JACQUELINE JONES, M.D.
NEW PATIENT REGISTRATION FORM
PLEASE PRINT

Date_____

PATIENT INFORMATION

Name(Last, First, MI)_____Age_____

Gender_____ Date of Birth_____/_____/_____ Marital Status_____

Address_____ Apt#_____

City_____State_____ Zip_____

Home Phone_____ Work Phone_____Ext_____

Mobile Phone_____ Other Phone_____

Email_____

Parent's Name _____Parent's Name_____

Emergency Contact_____Phone_____

BILLING: Please complete for guarantor or person responsible for bills.

Name_____Relation to Patient_____ Date of Birth_____

Address_____

City_____State_____Zip_____

Occupation_____ Employer_____

Home Phone_____ Work Phone_____

INSURANCE INFORMATION: Please note that if your carrier requires Pre Authorization or Pre Approval you are required to obtain prior to your appointment. You may need to check with your carrier if you have a waiting period.

Primary Ins_____ Ins Phone_____

Primary Ins Address _____

Subscriber_____ Relation to Patient: ❑Self ❑Spouse ❑Child ❑Other

Ins ID#_____ Ins Grp#_____

Secondary Ins _____ Ins Phone_____

Secondary Ins Address _____

Subscriber_____ Relation to Patient: ❑Self ❑Spouse ❑Child ❑Other

Secondary Ins ID#_____ Ins Grp#_____

MEDICAL CONTACT INFORMATION: A written report will be sent to your Primary Physician unless otherwise instructed.

Primary Care/Pediatrician_____ Phone_____

Address_____

Pharmacy_____ Phone_____

Address_____

Other Referral Source_____

JACQUELINE JONES, M.D.
Acknowledgement of Financial & Privacy Practice Policies

Dear Patients:

Welcome to our office! Our goal is to provide the highest standard of patient care and it is essential that we establish a clear understanding of our Financial & Privacy Policy with our patients. Should you have questions or concerns about our fees, policy, your financial responsibility or our privacy practices, please do not hesitate to ask.

IN-NETWORK INSURANCE - If Dr. Jones is considered "in-network" with your carrier, you are responsible for all co-payments at the time of service. You may also have in network deductibles and coinsurance and you will be required to leave a credit card on file with our office. Once we receive the EOB from your insurance carrier, we will send 1(one) statement. If we do not receive prompt payment, we will automatically charge the card we have on file.

OUT-OF-NETWORK INSURANCE - We ask for payment in full at the time of service and as a courtesy, we will gladly submit the claim form to your insurance carrier for your reimbursement consideration. Dr. Jones' team is committed to maximizing your insurance benefits and will work closely with you and your insurance carrier. Please contact your insurance company directly for details regarding your out-of-net work coverage.

SELF PAY PATIENTS & INTERNATIONAL INSURANCE - We ask for payment in full at the time of service and will provide you with a receipt for your records.

MEDICARE & MEDICAID PATIENTS - Dr. Jones does not accept Medicare or Medicaid and you will be responsible for payment at time of service. We will also require you to sign a Medicare release form.

REFERRALS - If your insurance company requires a referral to see a specialist, it is your responsibility to obtain this document prior to the appointment. Please remember that referrals expire and you are responsible for renewing with your primary care physician or pediatrician. If you do not obtain a referral, you will be responsible for the entire bill.

CANCELLATION POLICY - We understand that unexpected events occur and we ask that you contact the office as soon as possible to cancel or reschedule your appointment. In the event you do not arrive, the fee is $75. We ask you arrive promptly to your appointment as we want tor provide as much undivided attention and care to you and your family. If you are more then 10 minutes late to your appointment we will consider you a "fit in" patient and will be seen when time allows.

DIVORCED/SEPARATED PARENTS OF MINOR PATIENTS - The parent who consents to the treatment of a minor child is responsible for payment of services rendered. Dr. Jacqueline Jones or her staff will not be involved with separation or divorce disputes regarding payment and/or services.

PAYMENT METHODS - We accept Visa, MasterCard, American Express, checks and cash.

DIAGNOSTIC PROCEDURES – During the process of your evaluation and management by Dr. Jacqueline Jones, she may deem it appropriate and necessary to more closely examine your ears, nose, and/or throat using commonly tried and tested methods and in-office mildly invasive diagnostic procedures. Your insurance company may list these codes as surgical in nature even though they are performed in-office. Such procedures can include, but not limited to, Nasal Sinus Endoscopy (31231), Laryngoscopy (31575), Cerumen Removal (69210), and hearing exams. These procedures are the doctor's only tools to be better able to diagnose and treat your medical issues. You will be financially responsible for anything applied to your deductible and/or co-insurance arising from the billing of these codes.

AGREEMENT

I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Dr. Jacqueline Jones or my insurance company to release any information required to process my claims.

I have had full opportunity to read and consider the contents of your Notice of Privacy Practices. I understand that by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment; payment activities and heath care operations.

Responsible Party Signature_____ Date_____
Print Name_____ Relationship_____
Patient Name_____ Date of Birth_____

How would you like your appointments to be confirmed (Check all that apply):

☐ Home ☐ Cell ☐ Email ☐ Text ☐ Other:_____

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Park Avenue ENT
Dr. Jacqueline Jones and Dr. Michael Rothschild

Prescription Policy

According to **New York State Law, effective March 27, 2016,** all prescriptions must be sent electronically through our certified system. We can no longer provide ANY patient with a written prescription.

What this means to our patients is we must have a pharmacy of your choice stored in our computer in order to prescribe medication to the patient. Please complete all information below or we will not be able to prescribe medications. Since there are several chain store pharmacies, such as Duane Reade, we must have the exact address.

Patient Name:_____DOB:_____

Pharmacy Name:_____

Complete Address:_____

Pharmacy Phone Number:_____

All prescriptions will be sent to the pharmacy listed above. If you change your pharmacy, please notify us **before** any medications can be sent in. Otherwise, you will be responsible for picking up your prescription at the pharmacy you have listed above. The new law requires us to select a pharmacy when prescribed. Therefore, it must be accurate.

We are unable to refill prescriptions over the phone to patients who have not been seen in our office in the past six months time. Antibiotic prescriptions and narcotic prescriptions cannot be refilled over the phone.

All prescriptions will be electronically prescribed during office hours only. Please request your medications Monday to Friday, between 9am-4pm.

We appreciate your cooperation in allowing us to provide a high level of care to you and your family, and thank you for selecting our office to provide you with your healthcare needs.

PATIENT NAME: _____ **DOB:** _____

Agreement to Financial and Cancellation Policies

As the person financially responsible for services rendered by Dr. Jones to the abovenamed patient, I authorize that my insurance benefits be paid directly to Dr. Jones. I also agree to forward to Dr. Jones any funds that I receive from my insurance company if they are not reimbursement for payments that I have already made. This may include payment for audiological services, tests and procedures. I agree to pay all charges not covered by my insurance carrier(s). These charges include but are not limited to deductibles, copayments, and coinsurance charges. I authorize any holder of medical information about the abovenamed patient to release to the Health Care Financing Administration and its agent or any other health insurance, any information needed to determine these benefits or the payable for related services. I also acknowledge that there is a cancellation fee of $75 for appointments that are not cancelled 24 hours prior. I authorize Dr. Jones office to charge my credit card on file for any outstanding balances and cancellation fees. I have read and understand the above policies, and have been given opportunity to ask for clarification.

We accept cash, checks, Visa, Mastercard, American Express, or Debit cards.

_____

Signature of patient, or of legal guardian if patient is under 18 years of age Date

_____

Printed name of legal guardian and relationship to patient, if patient is under 18 years of age Date

_____

Credit card number

_____ _____

Credit card expiration Credit card security code

JACQUELINE JONES, M.D.
MEDICAL HEALTH HISTORY

Today's Date:_____

Patient Name _____

Patient Date of Birth_____ Age_____ Gender ❑ Male ❑ Female

Occupation:_____Height_____Weight_____

Reason for Consultation

❑ Ear Infection	❑ Sinusitis	❑ Foreign Body in Ear/Nose	❑ Headache	❑ Speech Concern
❑ Ear Aches	❑ Snoring	❑ Sore Throat	❑ Vertigo/Dizziness	
❑ Ear Discharge	❑ Sinus Problems	❑ Swallowing Difficulty	❑ Allergies	❑ Second Opinion
❑ Ringing in Ears	❑ Nasal Obstruction	❑ Mouth/Tongue Sores	❑ Asthma/Wheezing	
❑ Hearing Loss	❑ Nose Bleeds	❑ Thyroid Nodule	❑ Hoarseness	
❑ Earwax Build-Up	❑ Nose Fracture	❑ Neck Mass	❑ Other_____	

Chief Complaint:_____

MEDICATIONS: List ALL medications you are currently taking including herbs, supplements & over the counter medications.

Drug Name (Generic/brand)	Dosage	Frequency	Status
			❑Current ❑Chronic ❑Discontinued
			❑Current ❑Chronic ❑Discontinued
			❑Current ❑Chronic ❑Discontinued
			❑Current ❑Chronic ❑Discontinued
			❑Current ❑Chronic ❑Discontinued

PAST MEDICAL HISTORY: Please provide a complete history including all illnesses, injuries, & surgeries

Illness, Injury & Operations	Date	Treatment	Result

MEDICATION ALLERGIES

Medication Allergy	Reaction

FOOD & OTHER ALLERGIES

Allergic To	Reaction

Other health concerns:_____

_____

Physician Review

Signature:_____Date:_____