Gregg S. Govett, M.D., P.C.
1205 S. Air Depot Blvd., PMB #131
Midwest City, OK 73110
405-732-3755
FAX 405-733-1784

# PATIENT INFORMATION SHEET

PATIENT'S NAME______________________________
(LAST) (FIRST) (MIDDLE INITIAL)

HOME ADDRESS______________________________
(STREET)

______________________________
(CITY) (STATE) (ZIP)

HOME PHONE______________ WORK PHONE______________

MARITAL STATUS: S M D W SSN______________

DATE OF BIRTH______________________________

NAME OF POLICYHOLDER______________________________

ADDRESS OF POLICYHOLDER______________________________

______________________________
(CITY) (STATE) (ZIP)

DATE OF BIRTH OF POLICYHOLDER______________________________

PLACE OF EMPLOYMENT______________________________

ADDRESS OF EMPLOYMENT______________________________

HEALTH INSURANCE PLAN______________________________

MAILING ADDRESS______________________________

POLICY NUMBER______________ SSN OF INSURED______________

WHO IS FINANCIALLY RESPONSIBLE FOR THIS BILL?__________

SECONDARY INSURANCE______________________________________

________________________________________________________
(NAME) (ADDRESS) (POLICY #)

POLICYHOLDER'S NAME/DOB________________________________

EMAIL ADDRESS______________________________________

IF THE PATIENT IS A MINOR: FATHER'S NAME______________

FATHER'S HOME PHONE____________WORK PHONE__________

FATHER'S PLACE OF EMPLOYMENT_____________________

MOTHER'S NAME______________________________________

MOTHER'S HOME PHONE____________WORK PHONE_________

MOTHER'S PLACE OF EMPLOYMENT_____________________

EMERGENCY CONTACT__________________PHONE__________

NAME OF NEAREST RELATIVE NOT LIVING AT YOUR ADDRESS:

________________________________________________________

PHONE________________ADDRESS________________________

NAME OF REFERRING PHYSICIAN________________________

"I HEREBY AUTHORIZED THE OFFICE OF GREGG S. GOVETT, M.D., P.C. TO RELEASE MY INFORMATION OF TREATMENT FOR INSURANCE PURPOSES."

SIGNED:___________________________________DATE__________
(PARENT, IF PATIENT IS A MINOR)

IF OUR OFFICE PARTICIPATES IN YOUR HEALTH PLAN, YOU WILL BE ASKED TO PAY YOUR PERCENTAGE OR COPAYMENT AMOUNT EACH TIME YOU ARE SEEN. THIS IS A CONTRACTUAL OBLIGATION. WE DO ACCEPT PERSONAL CHECKS, CASH, VISA, MASTERCARD, DISCOVER CARD, AND AMERICAN EXPRESS. THANK YOU.

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REA

# HEALTH INSURANCE CLAIM FORM

PICA

MEDICARE (Medicare #) | MEDICAID (Medicaid #) | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes, return to and complete item 9 a-d.*

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

2. 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.

SIGNED X DATE X

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

SIGNED X

. 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

. 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

. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 3.

2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

| A DATE(S) OF SERVICE From MM DD YY | To MM DD YY | B Place of Service | C Type of Service | D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER | E DIAGNOSIS CODE | F $ CHARGES | G DAYS OR UNITS | H EPSDT Family Plan | I EMG | J COB | K RESERVED FOR LOCAL USE |
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FEDERAL TAX I.D. NUMBER SSN EIN
73 160 9543 [X] EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

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 #

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE FORM HCFA-1500 (12-90)

Gregg S. Govett, M.D., P.C.
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The professional practice of Gregg S. Govett, M.D., P.C., is a specialty practice of Otolaryngology-Head & Neck Surgery and Otolaryngic Allergy. Gregg S. Govett, M.D. makes every effort to follow current standards of care and practice guidelines for the diagnosis and treatment of otolaryngologic disorders in patients that retain his services. These standards and guidelines are often set by the America Academy of Otolaryngology-Head & Neck Surgery and the American Academy of Otolaryngic Allergy; Dr. Govett is a fellow of both institutions. Otolaryngology care often requires advanced and/or invasive diagnostic testing for evaluation of disorders affecting the head and neck. Some examples of advanced testing and standards of care are:

1. Flexible laryngoscopy for voice/swallowing evaluations
2. Rigid nasal endoscopy for sinus/nasal evaluations
3. Flexible nasopharyngoscopy for ear/throat evaluations
4. Binocular microscopy for external/middle ear evaluations
5. Audiology testing for hearing evaluations
6. Tympanograms for ear infection evaluations
7. Stroboscopy for voice evaluations
8. Transnasal esophagoscopy for swallowing evaluations
9. Sinus debridements after sinus surgery

This is not a complete list but most of the diagnostic evaluations used in this office are present. These evaluations are in addition to the office consultation. Many health plans consider these procedures to be surgical procedures even though most are only diagnostic evaluations. Therefore, those health plans place initial payment for these procedures in the deductible/out-of-pocket category of the patient.

Gregg S. Govett, M.D., P.C. is requesting your consent to perform any diagnostic procedures Dr. Govett feels necessary to fully evaluate your otolaryngologic complaints. These additional evaluations will be used to conform to current standards of care and practice guidelines. Thank you.

______________________________________ Date______________________

I refuse to allow Gregg S. Govett, M.D. to perform any additional diagnostic procedures to fully evaluate my otolaryngologic complaints. I acknowledge that my refusal to allow additional testing prohibits Dr. Govett from complying with current standards of care and practice guidelines. Therefore, by signing below I also waive my right to pursue claims of medical negligence against Gregg S. Govett, M.D. as my refusal to allow additional diagnostic testing has compromised Dr. Govett's ability to fully evaluate my condition.

______________________________________ Date______________________

# NOTICE OF PRIVACY PRACTICES

To My Patients: This notice describes how health information about you as a patient of this practice may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPPA) that has nothing whatsoever to do with portability of health insurance.

## OUR COMMITMENT TO YOUR PRIVACY

This practice is dedicated to maintaining the privacy of your health information. I am required by law to maintain the confidentiality of your health information; this has not changed since I started practicing medicine. I realize that these laws are complicated, unnecessary, and do not trump state law, but I must provide you with the following information:

## USE AND DISCLOSURE OF YOUR HEALTH INFORMATION IN CERTAIN SPECIAL CIRCUMSTANCES

The following circumstances may require me to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information. Although this is a blatant violation of your Fourth Amendment right to privacy, you have allowed politicians and their lackeys who are not good enough doctors to actually practice medicine to peruse your medical record at will.
2. Lawsuits and similar proceedings in response to a court or administrative order. If you truly are concerned about your health information being used against you in court, it is best to consider this prior to actually filing a claim with your health plan. If you truly want to remain private, a better option is to pay cash for the visit(s) as this will avoid third party knowlege of your claim as diagnosis codes are placed with each visit on the claim form.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. I will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of US or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. For Workers Compensation and similar programs.

## YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

1. Communications. You can request that my practice communicate with you about your health and related issues in a particular manner or at a certain location within reason.
2. You can request a restriction in my use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that I restrict our disclosure of your health information to only certain individuals involved in your care. I am not required to honor your request; however, if we do agree, we are bound by our agreement except who otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to me at my business address. You will need to pay $.25 per page for copying costs and it must be emphasized that the actual chart will not be given to you for your review.
4. You may ask me to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for my practice. I will not alter the medical record, but will instead place an amendment in the record. You must provide me with a reason that supports your request for an amendment in writing to me at my business address.
5. Right to a copy of this notice. This will be placed in your chart at the time of your visit.
6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaints with me or the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing and you will not be penalized for filing a complaint. However, please be advised that if your complaint is frivilous, I will pursue you in a civil action in court to recover lost revenue from my medical practice with interest.
7. Right to provide an authorization for other uses and disclosures. My practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or my health information privacy policies, please contact your senator or congressman and question their intellect for voting for this ridiculous legislation.

I hereby acknowledge that I have been present with a copy of Gregg S. Govett, M.D., P.C.'s Notice of Privacy Practices.

Signature ______________________________

Date ______________________________

Name of Patient ______________________________
(please print)

# OFFICE POLICIES REGARDING PAYMENTS AND CLAIM FILING

We are committed to providing you with the best possible medical care. If you have health insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our office policy.

Payment for service is due at the time it is rendered. If we are contracted with your particular health plan, we will be filing your claims for you. However, you are required to pay any percentage or copayment amount each time you are seen due to contractual agreements. We do not send statements for these amounts. If it becomes necessary to send a statement, there will be a rebilling fee added to the payment.

We will gladly discuss your proposed treatment and answer any questions relating to the office charges or surgical fees. If we are contracted with your health plan, these fees are set by a contractual agreement and cannot be changed.

ATTENTION MEDICARE PATIENTS: We are currently accepting assignment on Medicare claims. We will file all chages for you incurred in our office. We DO NOT file supplemental insurance to Medicare UNLESS we are contracted with your Medi-Gap plan. If we do not contract with your Medi-Gap supplemental plan, you will be responsible for filing any balance on your account left by Medicare. You will be asked to pay your 20% of the allowable charge each time services are rendered. This amount is in addition to your deductible for the calendar year.

If we are not contracted with your health plan, we will provide you with an itemized statement each time you are seen to enable you to file the claim with your health plan for reimbursement. Your insurance is a contract between you and the health plan. We do consider accounts in a PAST DUE status after a fifteen day period has passed from the date the service is rendered.

Our payment policy for other family members bringing in a minor is as follows:
1. The person accompanying the minor is responsible for paying the account.
2. If a legal document is involved stating another individual is responsible for paying medical costs, that document is between those individuals involved and DOES NOT involve our office. The bill must be paid at the time of service.
3. The person accompanying the minor will be given an itemized statement from which reimbursement can be obtained.
4. Please be advised that Oklahoma law states any medical information requested from a non-custodial parent must be given upon demand.

DATE____________________ Signed____________________________________

I also give Gregg S. Govett, M.D, P.C. and its contracted agents permission to contact me using any phone, email, mail, or other methods for purposes of bill collection.

# WAIVER

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorized the release of any medical information necessary to process this claim. I also request payment of the government/third party/commercial payor benefits to Gregg S. Govett, M.D., P.C.

GREGG S. GOVETT, M.D., P.C. IS UNDER FEDERAL REGULATION AND HEALTH PLAN REGULATION TO INFORM YOU THAT AUDIOMETRIC TESTING RELATING TO HEARING LOSS AS WELL AS OTHER DIAGNOSTIC/THERAPEUTIC TREATMENTS RELATING TO OTHER MEDICAL CONDITIONS MAY NOT BE CONSIDERED A COVERED BENEFIT. THE OFFICE WILL OBTAIN ANY PRECERTIFICATIONS NECESSARY AND WILL FILE YOUR CLAIM FOR YOU; HOPEFULLY THIS WILL BE PAID. HOWEVER, IF ANY DIAGNOSTIC/THERAPEUTIC MEASURES ARE NOT CONSIDERED A COVERED BENEFIT BY YOUR THIRD PARTY PAYOR, GREGG S. GOVETT, M.D., P.C. MUST INFORM YOU THAT YOUR OR YOUR REPRESENTATIVE IS RESPONSIBLE FOR THE CHARGES. THANK YOU FOR YOUR COOPERATION IN THIS MATTER.

Further, I understand that I am entering into a contractual relationship with Gregg S. Govett, M.D., P.C., for professional care. I further understand that meritless and frivolous claims for medical malpractice have an adverse effect upon the cost and availability of medical care, and may result in irreparable harm to a medical provider. As additional consideration for professional care provided to me by Gregg S. Govett, M.D., I and/or my representative agree not to advance, directly or indirectly, any false, meritless, and/or frivolous claim(s) of medical malpractice against Gregg S. Govett, M.D.

Furthermore; should a meritorious medical malpractice case or cause of action be initiated or pursued, I and/or my representative agree to use ABMS board-certified expert medical witness(es) in the same or similar specialty as Gregg S. Govett, M.D. Furthermore, I agree that these expert witnesses will adhere(s) to the guidelines and/or code of conduct defined by the specialty society(ies) for expert witnesses in the area of medicine that would typically have the background and experience to opine on such a case. In futher consideration for this, Gregg S. Govett, M.D. agrees to the same stipulations.

Physician________________________________________

Patient or Patient's Representative___________________________