REGISTRATION

PLEASE PRINT

PATIENT

LEGAL PATIENT NAME (**LAST**, FIRST, MIDDLE)	ALSO KNOWN AS (NICKNAME) / MAIDEN NAME	SOCIAL SECURITY NUMBER

DATE OF BIRTH	AGE	SEX ☐ M ☐ F	LANGUAGE ☐ English ☐ German ☐ Spanish ☐ Chinese ☐ French ☐ Other ☐ Vietnamese	MARITAL STATUS ☐ Legally Separated ☐ Married ☐ Single ☐ Divorced ☐ Life Partner ☐ Never Married ☐ Widowed

RACE ☐ Asian ☐ Caucasian ☐ Native American ☐ African American ☐ Hispanic ☐ Other	ARE YOU A STUDENT? ☐ Yes ☐ No	STUDENT STATUS ☐ Full Time ☐ Part Time	NAME OF ATTENDING SCHOOL

ADDRESS	CITY, STATE	ZIP CODE

TELEPHONE	PAGER / CELL PHONE	**PRIMARY PHYSICIAN (First & Last Name)**	**REFERRING PHYSICIAN (First & Last Name)**

EMPLOYER	EMPLOYER ADDRESS	CITY, STATE	ZIP CODE

EMPLOYER TELEPHONE	EXTENSION	PATIENT'S EMAIL (Optional)	OCCUPATION

RESPONSIBLE PARTY

RELATIONSHIP TO PATIENT	GUARANTOR NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH	AGE	SEX ☐ M ☐ F

ADDRESS	CITY, STATE	ZIP CODE

TELEPHONE	PAGER / CELL PHONE	EMPLOYER

EMPLOYER TELEPHONE	OCCUPATION

EMERGENCY CONTACT

NAME		RELATIONSHIP TO PATIENT
TELEPHONE	EMPLOYMENT TELEPHONE	PAGER / CELL PHONE
COMMENTS		

NEXT OF KIN (OPTIONAL)

NAME		RELATIONSHIP TO PATIENT
TELEPHONE	EMPLOYMENT TELEPHONE	PAGER / CELL PHONE
COMMENTS		

PRIMARY INSURANCE

INSURANCE COMPANY NAME	
ADDRESS	
CITY, STATE	ZIP CODE
TELEPHONE NUMBER	EFFECTIVE DATE
POLICY ID NUMBER	GROUP NUMBER
PATIENT'S RELATIONSHIP TO SUBSCRIBER	
SUBSCRIBER'S NAME	DATE OF BIRTH
SUBSCRIBER'S EMPLOYER	

SECONDARY INSURANCE

INSURANCE COMPANY NAME	
ADDRESS	
CITY, STATE	ZIP CODE
TELEPHONE NUMBER	EFFECTIVE DATE
POLICY ID NUMBER	GROUP NUMBER
PATIENT'S RELATIONSHIP TO SUBSCRIBER	
SUBSCRIBER'S NAME	DATE OF BIRTH
SUBSCRIBER'S EMPLOYER	

I hereby grant authorization to **Martin H. Janning, MD** to release to third party carriers any medical and other information about me needed to determine payment of my bill. I understand that I may revoke this consent at any time. This consent is effective only for this period of confinement.
I hereby grant directly to the above named physician the insurance benefits otherwise payable to me but not to exceed the balance due of the physician regular charges for the period of treatment. I understand that I am financially responsible to the physician for charges not covered by this authorization.

SIGNATURE	PRINTED NAME (PATIENT/LEAGAL GUARDIAN)	DATE

How did you hear about our office?

☐ Physician Referral ☐ Friend ☐ Radio ☐ Newspaper ☐ Internet ☐ Other ____________________

Thank you for your patronage!

Consent for Purposes of Treatment, Payment, and Health-Care Operations

Janning ENT Center, LLC, 1801 19th Avenue SW, Willmar, MN 56201
Telephone: (320) 231-3277, Fax: (320) 214-5758

I consent to the use or disclosure of my "Protected Health Information" (PHI) by Janning ENT Center, LLC, 1801 19th Avenue SW, Willmar, MN 56201, for the purpose of diagnosing or providing treatment to me or to my son or daughter as a minor patient. I consent to allowing Janning ENT Center, LLC to provide treatment to me (or a minor dependant), obtain payment from me for health-care bills, and to conduct health-care operations. I understand that diagnosis or treatment of me by Janning ENT Center, LLC may be conditioned upon my consent as evidenced by my signature of this document. I have the right to revoke this consent in writing at any time, except to the extent that Janning ENT Center, LLC has taken action and reliance on this consent.

I understand that I have the right to request a restriction as to how my PHI is used or disclosed to carry out treatment, payment, or health-care operations of this practice. Janning ENT Center, LLC is not required to agree to the restrictions that I may request. However, if Janning ENT Center, LLC agrees to the restrictions that I have requested, the restrictions are binding on Janning ENT Center, LLC.

My PHI includes my demographic and health related information collected from me and created and received by my physician, another health care provider, health plan, my employer, or a health-care clearinghouse. This PHI relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

Notice of Privacy Practices—Acknowledgement

We keep a record of the health-care services that we provide to you. You may ask to see a copy of that record. You may also ask to correct that record. The Notice of Privacy Practices describes the types of uses and disclosures of your protected health information that will occur in your treatment, payment of your bills, or in the performance of health-care operations of Janning ENT Center, LLC. You should review this notice. A paper copy will be provided upon request. We will not disclose your records to others unless you direct us to do so or the law authorizes or compels us to do so. Janning ENT Center, LLC reserves the right to change the privacy practices that are described in the notice. You may see your records, get more information about them, or complain by contacting us (see below).

By my signature below I acknowledge that I received or was offered a copy of the Notice of Privacy Practices. I authorize Janning ENT Center, LLC to release any medical and billing information to my referring doctor, insurance company, the responsible party named above, and immediate family on behalf of myself and/or dependents. I authorize payment of medical benefits to Janning ENT Center, LLC for services rendered to myself and/or dependents. I agree to pay for services provided to me, to my spouse, and to my minor children. I/we agree to pay all charges not covered by insurance. *Please also review and sign the "Financial Policy Form" contained within this registration packet.*

X ______________________________
Signature of patient/guardian or authorized representative

____
Printed name of signer *Relationship to patient (if other than "self")*

____
Printed name of patient if different from signed (ex: child)

____
Date

Janning ENT Center, LLC
Attn: Marik Jensen
(Compliance Officer)

1801 19th Avenue SW
Willmar, MN 56201-4946

Telephone: (320) 231-3277

Fax: (320) 214-5758

Review, sign and date both sides of this document. This document will be kept on file at our office.

Office Tel: (320) 231-3277

1801 19th Avenue SW · Willmar, MN 56201-4946 · Fax: 320.214.5758
www.janningentcenter.com

PATIENT NAME: ________________________________

FINANCIAL RESPONSIBILITY

Co-payments ______ (Initial)

All office visits require a co-payment from your insurance company. Exceptions may include post operative visits for a determined period of time for some surgical procedures. Some insurance plans require co-payments for post-operative visits.

Deductible ______ (Initial)

A deductible is a portion of the bill that is the responsibility of the patient to pay before an insurance company will cover the service. An office visit with our physicians will include a face-to-face encounter and evaluation. Generally, a co-payment is required for the visit. In addition, some services and ALL procedures performed in the office require the patient to meet their deductible before insurance pays benefits. If you have not met your deductible, you will be responsible for full or partial payment, depending on your Insurance contract. Procedures performed in the office are considered the same as surgery to the insurance company, and are billed as surgery.

Diagnostic Procedure Consent ______ (Initial)

Your office visit today may include a scope being placed in your nose or throat. This is considered a diagnostic procedure, which will be coded to your insurance carrier as an INVASIVE OR SURGICAL PROCEDURE. Depending on the specifics of your particular policy, your insurance carrier will pay all, part, or none of the cost of this procedure. ***It is the responsibility of you, the insured, to be aware of the limits of coverage of your policy prior to this procedure.*** Any charges not covered by the insurance carrier will be the responsibility of the patient. By initialing this section you are acknowledging these terms. **YOU HAVE THE RIGHT TO REFUSE THE DIAGNOSTIC PROCEDURE.**

Guarantee of Payment for Services & Assignment of Benefits ______ (Initial)

It is the policy of the office that you must pay for services when rendered except in the cases of surgery in an operating room. If this applies to you, we will file your claim and you will be expected to pay only the portion that is not covered by your insurance. If you have any questions, please ask about this before leaving the office.

In the event that any of the above named companies or individuals fail to make prompt payment, I hereby give my personal guarantee of payment for all charges herein occurred. This includes all charges related to office visits, procedures performed, co-payments and deductibles. If this account is placed in collections, the undersigned agrees to pay the balance plus a $25 surcharge for collections.

I hereby authorize insurance benefits to be paid directly to the physician, and I am financially responsible for non-covered services. I also authorize the physician to release my medical information in the processing of this claim.

Insurance Coverage ______ (Initial)

I understand that my eligibility for coverage by ____________________________ (insurance carrier) has not been verified at the time of my appointment, but I want to receive medical services from Dr. Janning and/or Cindy Bjur, CCC-MA.

I am aware that when the insurance is finally verified, there is a disclaimer which states my insurance does not guarantee payment, even though I may be eligible for benefits at the time of service. If it is determined that I am not eligible for coverage or the medical services are not covered, I understand that I will be responsible for payment for all services provided.

Referral Waiver ______ (Initial)

I understand that if my insurance requires a referral for my visit, I am responsible for making sure that the referral is obtained from my primary care physician. I also understand that if the referral from the primary care physician's office is not received before/on the day of my appointment, I agree to pay for all services rendered on the day of the visit.

Some offices offer the use of Care Credit for qualifying persons.

____ ______________________________

Patient Signature (Guardian if patient is a minor) **Date**