203 S. 12th Avenue
Laurel, MS 39440

Carl W. "Rusty" Stevens, MD
Jamie D. Sisk, MD

Phone: (601) 649-9706
Fax: (601) 649-9708

REGISTRATION SHEET

Patient Information

Name: _____ (Last) _____ (First) _____ (M.I.)

Address: _____ (Street) _____ (Apt #) _____ (City) _____ (State) _____ (Zip)

Phone: _____ (Home) _____ (Cell) _____ (Work)
(please circle preferred contact number)

Email: _____ Sex: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Date of Birth: _____ (Month) _____ (Day) _____ (Year) SSN: _____ - _____ - _____

Preferred Language: _____ Preferred Pharmacy: _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ African American
☐ Native Hawaiian ☐ Caucasian (white) ☐ Other Race

Responsible Party Information *(If patient is under age 18, parent or guardian completing registration sheet)*

Name: _____ (Last) _____ (First) _____ (M.I.)

Address: _____ (Street) _____ (Apt #) _____ (City) _____ (State) _____ (Zip)

Date of Birth: _____ (Month) _____ (Day) _____ (Year) SSN: _____ - _____ - _____

Phone: _____ Relationship: ☐ Parent ☐ Guardian

Employer Information

Employer Name: _____ Phone: _____

Address: _____ (Street) _____ (Suite #) _____ (City) _____ (State) _____ (Zip)

PLEASE COMPLETE INSURANCE INFORMATION

INCLUDING MEDICAID

Insurance Information *(Primary)*

Insurance Company: _____

Insured's Name: _____ (Last) _____ (First) _____ (M.I.)

Address: _____ (Street) _____ (Apt #) _____ (City) _____ (State) _____ (Zip)

Date of Birth: _____ (Month) _____ (Day) _____ (Year) SSN: _____ - _____ - _____

Patient's Relationship to Insured: ☐ Self ☐ Child ☐ Spouse ☐ Other: _____

Policy # / Member ID: _____ Group #: _____

Insurance Information *(Secondary)*

Insurance Company: _____

Insured's Name: _____ (Last) _____ (First) _____ (M.I.)

Address: _____ (Street) _____ (Apt #) _____ (City) _____ (State) _____ (Zip)

Date of Birth: _____ (Month) _____ (Day) _____ (Year) SSN: _____ - _____ - _____

Patient's Relationship to Insured: ☐ Self ☐ Child ☐ Spouse ☐ Other: _____

Policy # / Member ID: _____ Group #: _____

Referral Information

Referred By: _____ Family Doctor: _____

Payment Type: _____Check _____Credit Card _____ Cash

EAR, NOSE & THROAT surgical clinic

203 S. 12th Avenue
Laurel, MS 39440

Carl W. "Rusty" Stevens, MD
Jamie D. Sisk, MD

Phone: (601) 649-9706
Fax: (601) 649-9708

Financial Agreement

I acknowledge that payment is due at the time of treatment, unless other arrangements have been made. I accept the financial responsibility for all charges not covered by my insurance company. Past due accounts will be referred to a collection agency and credit bureau.

_____ _____
Patient or Legal Guardian **Date**

Authorization for Treatment

I hereby authorize and request examination and/or medical treatment by the physicians and the staff of Ear, Nose and Throat Surgical Clinic. I further authorize any procedure that the judgment of the above named physicians and staff may deem necessary during any treatment. I also authorize the administration of any anesthetics and analgesics, which above physicians and staff deem advisable.

_____ _____
Patient or Legal Guardian **Date**

Medicare Assignment & Supplement

I authorize Ear, Nose and Throat Surgical Clinic to release to the Centers of Medicare and Medicaid Services information about me needed to determine benefits payable for related services. I request that payment of authorized Medicare and Medicaid be made to Ear, Nose and Throat Surgical Clinic for services furnished to me by their physicians. I realize this is a lifetime authorization.

_____ _____
Patient or Legal Guardian **Date**

Insurance Assignment

I request that payment of Insurance benefits be made to Ear, Nose and Throat Surgical Clinic for services furnished to me by their physicians. I realize this is a lifetime authorization. I also authorize release of any medical information to my insurance company listed above.

_____ _____
Patient or Legal Guardian **Date**

Consent to Send or Receive Medical Records

Ear, Nose and Throat Surgical Clinic has my consent to use and disclose my health information for the following purposes: to provide medical service and treatment alternatives, to collect payment for services rendered, for healthcare operations, to contact you with appointment reminders, and to inform you of health-related products and services.

_____ _____
Patient or Legal Guardian **Date**

Picture Consent

I authorize Ear, Nose and Throat Surgical Clinic to obtain a photo of myself to be kept in my medical records for the purpose of identification and medical documentation.

_____ _____
Patient or Legal Guardian **Date**

203 S. 12th Avenue
Laurel, MS 39440

Carl W. "Rusty" Stevens, MD
Jamie D. Sisk, MD

Phone: (601) 649-9706
Fax: (601) 649-9708

Notice of Privacy Practices for Protected Health Information

ENT Surgical Clinic of South Central Mississippi has provided me with a copy of its Notice of Privacy Practices for Protected Health Information. I understand that this Notice describes how my medical information will be protected. I understand that the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires ENT to protect my information. I understand how ENT Surgical Clinic may use and disclose my health information.

I hereby acknowledge receipt of the Notice of Privacy Practices:

_____ _____

Patient Signature or Legal Guardian Date

I received Version #003 of the Privacy Notice.

Patient Health/Patient Account Information Permission

According to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), our clinic is not authorized to discuss your medical information or patient account information with anyone but the patient. Sometimes, this is not always convenient or possible, therefore, by completing the below listed information, you are granting our clinic said permission.

Date: _____

I, _____ , give the staff of Dr. Carl W. Stevens and Dr. Jamie D. Sisk,
Patient or Legal Guardian

permission to discuss my patient chart and/or account with the following listed persons:

Patient Health/Account Information Yes ____ No ___

1. _____ Relationship _____
2. _____ Relationship _____
3. _____ Relationship _____