PRINCETON EYE AND EAR

Adult & Pediatric Otolaryngology - Head and Neck Surgery
Ear Nose & Throat Specialists
Facial Plastic & Reconstructive Surgery

- ☐ Chetan Shah, MD FACS
- ☐ Rakesh Patel, MD FACS
- ☐ Michael Ondik, MD
- ☐ Kelly Kilcollins, APN-C
- ☐ Jessica Keel, PA-C
- ☐ Michael O'Connor, PA-C
- ☐ Allison Dertouzos, PA-C
- ☐ Irene Cohen, AuD
- ☐ Florence Belhassen, AuD
- ☐ James Dublin, AuD
- ☐ Michael Perl, AuD

PATIENT REGISTRATION

Last Name: _____ First Name: _____ MI: _____

Address: _____Apt#: _____ City: _____

State: _____ Zip Code: _____ Home Phone: _____

Birth Date:_____ Age: _____Sex: _____ Cell Phone:_____

Marital Status: _____ Referred By: _____Phone: _____

Medical Doctor: _____ Phone: _____

Pharmacy Name: _____ Town_____ Pharmacy Phone: _____

Employer: _____Work Phone:

_____

Occupation: _____ Email: _____

Emergency Contact: _____Phone: _____

INSURANCE INFORMATION: ***Please present all insurance ID cards and referrals to the receptionist.***

Medical Insurance Policy:_____ID #_____

Name of Policy Holder:_____ Relationship: _____DOB:_____

1. I am responsible to provide the referral, where required.
2. I am responsible to provide the payment and co-payment when services are rendered.
3. I understand that I am financially responsible for any balance not covered by my insurance, such as deductible, co-insurance and co-payment.
4. I authorize the release of any medical information necessary to process an insurance claim.
5. I will immediately notify your office of any change in my address, phone number and insurance information.
6. I am responsible to inform you about the complete benefits provided by my insurance.
7. I consent to endoscopy [looking into nose, sinuses, food and wind pipe with camera], audiological (hearing) testing, vestibular (balance) testing, and allergy testing on the skin and given allergy injections, if applicable.

Patient/ Parent/ Guardian Signature_____ Date: _____

BACK

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CONSENT AGREEMENT

I, _____ understand that as part of my healthcare, the doctor's office originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care of treatment. I understand that this information serves as a:

- basis for planning my care and treatment.
- means of communication among the many health professionals who contribute to my care.
- source of information for applying my diagnosis and surgical information to my bill.
- means by which a third party payer can verify that the services billed were actually provided.
- tool for routine healthcare operations, such as assessing quality and reviewing the competence of healthcare professionals.

Consent to Release Medical Records: I authorize the release of my medical records and information for the purpose of coordinating care. I understand that the information disclosed may include specially protected health information such as records, testing, diagnosis, and treatment. I may revoke this authorization as it relates to specially protected health information by providing written notice to Princeton Eye and Ear.

I understand and I have been provided a Notice of Health Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. 1 understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided.

HIPPA CONSENT TO RELEASE MEDICAL INFORMATION

The following individuals may be contacted regarding my medical information pertaining to my medical care.

Name:_____ Relationship:_____ Phone:_____

Name:_____ Relationship:_____ Phone:_____

I fully understand and accept the terms of this consent.

Parent/Guardian/Patient Signature: _____Date:_____

CONFIDENTIAL
If you are under 18 years of age, you must be accompanied by an adult