

# LOW COUNTRY ENT. P.A.

EAR • NOSE • THROAT • HEAD AND NECK SURGERY  
FACIAL PLASTIC AND RECONSTRUCTIVE SURGERY

2850 TRICOM STREET • CHARLESTON, SC 29406  
843-863-1188 • 843-863-8286 FAX

## PATIENT INFORMATION

LAST NAME		FIRST NAME		MIDDLE INITIAL	
STREET ADDRESS				APT #	
ZIP CODE - 9 DIGIT		CITY		STATE	
HOME PHONE		SOCIAL SECURITY #		BIRTHDAY	AGE
SEX (M/F)		MARITAL STATUS		STUDENT	P-PART
		<input type="checkbox"/> M-MARRIED <input type="checkbox"/> W-WIDOWED <input type="checkbox"/> S-SINGLE <input type="checkbox"/> D-DIVORCED <input type="checkbox"/> X-SEPARATED		<input type="checkbox"/> F-FULL <input type="checkbox"/> N-NONE	
RELATION TO INSURED		EMPLOYER/SCHOOL NAME			
<input type="checkbox"/> OT-OTHER <input type="checkbox"/> SE-SELF <input type="checkbox"/> SP-SPOUSE <input type="checkbox"/> CH-CHILD					
STREET ADDRESS			CITY		
STATE		ZIP		BUSINESS PHONE	

## SPOUSE INFORMATION

SPOUSE NAME		SPOUSE'S EMPLOYER			
SPOUSE SOCIAL SECURITY #		SPOUSE'S BIRTHDAY	SPOUSE EMPLOYER'S ADDRESS	CITY	STATE    ZIP

## SUBSCRIBER / PARENT INFORMATION IF STILL UNDER PARENTAL CARE

FATHER'S NAME				MOTHER'S NAME					
ADDRESS		CITY	STATE	ZIP	ADDRESS		CITY	STATE	ZIP
BIRTHDATE		SOCIAL SECURITY NUMBER			BIRTHDATE		SOCIAL SECURITY NUMBER		
HOME PHONE		BUSINESS PHONE			HOME PHONE		BUSINESS PHONE		
EMPLOYER				EMPLOYER					
EMPLOYER'S ADDRESS		CITY	STATE	ZIP	EMPLOYER'S ADDRESS		CITY	STATE	ZIP

## INSURANCE INFORMATION

PRIMARY INS. COMPANY		POLICY#	
SECONDARY INS. COMPANY		POLICY#	

REFERRING PHYSICIAN  
FIRST AND LAST NAME \_\_\_\_\_ FAMILY PHYSICIAN \_\_\_\_\_

COMPLAINT OR SYMPTOMS \_\_\_\_\_

DATE OF ONSET/ACCIDENT \_\_\_\_\_ KNOWN DRUG ALLERGIES \_\_\_\_\_

MEDICATION NOW TAKING \_\_\_\_\_

DO YOU TAKE ASPIRIN PRODUCTS? \_\_\_\_\_ IF YES, HOW OFTEN? \_\_\_\_\_

(OVER)

# MEDICAL HISTORY

To the best of your knowledge, do you have or have had any of the following problems?

DESCRIPTION	YES	NO	DESCRIPTION	YES	NO
Previous Surgeries	_____	_____	Neurological	_____	_____
Stroke	_____	_____	Previous Head Trauma	_____	_____
Recurrent Tonsillitis	_____	_____	Swallowing Problems	_____	_____
Neck Pain/Problems	_____	_____	Lung Problems	_____	_____
Heart Problems	_____	_____	High Blood Pressure	_____	_____
Diabetes	_____	_____	Hiatal Hernia	_____	_____
Stomach Ulcers	_____	_____	Intestinal Problems	_____	_____
Kidney Disease	_____	_____	Bladder Problems	_____	_____
Reproductive Problems	_____	_____	Bone/Joint Problems	_____	_____
Epilepsy/Seizures	_____	_____	Arthritis	_____	_____
Tuberculosis	_____	_____	Emphysema/Bronchitis	_____	_____
Psychoneurotic Disability	_____	_____	Cancer Tumor	_____	_____
Rheumatic Fever	_____	_____	Asthma	_____	_____
Skin Rash/Hives	_____	_____	Do you use alcohol?	_____	_____
Anemia	_____	_____	If yes, how much?	_____	_____
Hepatitis/Jaundice	_____	_____	Thyroid Disease	_____	_____
Hemophilia	_____	_____	HIV/AIDS	_____	_____
Are you pregnant?	_____	_____	Deafness	_____	_____
			Do you smoke?	_____	_____
			If yes, how much?	_____	_____

Please list any Previous Surgeries:

\_\_\_\_\_

\_\_\_\_\_

Please list any other pre-existing disease, condition, or impairment not asked above:

\_\_\_\_\_

\_\_\_\_\_

IN THE EVENT SURGERY IS REQUIRED DO YOU HAVE ANY OBJECTIONS TO ADMINISTRATION OF BLOOD OR BLOOD PRODUCTS? YES \_\_\_ NO \_\_\_

Please name any other physician or practitioner you are seeing: \_\_\_\_\_

Whom to notify in case of emergency: Name \_\_\_\_\_ Phone # \_\_\_\_\_

## PATIENT RESPONSIBILITY

### INSURANCE AUTHORIZATION AND ASSIGNMENT

Name of Policy Holder \_\_\_\_\_ HIC Number \_\_\_\_\_

I request that payment of authorized Medicare/Other Insurance company benefits be made either to me or on my behalf to Low Country ENT for any services furnished me by that party who accepts assignment/physician. Regulations pertaining to Medicare assignment of benefits apply.

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim / other Insurance Company claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information).

Legal Signature: \_\_\_\_\_

Date: \_\_\_\_\_



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I \_\_\_\_\_ give Low Country ENT my permission to disclose any medical information about myself or my child to the people listed below. If the patient is a minor child ( under the age of 18 ) please list anyone who can bring the child to the appointment.

Spouse \_\_\_\_\_

Grandparents \_\_\_\_\_

Parent/Guardian \_\_\_\_\_

Please list anyone else that we can disclose medical information to. If you don't have anyone, please sign the signature line.

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

\*\*\*\*\* I have received and read a copy of the privacy policy\*\*\*\*\*

Signature \_\_\_\_\_ Date \_\_\_\_\_

**LOW COUNTRY ENT, P.A.**  
**FINANCIAL POLICY**

**YOUR INSURANCE:**

We accept assignment of benefits from many insurance companies. For those insurance companies we have a contract with we will bill those plans and only require you to pay the co-payment at the time of service. If you have not met any applicable deductibles this will be due at time of service. If you have an insurance that requires an authorization it is ultimately the patient's responsibility to obtain this from their Primary Care Physician. All charges that remain after 30 days will be charged a minimum fee of \$10.00 per month unless payment arrangements have been made. Any account that goes to collections will be charged a collection fee.

**COPAYS:**

All copays are due at CHECK-IN. If you do NOT have insurance or your copay is a percentage, (ex: 20%, 15%) only those copays will be figured at check-out. However, if you are a NEW PATIENT and you have no insurance you will be expected to bring \$150.00 with you at your first visit and that will be collected at CHECK-IN. That amount sometimes does not cover the visit cost in full depending on what needs to be done in the office to help you get well.

**MINOR PATIENTS:**

Any patient under the age of 18 will not be seen without a parent or guardian present.

**NO-SHOW FOR AN APPOINTMENT:**

There will be a \$25 charge for any appointments that are not cancelled with at least a 12 hour notice.

**RETURN CHECK POLICY:**

There will be a \$35 fee for all returned checks.

I have read and understand the financial policy of the practice and I agree to be bound by its terms. I understand and agree that such terms may be amended from time to time by the practice.

Sign \_\_\_\_\_ Date \_\_\_\_\_

PLEASE  
DO NOT  
STAPLE  
IN THIS  
AREA

This is so we can file your insurance - Thank You!

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> <small>(Medicare #) (Medicaid #) (Sponsor's SSN) (VA File #) (SSN or ID) (SSN) (ID)</small>		1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>	
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code) ( ) ( )		6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( ) ( )	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	
c. EMPLOYER'S NAME OR SCHOOL NAME		11. INSURED'S POLICY GROUP OR FECA NUMBER	
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. RESERVED FOR LOCAL USE	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.		11. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE		b. EMPLOYER'S NAME OR SCHOOL NAME	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE		c. INSURANCE PLAN NAME OR PROGRAM NAME	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>	

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE		17a. I.D. NUMBER OF REFERRING PHYSICIAN		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)		23. PRIOR AUTHORIZATION NUMBER		23. PRIOR AUTHORIZATION NUMBER	

A		B		C		D		E		F		G		H		I		J		K	
DATE(S) OF SERVICE		Place of Service		Type of Service		PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		DIAGNOSIS CODE		\$ CHARGES		DAYS OR UNITS		EPSDT Family Plan		EMG		COB		RESERVED FOR LOCAL USE	
From	To																				
MM	DD	YY	MM	DD	YY																
1																					
2																					
3																					
4																					
5																					
6																					

25. FEDERAL TAX I.D. NUMBER SSN EIN		26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$		29. AMOUNT PAID \$		30. BALANCE DUE \$	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)				32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)				33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE			

SIGNED DATE

PIN# GRP#

LOW COUNTRY ENT, PA  
2850 TRICOM STREET  
CHARLESTON SC 29406

750-0110 (1/2/85) (C) 1 pt.