yes ☐ No Neurologic Disorder: ☐ Yes ☐ No Autoimmune Disorder: ☐ Yes ☐ No

Kidney Disease: ☐ Yes ☐ No Diabetes: ☐ Yes ☐ No Liver Disease: ☐ Yes ☐ No

HIV Positive: ☐ Yes ☐ No

- Have you ever been diagnosed with an Upper Respiratory Infection (URI) that did NOT result in an antibiotic being prescribed? ☐ Yes ☐ No
- Have you ever been diagnosed with Acute Otitis Externa (AKA swimmer's ear)? ☐ Yes ☐ No
- Did you receive antimicrobial therapy? ☐ Yes ☐ No
- Have you been diagnosed with Otitis Media? ☐ Yes ☐ No
- Did you receive antibiotics for the ear infection? ☐ Yes ☐ No
- Have you been diagnosed with and/or treated for adult sinusitis? ☐ Yes ☐ No
- Did you have Amoxicillin prescribed? ☐ Yes ☐ No

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- Any history of major medical or surgical treatment for your heart or lungs? ☐ Yes ☐ No
  If yes, please list them: _____
- Do you have any personal or family history of bleeding disorders? ☐ Yes ☐ No (Check one): ☐ Personal ☐ Family
- Do you take any blood-thinning medications? ☐ Yes ☐ No If yes, why do you take the medication? Select one:
  ☐ Atrial Fibrillation ☐ Blood Clot ☐ Heart or Vascular Stent ☐ Other: _____
- What blood-thinning medications are you taking? ☐ Apixaban (Eliquis) ☐ Dabigatran (Pradaxa)
  ☐ Rivaroxaban (Xarelto®) ☐ Warfarin ☐ Aspirin ☐ Not Taking Any ☐ Other: _____

Surgeries and Hospitalizations:

Have you ever had any problems with anesthesia? ☐ Yes ☐ No If yes, please explain: _____

Have you ever had a surgical site infection? ☐ Yes ☐ No If yes, please explain: _____

List any past surgeries or major procedures and the dates or estimate when they were performed:

_____

_____

Have you received the following vaccines:

COVID-19 Vaccine? ☐ Yes ☐ No Last year of vaccination: _____

Influenza Vaccine? ☐ Yes ☐ No Last year of vaccination: _____

Pneumococcal Vaccine? ☐ Yes ☐ No Last year of vaccination: _____

List the month and year (estimates are fine) of any recent diagnostic/screening tests:

Pap Smear: _____ Colonoscopy: _____ Sigmoidoscopy: _____ Esophagoscopy: _____ Mammography: _____

Current Smoking Status: ☐ Never ☐ Smoked ☐ Former Smoker ☐ Current Smoker

Have you received a tobacco cessation intervention from a physician? ☐ Yes ☐ No

Do you have any history of drug abuse? ☐ Yes ☐ No

Please list any medications you are currently taking:

Name:	Dosage:	How often do you take it?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List any allergies you have to medications: ☐ CHECK HERE IF YOU DO NOT HAVE ANY DRUG ALLERGIES

Name of medication:	Type of reaction:
_____	_____
_____	_____
_____	_____

List your Pharmacy Preference: _____ City: _____

Print Patient Name: _____ Patient Date of Birth: _____

Print Guardian Name: _____

Signature of Patient/Guardian: _____ Date: _____

GLACIER
ENT & Hearing

NOTICE OF PRIVACY PRACTICES

Clinic Name: Glacier Ear, Nose and Throat, Head and Neck Surgery; Effective Date: 2017

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. If you have any questions about this notice, please contact Glacier Ear, Nose and Throat, Head and Neck Surgery; Privacy Officer; 160 Heritage Way, Kalispell, MT 59901; Phone Number: (406) 752-8330.

WHO WILL FOLLOW THIS NOTICE: This Notice of Privacy Practices applies to our clinic and describes our practices and those of (1) Any health care professional authorized to enter information into your chart; (2) All departments and units of the organization covered by this notice; (3) Any member of a volunteer group we allow to help you; (4) Any organization that we retain to support the operation of this practice that has executed an agreement regarding uses and disclosures of your protected health information.

OUR LEGAL DUTY REGARDING YOUR MEDICAL INFORMATION: We may share medical information for treatment, payment or operational purposes described in this notice. We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive. We need this record to provide you with quality care and to comply with certain legal requirements. Medical information covered by the notice is information (1) That identifies you or could be used to identify you; (2) That we collect from you or that we create or receive; and (3) That is related to your past, present or future physical or mental health condition, including health care services provided to you and past, present or future payment for such health care services. This notice applies to all of the protected health information created by any of the organizations listed in this notice. Your doctor may also create information at the hospital or other medical facility. These facilities may have different policies or notices regarding their use and disclosure of your medical information created by your doctor while at the facility. This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information. We are required by law to (1) Make sure that medical information that identifies to you is kept private; (2) Give you this notice of our legal duties and privacy practices with respect to medical information about you; and (3) Follow the terms of the current notice.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU: The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures, we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

USES OR DISCLOSURES THAT CAN BE MADE WITHOUT YOUR AUTHORIZATION OR AN OPPORTUNITY FOR YOU TO OBJECT.

1. For Treatment: We may use medical information about you to provide you with medical treatment or services. We will contact you to provide appointment reminders. We may disclose medical information about you to doctors, nurses, technicians, medical students or personnel involved in taking care of you. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. We may share medical information about you to coordinate the different things you need, such as prescriptions, lab work and X-rays that are provided by other health care organizations. We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.
2. For Payment: We may use and disclose medical information about you so that the treatment and services you receive here may be billed to you and that payment may be collected from you, an insurance company or a third party. For example, we may need to give your health information about the surgery you received so your health plan will pay

us or reimburse you for the surgery. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment. We may also share information about you and any insurance information with other health care providers to assist them in getting payment for a service they have provided you. For example, we can share this information with a laboratory service that evaluates your laboratory specimen.

3. For Health Care Operations: We may use and disclose medical information about you for the operation of the organization listed in this notice. These uses and disclosures are necessary to run our organization and to make sure that all of our patients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine medical information about many patients to decide what additional services we should offer, what services are not needed and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians, medical students and other organization personnel for review and learning purposes. We may also combine the medical information we have with medical information from other organizations to compare how we are doing and see where we can make improvements in the care and services we offer. We may use your medical information to send questionnaires to you about your experience so that we can identify ways to improve your satisfaction with the services we provide. We may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning who specific patients are. We may also produce limited data sets that are partially deidentified and must be used under restrictive agreements for purposes of research, public health and other health care operations described above. We may use or disclose your medical information to other health providers who also have a relationship with you for activities related to evaluating the quality of care, coordinating your care, evaluating the competence of health care providers, conducting training or investigating fraud or abuse.
4. Research: Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another for the same condition. All research projects are subject to a special approval process. This process evaluates a proposed research project and its use of medical information, trying to balance the research needs with patients' need for the privacy of their medical information. Before we use or disclose medical information for research, the project will have been approved through this research approval process. However, we may disclose medical information about you to people preparing to conduct a research project, for example, to help them look for patients with specific medical needs, so long as the medical information they review does not leave the organization. We will almost always ask for your specific permission if the researcher will have access to your name, address or other information that reveals who you are or who will be involved in your care.
5. As Required by Law: We will disclose medical information about you when required to do so by federal, state or local law.
6. To Avert a Serious Threat to Health/Safety: We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. Disclosures regarding infectious diseases must comply with applicable state laws limiting the disclosure of patient identity and related information.
7. Organ and Tissue Donation: We may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank as necessary to facilitate organ or tissue donation and transplantation.
8. Military and Veterans: If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.
9. Workers' Compensation: We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.
10. Public Health Risks: We may disclose medical information about you for public health activities. These activities generally include the following: to prevent or control disease, injury or disability; to report births and deaths; to report child abuse or neglect; to report reactions to medications or problems with products; to notify people of recalls of products they may be using; to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

11. Health Oversight Activities: We may disclose medical information authorized by law to a health oversight agency to conduct activities such as audits, investigations, inspections and licensure. These activities are necessary for the government to monitor the health care system, government programs and compliance with civil rights laws.
12. Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.
13. Law Enforcement: We may release medical information if asked to do so by a law enforcement official. In response to a court order, subpoena, warrant, summons or similar process; to identify or locate a suspect, fugitive, material witness or missing person; about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement; about a death we believe may be the result of criminal conduct; about criminal conduct in our clinic and, in emergency circumstances, report a crime, location of a crime or victims or the identity, description or location of the person who committed the crime.
14. Coroners, Medical Examiners and Funeral Directors: As necessary, we may release medical information to a coroner or medical examiner, for example, to identify a deceased person or determine the cause of death, and may release medical information about patients to funeral directors.
15. National Security and Intelligence Activities: We may release medical information about you to authorized federal officials for intelligence, counterintelligence and other national security activities authorized by law.
16. Protective Services for the President and Others: We may disclose medical information about you to authorized federal officials so they may provide protection to the president, other authorized persons or foreign heads of state or conduct special investigations.
17. Schools: We may disclose medical information to a school about an individual who is a student or prospective student at the school if the medical information is limited to proof of immunization, the school is required by state or other law to have that proof of immunization prior to admitting the individual and we obtain and document the agreement to the disclosure from either the individual's parent/guardian or from the individual if the individual is an adult or emancipated minor.
18. Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary (1) For the institution to provide you with health care, (2) To protect your health and safety or the health and safety of others or (3) For the safety and security of the correctional institution.

USES OR DISCLOSURES WHEN YOU HAVE AN OPPORTUNITY TO OBJECT

1. **Facility Directories and Religious Preferences:** Unless you object, we may include your name in a facility directory, and we may list any religious preference you tell us in a directory provided to members of the clergy.
2. **Individuals Involved in Your Care or Payment of Your Care:** Unless you object, we may release medical information about you to a friend or family member involved in your medical care. We may also give information to someone who helps pay for your care. We may also tell your family or friends your general condition and that you are in the hospital. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

USES OR DISCLOSURES THAT CAN ONLY BE MADE WITH YOUR AUTHORIZATION: Uses and disclosures of medical information not covered by this notice or laws that apply to us will be made only with your written authorization. If you provide us permission to use or disclose medical information about you, you may revoke that permission in writing at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission and that we are required to retain our records of the care we have provided to you.

1. Mental Health Treatment: Uses or disclosures for mental health treatment can be made only to professionals for treatment, to obtain payment for services provided, or as otherwise required by state law.
2. Psychotherapy: Should your treatment involve the creation of psychotherapy notes (a subject of mental health records), we will obtain your written authorization for the use and disclosure of psychotherapy notes in most cases. The exceptions are (1) To carry out the following treatment, payment or health care operations activities: (a) use by the originator of the psychotherapy notes for treatment, (b) use or disclosure for our training programs in which students, trainees or practitioners in mental health learn under supervision to practice or improve their

skills in group, joint, family or individual counseling or (c) use or disclose to defend ourselves in legal action or other proceeding brought by you; (2) Required uses or disclosures required by the Secretary of the Department of Human Health and Services for determinations of our compliance with the law; or (3) Permitted uses or disclosures: (a) to health oversight agencies as permitted by law for oversight of the originator of the psychotherapy notes, (b) to coroners and medical examiners for the identification of a deceased person or (c) made in good faith to avert a serious threat to public safety.

3. Marketing: We are required to obtain your authorization for any use or disclosure of your medical information for marketing purposes unless the communication is in the form of a face-to-face communication made by us to you or if we provide you with a promotional gift of nominal value.
4. Sale of Medical Information: We are required to obtain your authorization for any disclosure of your medical information that constitutes a sale of medical information.
5. Drug or Alcohol Abuse Treatment: Federal law and regulations protect the confidentiality of drug and alcohol abuse patient records maintained by us. Generally, we may not disclose information regarding drug and alcohol abuse–related treatment, a patient's presence in a drug and alcohol abuse treatment program or a patient's status as an alcohol or drug abuser unless (1) The patient consents in writing; (2) The disclosure is allowed by a court order; or (3) The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit or program evaluation. Federal law and regulations do not protect any information about a crime committed by a patient in a drug and alcohol abuse program or against any person who works for a drug and alcohol abuse program or about any threat to commit such a crime. Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under state law to appropriate state or local authorities.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU: You have the following rights regarding medical information we keep about you:

1. Right to Inspect and Copy: You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records but does not include psychotherapy notes. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to **Glacier Ear, Nose and Throat, Head and Neck Surgery**; Privacy Officer; 160 Heritage Way, Kalispell, MT 59901. <u>If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.</u> We may deny your request to inspect and copy in certain very limited circumstances if we judge that disclosing information could be detrimental to you or to another party. You have the right to appeal any such denial.
2. Right to Amend: If you feel the medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as your information is kept by the organization. To request an amendment, your request must be made in writing and submitted to **Glacier Ear, Nose and Throat, Head and Neck Surgery**; Privacy Officer; 160 Heritage Way, Kalispell, MT 59901. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that was not created by us unless the person or entity that created the information is no longer available to make the amendment; is not part of the medical information kept by or for the organization; is not part of the information that you would be permitted to inspect and copy; or is accurate and complete.
3. Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you. To request this list or accounting of disclosures, you must submit your request in writing to **Glacier Ear, Nose and Throat, Head and Neck Surgery**; Privacy Officer; 160 Heritage Way, Kalispell, MT 59901. Your request must state a time period that may not be longer than six years and may not include dates before April 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved, and you may choose to withdraw or modify your request at that time before any costs are incurred.
4. Right to Request Restrictions: You have the right to request a restriction or limitation on the medical information we use or disclose about your treatment, payment or health care operations. You also have the right to request a limit on medical information we disclose about you to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had. *We are not required to agree with your request*. If we do agree, we will comply with your request unless

the information is needed to provide you with emergency treatment. To request restrictions, you must make your request in writing to **Glacier Ear, Nose and Throat, Head and Neck Surgery**; Privacy Officer; 160 Heritage Way, Kalispell, MT 59901. In your request, you must tell us (1) What information you want to limit; (2) Whether you want to limit our use, disclosure or both; and (3) To whom you want the limits to apply, for example, disclosures to your spouse. A restriction is not granted until you receive written notice of its approval.

5. Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to **Glacier Ear, Nose and Throat, Head and Neck Surgery**; Privacy Officer; 160 Heritage Way, Kalispell, MT 59901. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.
6. Right to a Paper Copy of This Notice: You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, contact **Glacier Ear, Nose and Throat, Head and Neck Surgery**; Privacy Officer; 160 Heritage Way, Kalispell, MT 59901; Phone Number: (406) 752-8330.
7. Right to a Notice of a Breach: You have the right to receive written notification of a breach if your unsecured medical information has been accessed, used, acquired or disclosed to an unauthorized person as a result of a breach and if the breach compromises the security or privacy of your medical information. Unless you request in writing to receive the notification by electronic mail, we will provide the written notification by first-class mail or, if necessary, by other substituted forms of communication allowable under the law.
8. Photographs: Medical photographs or other video images may be taken before, during or after a surgical procedure or treatment to be used as part of the medical record to document a patient's appearance and response to treatment. Images in which the patient is not able to be identified and that are not connected to identifying personal information may also be used at our discretion for professional medical or other purposes, including but not limited to professional medical education, patient education, advertising or other publication in scientific or nonscientific publications, electronic digital networks or other electronic or print media, including television.

COMPLAINTS: If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint, contact **Glacier Ear, Nose and Throat, Head and Neck Surgery;** Privacy Officer; 160 Heritage Way, Kalispell, MT 59901. All complaints must be submitted in writing. **You will NOT be penalized for filing a complaint.**

CHANGES TO THIS NOTICE: We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you and any medical information we receive in the future. We will post a copy of the current notice at each covered entity covered by this notice. The notice will contain the effective date on the first page in the top right-hand corner. In addition, each time you are seen at one of our clinics for treatment or health care services, we will make available a copy of the current notice in effect.

OTHER USES OF MEDICAL INFORMATION: Other uses and disclosures of your medical information not covered by this notice or the laws that apply to us will be made only with your written authorization. If you provide us permission to use or disclose your medical information, you may revoke that permission in writing at any time. If you revoke your permission, we will no longer use or disclose your medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission and that we are required to retain our records of the care that we provided to you.

GLACIER
ENT & Hearing

PERMISSION TO DISCLOSE MEDICAL/BILLING INFORMATION

Print Patient's Name: _____ Date of Birth: _____

I give permission to Glacier Ear, Nose & Throat and/or Glacier Hearing services to discuss my medical/billing information with the individual(s) indicated below. Please include any individual (i.e., your spouse) whom you would like us to contact at any time regarding your bill or medical information. If they are not listed, we cannot speak to them.

I understand that this permission will remain in effect until I submit a written request stating my intentions otherwise.

Name	**Relationship**
_____	_____
_____	_____
_____	_____
_____	_____

Patient/Guardian Signature: _____ Date: _____

If the patient is a minor, complete the following:
****Please list any adult(s) who may accompany the minor to appointment(s)****

Name	**Relationship**
_____	_____
_____	_____

****Please Note****
If the patient listed above is unable to sign on their own behalf (i.e., minor, incapacitated) and you are acting as this patient's guardian/representative, please complete the section below:

Print Guardian/Representative's Name: _____ Relationship to Patient: _____

Signature Guardian/Representative: _____ Date: _____

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GLACIER
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Assignment of Insurance Benefits—
Appointment of Legal Authorized Representative

I hereby assign all applicable health insurance benefits and all rights and obligations that I and my dependents have under my health plan to Glacier Ear, Nose & Throat and its representatives (hereinafter, "My Authorized Representative"), and I appoint them the power to:

- File medical claims, appeals and grievances with the health plan;
- Participate in any administrative and judicial action;
- Discuss or divulge any of my personal health information or that of my dependents with any third party, including the health plan.

I certify that the health insurance information I provided to Glacier Ear, Nose & Throat is accurate as of the date set forth below and that I am responsible for keeping it up to date. I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services from Glacier Ear, Nose & Throat are paid in full. I also understand that I am responsible for all amounts not covered by my health insurance, including co-payments, co-insurance and deductibles.

Authorization to Release Information:
I hereby authorize My Authorized Representatives to: (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked in writing by me.

ERISA Authorization:
I hereby designate, authorize and convey to My Authorized Representatives to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan: (1) the right and ability to act on my behalf in connection with any claim, right or cause in action that I may have under such insurance policy and/or benefit plan; and (2) the right and ability to act on my behalf to pursue such claim, right or cause of action in connection with said insurance policy and/or benefit plan (including but not limited to, the right to act on my behalf in respect to a benefit plan governed by the provisions of ERISA as provided in 29 C.F.R. §2560.5031(b)(4)) with respect to any healthcare expense incurred as a result of the services I received from Provider and, to the extent permissible under the law, to claim on my behalf, such benefits, claims or reimbursement, and any other applicable remedy, including fines. This lifetime assignment will remain in effect until revoked by me in writing. A photocopy of this Assignment/Authorization shall be as effective and valid as the original.

Print Patient Name: _____

Patient Date of Birth: _____

Print Guardian Name: _____

Signature of Patient/Guardian: _____

Date: _____

160 Heritage Way, Kalispell, MT 59901
ENT • P: (406) 752-8330 • F: (406) 752-8412
HEARING • P: (406) 752-1014 • F: (406) 756-1379
www.glacierentclinic.com

GLACIER
ENT & Hearing

Financial Policy

Welcome, and thank you for choosing our medical clinic! We are committed to providing you with the highest quality of health care in a caring manner. Please understand that payment of your bill is part of this care, and we appreciate your attention to our payment terms. If you have any questions, do not hesitate to ask a staff member. *Please read each section carefully and sign below.*

Appointments

1. We value the time we have allotted for you to see our professionals. We do not double-book appointments. If you are unable to keep an appointment, we would appreciate a 24-hour notice. We reserve the right to charge a $25 fee for missed or late-canceled appointments. Excessive abuse of scheduled appointments may result in discharge from the practice.
2. We strive to minimize any wait time; however, emergencies occur and will take priority over a scheduled visit. We appreciate your understanding.

Insurance Plans

Please understand that professional 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. We cannot render services under the assumption that the insurance company will pay the charges. It is not the policy of this office to routinely write off balances that insurance companies do not pay or cover.

1. It is your responsibility to keep us updated with your correct insurance information. If the insurance company you designate is incorrect, you will be responsible for payment of the visit and submitting the charges to the correct plan for reimbursement.
2. It is your responsibility to understand your benefit plan with regard to your benefits and payment of these benefits.
3. It is your responsibility to know if a written referral or authorization is required to see specialists, whether preauthorization is required prior to a procedure and what services are covered.
4. While filing insurance claims is a courtesy that we extend to our patients, **all charges not covered by your insurance company are your responsibility.**

Financial Responsibility—Payment is due at the time of service.

1. According to your insurance plan, you are responsible for all co-payments, deductibles and co-insurance.
2. **Co-payments are due at the time of service.**
3. Self-pay patients are expected to pay the estimated charges for services at the time of the visit. Cash payments in full will be given a 10% discount. The charges at checkout time are an estimate, and accurate charges will be billed at a later date.
4. Patient balances are billed immediately upon receipt of your insurance plan's explanation of benefits. Your remittance is due within **10** business days of your receipt of your bill.
5. If previous arrangements have not been made with our finance office, any account balance outstanding longer than 28 days will be charged a $10 fee for each 28-day cycle. Any balance outstanding longer than 90 days will be forwarded to a collection agency. In addition to the amount owed, you will also be responsible for the fee charged by the collection agency for the cost of collections.
6. For scheduled appointments, you must pay any outstanding balances prior to your new visit unless financial arrangements have been made beforehand.
7. Your office visit charge will be based on the time spent, complexity, visit comprehensiveness and medical decision-making. Any additional procedure(s) completed during the visit will be at an additional charge to the office visit charge.
8. Audiological services are billed separately from physician charges. Please note that the audiologist is a separate provider and that your insurance company may require an additional co-pay.
9. A $30 fee, payable by cash or money order, will be due for any checks returned for insufficient funds.
10. No refund amounting to less than $10 shall be paid by Glacier Ear, Nose & Throat, except upon the specific request of the person entitled to receive the refund. All refund requests must be received in writing.

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Financial Hardship

1. We recognize that certain members of our community may be unable to pay the full cost of their medical care. Financial assistance applications are available by notifying your physician of your need. We offer extended payment arrangements and charitable discounts based on demonstrated need. You must make any financial assistance requests and arrangements prior to your visit and provide proof of hardship. Any charitable discounts are not transferable to any other medical facility, lab or pharmacy.

Duplication of Records

1. A copy of your complete record is available, but depending on the situation, there may be a copying and postage fee. Please ask a member of the office staff for details of these charges.

I certify that I have read and understand the above information. I agree to be responsible for payment of all services rendered on my behalf or my dependents, including fees above those designated as "usual and customary" by my insurance carrier. I agree that in the event of a dispute over the collection of fees, the prevailing party shall be entitled, in addition to such other relief as granted, to be reimbursed by the losing party for all costs and expenses incurred thereby, including but not limited to reasonable attorney fees and costs.

Patient Name (Printed): _____ Date: _____

Person Signing Printed Name: _____

(If different from patient)

Person Signing Signature: _____

If requested, we will provide you with a copy of this document for your records.

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