(1)

TODAYS DATE: _____

NAME OF PATIENT: _____ SEX: Male or Female (circle one)
Ms. Miss Mr. Mrs. (circle one) Last Middle First

ADDRESS: _____ _____ _____
Street City Zip Code

DATE OF BIRTH: _____ Age: _____ HOME PHONE NUMBER: _____
Month Day Year

CELL PHONE NUMBER: _____

EMPLOYER: _____ WORK PHONE NUMBER: _____

EMAIL ADDRESSS: _____

SOCIAL SECURITY #: _____ OCCUPATION: _____

EMERGENCY CONTACT: _____ _____ RELATIONSHIP: _____ PHONE #: _____
First Name Last

RESPONSIBLE PARTY:

NAME: _____ _____ _____ _____
Last Name First Initial Relationship

ADDRESS: _____ _____ _____
Street City Zip Code

OCCUPATION: _____ EMPLOYER: _____

BUSINESS PHONE: _____ SOCIAL SECURITY #: _____

WHO REFERRED YOU TO US? Please Print Name _____
Referring Doctor's Name

ADDRESS: _____ _____ _____ PHONE #: _____
Street City Zip Code

DESCRIBE PROBLEMS WITH EARS: _____

ALLERGIC TO: _____

INSURANCE INFORMATION:

I PLAN TO MAKE PAYMENT OF MY MEDICAL EXPENSES AS FOLLOWS: CASH / CHECK MASTERCARD / VISA / AM EX / DISCOVER

IN ORDER TO AVOID ERROR OR DELAY IN THE PROCESSING OF ANY INSURANCE CLAIMS IT IS ESSENTIAL THAT THIS SECTION BE **COMPLETELY FILLED OUT**. (IF YOU **DO NOT** HAVE INSURANCE, PLEASE WRITE "NONE" NEXT TO SUBSCRIBER OR INSURED'S NAME.)

PRIMARY INSURANCE We will make a copy of your Driver's Lic. and Ins. card.

POLICY HOLDER OR INSURED'S NAME: _____ DATE OF BIRTH: _____

SOCIAL SECURITY #: _____ EMPLOYER NAME: _____

INSURANCE CO.: _____ CLAIMS ADDRESS: _____

CONTRACT #: _____ GROUP #: _____

SECONDARY INSURANCE

POLICY HOLDER OR INSURED'S NAME: _____ DATE OF BIRTH: _____

SOCIAL SECURITY #: _____ EMPLOYER NAME: _____

INSURANCE CO.: _____ CLAIMS ADDRESS: _____

CONTRACT #: _____ GROUP #: _____

ALL CHARGES ARE DUE AT THE TIME OF SERVICE UNLESS OTHER FINANCIAL ARRANGEMENTS HAVE BEEN MADE IN ADVANCE

I hereby authorize payment of insurance benefits otherwise due to me to be made directly to Ronald L. Steenerson, M.D. I hereby authorize Ronald L. Steenerson, M.D. to:

1. obtain medical records from other sources as may be needed in the treatment of this patient;
2. release information concerning this patient's treatment to other physicians involved in the care and treatment of this patient:
3. release information to the insurance company as needed to file for charges incurred by this patient.

A copy of this authorization shall be as valid as the original. This information shall remain valid until Ronald L. Steenerson is provided with a written notice of cancellation.

I understand that I am responsible for any amount not covered by the Insurance company.

_____ X _____ _____
Witness Patient or Responsible Party Today's Date

(2)

PATIENT RESPONSIBILITIES AND RIGHTS

PATIENT RIGHTS: You have the right to:

- Voice your opinion about the managed care organization or the care provided and to recommend changes in policies and services by contacting Member Services.
- Be provided with information about the managed care organization and its services.
- Participate in decisions about your health care and treatment plan.
- Receive from your health care provider complete information about your diagnosis and proposed procedure or treatment alternative, including non-treatment, in order to give informed consent.
- Refuse any procedure or treatment, if you so desire, and to the extent permitted by law, be told what effect this may have on your health.
- Receive full consideration of privacy or confidentiality with regard to all information and records about your care.
- Know the cost (co-payment, deductible, coinsurance) of care and treatment and receive an explanation of your financial obligation when required.
- Change your Primary Care Physician by contacting Member Services.
- Have 24-hour access to your Primary Care Physician or covering physician. If out-of-area or traveling, you have the right to receive emergency care if needed.
- Be informed of the names, specialties, and qualifications of the physicians.
- Receive prompt and reasonable responses to questions and requests.

PATIENT RESPONSIBILITIES: You have the responsibility to:

- Provide an updated written referral (from Primary Care Physician) if an HMO member. You will not be seen without a written referral.
- Keep up with the number of visits remaining on your referral and when it expires.
- Know the benefits and exclusions of your coverage.
- Provide your health care provider with complete and accurate health information.
- Follow the treatment plan agreed upon by you and your health care provider.
- Know how to access health care services in routine, urgent, and emergency situations.
- Provide current Insurance information and personal Contact Information.

PATIENT SIGNATURE _____ DATE _____

(3)

ATLANTA
EAR
CLINIC
Professional Corporation

RONALD LEIF
STEENERSON, M.D.

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Doctors Medical Bldg.
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Email:earclinic@mindspring.com

Tel: 404/851-9093
Fax: 404/851-9097

OTOLOGY
~~NEUROLOGY~~
Diplomate American Board
of Otolaryngology

SURGERY AND
DISORDERS OF THE EAR
- Hearing Loss
- Vertigo
- Acoustic Neuroma
- Facial Nerve Paralysis
- Cochlear Implants
- Tinnitus

AUDIOLOGY AND
NEUROAUDIOLOGY
- ABR
- ENG
- ECoG
- ENoG
- Otoacoustic Emissions
- Hearing Aids

Robin B. Hardin, M.A., FAAA, CCC-A

Julie Shepard, M.Ed., CFY-A

Lucinda B. Gray, M.A., FAAA, CCC-A
- Cochlear Implant Evaluation
and Rehabilitation

René N. Wysocki, M.S., FAAA

REHABILITATION
Gaye W. Cronin, MHE, OTR
- Vestibular Rehabilitation
- Facial Re-training
- Tinnitus Reduction

Peggy Marbach, M.S., OTR

PRIVACY POLICY
ACKNOWLEDGEMENT STATEMENT

I have been told that the Atlanta Ear Clinic has a privacy Policy in place according to the Health Insurance Portability and Accountability Act of 1996 (HIPPAA). As a patient of the Atlanta Ear Clinic, I understand and acknowledge the following:

1. The Atlanta Ear Clinic has privacy policy in effect in their office.
2. The Atlanta Ear Clinic has made this policy available to me. A complete written version of the policy is in a binder and in a poster version in the waiting room.
3. The Atlanta Ear Clinic has made me aware, that as a patient, I am entitled to a copy of this Privacy Policy if I desire a copy for my personal files.

After reading these statements please sign at the bottom acknowledging that you have been advised of the privacy policy implemented by the Atlanta Ear Clinic and have read and understand the acknowledgement form. If you would like a copy of the Privacy Policy, please ask for one at our front desk.

_____**No, I do not want a copy of the policy but I do acknowledge that it exists.**

_____**Yes, I have requested and been given a copy of the Privacy Policy.**

Patient Name Date

For more information, please contact the Atlanta Ear Clinic Compliance and Privacy Officer at 404-851-9093.-

(4)

PATIENT AUTHORIZATION

I,_____, hereby authorize Ronald Leif Steenerson, MD and the Atlanta Ear Clinic to use and release protected information (paper, verbal or electronic) concerning my medical treatment to other physicians and health care professionals involved in my care and treatment.

I release Ronald Leif Steenerson, MD and the Atlanta Ear Clinic to release information to my insurance company as needed to file charges for services. I authorize the payment of insurance benefits to be made directly to Ronald Leif Steenerson, MD and the Atlanta Ear Clinic and I understand that I am responsible for any amount not covered by the insurance company.

I authorize and give consent for observation of treatments by medical and health care students/professionals.

I understand that I have the right to revoke this authorization, in writing, by sending a written notice to the office of Ronald Leif Steenerson, MD and the Atlanta Ear Clinic.

I understand that I have the right to inspect or copy my medial records that are being used or disclosed.

A copy of this authorization shall be as valid as the original. This authorization shall be in force indefinitely, unless rescinded in writing.

_____ _____

Signature of Patient or Representative **Date**

_____

Printed Name of Patient or Representative

_____

Relationship of Representative