Conway Physicians Group

CPG Carolina Bays ENT

Patient Information				
Patient name	DOB	Age	Gender – Circle one Male Female	Today's Date
Address	Home phone		Cell phone	
City/State/Zip	SS#		Marital Status - Circle one S M D W	
Emergency Contact	Relationship		Phone # (H) (C)	

Patient Employment Information		
Employer	Contact name	Work number
Address	City/State/Zip	

Guarantor Insurance Information			
Primary Insurance	Employer	Secondary Insurance	Employer
Policy #	Group #	Policy #	Group #
Insured Name		Insured Name	
Address		Address	
City/State/Zip		City/State/Zip	
Insured DOB	Insured SS#	Insured DOB	Insured SS#

Guarantor Employment Information		
Employer	Contact name	Work number
Address	City/State/Zip	

Additional Information	
Parent/Guardian Name	Day Phone

Referral Information
How did you hear about us?

Consent for Healthcare and Release of Medical Information

I voluntarily consent to treatment at this facility by its physicians and staff. No guarantees have been made to me about the results of treatments or examination by staff at this practice. I consent to the use and disclosure of my protected health information for treatment, payment and healthcare operations. I have read this form and had the opportunity to ask questions.

Financial Responsibility and Assignment of Insurance Benefits

I authorize **CPG Carolina Bays ENT** to bill my insurance company using the information I have provided to this office for payment to their **MEDICAL FACILITY**. I assign payment for the unpaid charges for certain physician services to **CPG Carolina Bays ENT**. I understand I am responsible for any health insurance deductible and co-insurance payments. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any medical or any other information about me to be released to the Social Security Administration or its intermediaries or carriers and any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf.

Signature of Patient or Authorized Person: _____ **Date:** _____

Acknowledgement of Receipt of Notice of Privacy Practices

I have received a copy of the Notice of Privacy Practices. I am aware that the Notice may be changed at any time and that I may request a copy of the revised notice by contacting the Office Manager.

Signature of Patient or Authorized Person: _____ **Date:** _____

FOR STAFF USE ONLY

☐ Patient refused to sign
☐ Patient refused to sign after receiving the Notice. Explanation provided that signature only documents that the Notice was received.
☐ Unable to provide NPP due to an emergency situation and the patient was not able to sign
☐ Patient refused copy of NPP but understands a copy is available upon request.

Signature of: _____ **Date:** _____