

## Patient Registration Form

### PATIENT INFORMATION *(please print)*

First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Last Name \_\_\_\_\_  
Home Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Billing Address (if different) \_\_\_\_\_  
Employer \_\_\_\_\_ Employer Phone \_\_\_\_\_  
Work Address \_\_\_\_\_  
Home Phone \_\_\_\_\_ E-mail Address \_\_\_\_\_  
Work Phone \_\_\_\_\_ FAX \_\_\_\_\_ Cell Phone \_\_\_\_\_ Pager \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Social Sec. # \_\_\_\_\_ Sex M  F   
Marital Status: S  M  D  W  Other \_\_\_\_\_ How did you hear about us? \_\_\_\_\_  
Primary Care Physician \_\_\_\_\_  
Guardian Last Name (if applicable) \_\_\_\_\_ First \_\_\_\_\_ Initial \_\_\_\_\_  
Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

### INSURANCE INFORMATION

Primary Insurance \_\_\_\_\_  
Policy Holder's Name \_\_\_\_\_ DOB \_\_\_\_\_ SS# \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Policy ID \_\_\_\_\_ Group # \_\_\_\_\_ Member # \_\_\_\_\_  
Co-pay Amount \_\_\_\_\_ Policy Effective Dates: From \_\_\_\_\_ To \_\_\_\_\_  
Patient Relation to Policy Holder: Self  Spouse  Child  Other \_\_\_\_\_  
Secondary Insurance \_\_\_\_\_  
Policy Holder's Name \_\_\_\_\_ DOB \_\_\_\_\_ SS# \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Policy ID \_\_\_\_\_ Group # \_\_\_\_\_ Member # \_\_\_\_\_  
Policy Effective Dates: From \_\_\_\_\_ To \_\_\_\_\_  
Patient Relation to Policy Holder: Self  Spouse  Child  Other \_\_\_\_\_

### BILLING INFORMATION

All professional services rendered are the responsibility of the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage. If it is necessary to turn this service over to collection for non-payment after 90 days, the patient will be responsible for the bill, the interest, and collection and attorney fees.

#### AUTHORIZATION TO PAY BENEFITS TO PROVIDER

By signing below, I hereby authorize payment directly to Dr. William A. Ingram, MD, PC for my charges.

#### AUTHORIZATION TO RELEASE INFORMATION

By signing below, I hereby authorize the practice of Dr. William A. Ingram, MD, PC to release any information acquired in the course of my examination or treatment to my insurance company in writing or by fax.

Signature (Patient or Parent/Guardian) \_\_\_\_\_ Date: \_\_\_\_\_

**Please list all of your prescription drugs, over the counter drugs, and supplements**

**Prescription Drugs:**

| <u>Drug</u> | <u>Dosage</u> | <u>Frequency</u> |
|-------------|---------------|------------------|
|             |               |                  |
|             |               |                  |
|             |               |                  |
|             |               |                  |
|             |               |                  |
|             |               |                  |
|             |               |                  |
|             |               |                  |
|             |               |                  |
|             |               |                  |

**Over the Counter Drugs and Supplements:**

| <u>Drug</u> | <u>Dosage</u> | <u>Frequency</u> |
|-------------|---------------|------------------|
|             |               |                  |
|             |               |                  |
|             |               |                  |
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|             |               |                  |
|             |               |                  |
|             |               |                  |
|             |               |                  |
|             |               |                  |

**Allergies to Medications:**

| <u>Drug</u> | <u>Type of Reaction</u> |
|-------------|-------------------------|
|             |                         |
|             |                         |
|             |                         |
|             |                         |

**Pharmacy** \_\_\_\_\_ **Phone #** \_\_\_\_\_

For insurance purposes, if Dr. Ingram or our Nurse Practitioner prescribe a nasal steroid or an antihistamine for you, we need to know which of the following you have tried:

- I have tried:    Flonase     Nasonex     Allegra     Zyrtec     Claritin

## Health History & Allergy Questionnaire

Please printout this form, complete it, and bring it with you to your first appointment.

Name \_\_\_\_\_ Male  Female

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Family Physician \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Referring Physician \_\_\_\_\_ Phone \_\_\_\_\_

### Personal Health History

Please check any of the medical concerns that other doctors have diagnosed you with in the past.

|  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> Allergies                   | <input type="checkbox"/> Anxiety               | <input type="checkbox"/> Arthritis              | <input type="checkbox"/> Asthma                  |
| <input type="checkbox"/> Blood Clots                 | <input type="checkbox"/> Bronchitis            | <input type="checkbox"/> Cancer                 | <input type="checkbox"/> COPD/Emphysema          |
| <input type="checkbox"/> Colon/Rectal Disorders      | <input type="checkbox"/> Depression            | <input type="checkbox"/> Diabetes               | <input type="checkbox"/> Easy Bleeding           |
| <input type="checkbox"/> Endocrine/Thyroid Disorders | <input type="checkbox"/> Epilepsy/Seizures     | <input type="checkbox"/> Fibromyalgia           | <input type="checkbox"/> Glaucoma                |
| <input type="checkbox"/> Headaches                   | <input type="checkbox"/> Heart Problems        | <input type="checkbox"/> Hepatitis              | <input type="checkbox"/> HIV/AIDS                |
| <input type="checkbox"/> High Blood Pressure         | <input type="checkbox"/> Kidney Disease        | <input type="checkbox"/> Liver Disease          | <input type="checkbox"/> Measles                 |
| <input type="checkbox"/> MONO/EBV/CMV                | <input type="checkbox"/> Myocardial Infarction | <input type="checkbox"/> Neurological Disorders | <input type="checkbox"/> Obstructive Sleep Apnea |
| <input type="checkbox"/> Osteoporosis                | <input type="checkbox"/> Other                 | <input type="checkbox"/> Pneumonia              | <input type="checkbox"/> Rheumatic Fever         |
| <input type="checkbox"/> Skin Disorder               | <input type="checkbox"/> Stomach Ulcer         | <input type="checkbox"/> STD                    | <input type="checkbox"/> Whooping Cough          |

Surgeries \_\_\_\_\_

\_\_\_\_\_

Hospitalizations \_\_\_\_\_

\_\_\_\_\_

Serious Accidents \_\_\_\_\_

\_\_\_\_\_

History of Family Illnesses/Allergies \_\_\_\_\_

\_\_\_\_\_

Are you pregnant? Yes  No

Do you smoke? Yes  No  How much? \_\_\_\_\_ How long? \_\_\_\_\_

Quit  When? \_\_\_\_\_ Do you drink alcohol? Yes  No  How much? \_\_\_\_\_

Are you employed? Yes  No  What is your job? \_\_\_\_\_

Describe your work environment \_\_\_\_\_

\_\_\_\_\_

## Review of Systems

Please check the problems that you are having:

### **EARS:**

- Pain
- Hearing loss
- Fullness
- Drainage
- Ringing
- Dizziness
- Noise exposure

### **NOSE:**

- Pain
- Obstruction
- Congestion
- Drainage
- Nosebleeds
- Snoring
- Polyps
- Changes in smell

### **THROAT:**

- Pain
- Swelling
- Drainage
- Tonsillitis
- Swallowing

### **NECK:**

- Pain
- Hoarseness
- Thyroid problems

### **ALLERGIES:**

- Hives
- Hay fever

### **EYES:**

- Pain
- Itching
- Double vision
- Blurred vision
- Glaucoma
- Cataracts

### **SKIN:**

- Rashes
- Psoriasis
- Itching
- Jaundice

### **LUNGS:**

- Cough
- Bloody cough
- Bronchitis
- Asthma
- Emphysema

### **CARDIAC:**

- Chest pain
- Fluttering
- Extra beats
- Prolapsed valve
- Swelling

### **GI:**

- Heartburn
- Ulcers
- Cramping
- Diarrhea
- Constipation

### **GU:**

- Burning
- Frequency
- Bleeding
- Kidney infections

### **CONSTITUTIONAL:**

- Weight gain
- Weight loss
- Fevers
- Fatigue

### **MUSCLE/BONES:**

- Neck pain
- Back pain
- Joint pain
- Weakness

### **NEURO:**

- Seizures
- Numbness
- Paralysis
- Tingling

### **HEAD:**

- Headaches
- Migraine
- Cluster

### **PSYCH:**

- Depressed
- Anxious
- Irritable

**ALLERGY SCREENING**

**POLLEN SYMPTOMS:**

- Worse outdoors
- Worse on windy days
- Worse on clear days
- Worse outdoors 7 – 11 am
- Worse in warm air
- Worse in cool air
- Better indoors
- Better outdoors

**DUST SYMPTOMS:**

- Worse indoors
- Better outdoors
- Worse 30 minutes after retiring
- Worse in cold weather
- Worse when sweeping
- Worse when dusting

**MOLD SYMPTOMS:**

- Worse outdoors from 4-9 pm
- Worse on cool evenings
- Worse in low, damp areas/buildings
- Worse mowing or playing in grass
- Worse on windy days

**CONTACT SYMPTOMS:**

- Worse after lights are on 1 hour
- Worse in certain rooms

Which one(s) \_\_\_\_\_

- Worse in basement
- Worse near a barn
- Worse around animals

Which one(s) \_\_\_\_\_

Season(s) of symptoms? \_\_\_\_\_

Worst Season (which months?) \_\_\_\_\_

\_\_\_\_\_

**William A. Ingram, MD, PC  
18015 Oak Street, Suite B  
Omaha, NE 68130  
402-991-1975**

To the Patients of Dr. William A. Ingram:

My primary concern as your physician is to provide you with the best possible care. Your insurance may not pay for services. I am notifying you in advance that some services may NOT be a covered benefit. **It is your responsibility to check with your insurance carrier to determine whether or not services are covered.**

We require that you read the following agreement and sign it.

I, \_\_\_\_\_, knowing that I have a condition(s) requiring diagnosis and medical treatment, do hereby voluntarily consent to such diagnostic examination procedures and to such medical treatment by Dr. William A. Ingram, his Nurse Practitioner, his assistants, or his designees as necessary in his judgement.

I have been informed by William A. Ingram, MD, FAAOA that he believes in my case, that insurance may deny payment for some or all services. Please note that certain services are NOT covered by insurance. These may include certain forms of immunotherapy and IM or IV injections. These things will NOT be submitted for reimbursement to your insurance company.

I understand that I am financially responsible for all charges that are not covered by my insurance. If my insurance denies payment, I agree to be personally and fully responsible for payment.

Beneficiary's Name (Print) \_\_\_\_\_ Date \_\_\_\_\_

Beneficiary's Signature \_\_\_\_\_ Date \_\_\_\_\_

OR

Authorized Representative's Signature \_\_\_\_\_

William A. Ingram, MD, PC  
18015 Oak Street, Suite B  
Omaha, NE 68130  
Telephone: 402-991-1975  
Fax: 402-991-1974

**Permission/Revocation of Access to Personal Health Information (PHI) by someone other than patient:**

Patient Name: \_\_\_\_\_

Patient Date of Birth: \_\_\_\_\_

I, \_\_\_\_\_ hereby  
(Patient/Patient Representative)

Check one:

Permit

Revoke

The following person(s) access to protected health information from William A. Ingram, MD, PC

Family (Specify) \_\_\_\_\_

Attorney (Specify) \_\_\_\_\_

Employer (Specify) \_\_\_\_\_

Other (Specify) \_\_\_\_\_

I acknowledge that I have been given the opportunity to review or receive a copy of the Notice of Privacy Practices Regarding HIPPA/PHI.

\_\_\_\_\_ Date \_\_\_\_\_

Signature of Patient/Patient's Representative

\_\_\_\_\_ Relationship \_\_\_\_\_

Printed Name of Patient/Patient's representative



**FOR WILLIAM A. INGRAM, MD, PC USE:**

Received by: \_\_\_\_\_ (Employee's Initials)

## William A. Ingram, MD, PC Financial Policy

**Insurance:** The Practice will file claims with both your primary and secondary insurance companies. It is the responsibility of you, the patient, to familiarize yourself with the coverage, benefits and eligibility provided to you through your individual insurance plan. Your insurance carrier makes the final determination regarding eligibility and coverage. You agree to pay any portion not covered by your insurance. Insurance changes must be brought to our attention immediately as you, the patient, will be responsible for all charges not paid as a result of any change in insurance coverage. If the insurance company does not pay within 45 days following the submission of your claim, you are responsible for the remaining balance.

**Co-Payments:** If your coverage requires a patient co-pay, we are obligated by your insurance carrier to collect your co-pay at the time of service. Failure to collect co-pays puts both the patient and William A. Ingram MD, PC in default of the insurance contract. Please be prepared to pay the co-pay at each visit. Without it, you may be asked to reschedule.

**Deductibles:** If your coverage includes a patient deductible, you will be asked for payment in full at the time of service. Patients with high unmet deductible plans will be asked to remit a **minimum** deposit of \$150 at the time of your visit. (We will collect your credit card information when you check in.) Any remaining balance will be billed to your credit card upon receipt of your insurance carrier's Explanation of Benefits (EOB). Should the **remaining balance** exceed \$300, we will contact you to discuss payment arrangements.

**Self-Pay Patients:** If you do not have insurance, you will be asked to pay for services at the time of your visit. For many services, you will receive a 20% discount for payment in full on the day of your visit.

**Medicare:** William A. Ingram, MD, PC accepts Medicare assignment. By accepting assignment, Dr. Ingram agrees to accept Medicare's approved amount as payment for covered services. You, the patient, are responsible for any remaining balances. We will file a claim with your secondary insurance plan for you.

**Medicare ABN Form:** If you receive a service that may not be considered medically necessary by Medicare, you will be advised by the clinic staff and asked to sign an Advanced Beneficiary Notice (ABN). Medicare's determination that a service is not medically necessary does not mean that the service should not be provided to you. Dr. Ingram will recommend services based on your current health condition and his expert medical opinion. The ABN Form is your advance notification that the service(s) may not be covered, and you may be financially responsible. Testing or treatment will not proceed without your informed consent.

**Medicaid:** Clinic staff will verify Medicaid eligibility **at each visit**. Please have your current Medicaid card available. If a co-pay is required, your co-pay is due at the time of service.

**Referrals:** If you have an insurance plan that requires a referral from your primary care physician prior to a visit to a specialist, it is YOUR responsibility to obtain the referral. If you choose to seek the services of William A. Ingram, MD without the referral, YOU will be responsible for the payment of the charges, should your insurance company not approve the charges.

**Patient Statements:** You will be mailed your patient statement if a balance is due on your account. Payment is due upon receipt of your statement. Please contact our Billing Department at 1(888) 611-0851 for questions or concerns regarding your statement.



**Payment Arrangements:** If you are unable to pay for your patient statement balance in full, contact our Billing Department at 1(888) 611-0851 to discuss payment options. Payment plans may be available to payoff balances within 90 days.

**Outstanding Balances:** If you have any outstanding self-pay or insurance designated outstanding balances for co-pays, deductibles and other unpaid out-of-pocket expenses, you will be asked to remit payment at your next visit or you may be required to reschedule your appointment. Chronic non-payment of bills can constitute separation from the practice.

**Collections:** Unpaid balances will be forwarded to our collection agency. Once an account has been referred to a collection agency, you must work directly with them to satisfy your debt. If you return to our office for services, you will be required to pay in full **prior** to receiving any future services.

**Payment Methods:** We accept cash, checks and most major credit cards. There will be a fee for returned checks.

All fees for the professional services rendered are the responsibility of the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage.

If it is necessary to turn the fee(s) for services rendered over to collection for non-payment after 60 days, then the patient is responsible for the bill, interest, collection and attorney fees.

I have read the Financial Policies of William A. Ingram MD, PC and agree to comply with the Financial Policies. In addition, William A. Ingram MD, PC has my permission to provide medical documentation in order to obtain reimbursement.

Printed Patient Name: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
{Patient or Parent of Minor}



**RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I have received a copy of William A. Ingram, MD, PC's Notice of Privacy Practices which are effective September 23, 2013.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Signature

**Note: If signed by someone other than the patient, we need written proof of your authority.**

|  |
|--|
| <b>For Office Use Only: A signature was not obtained because:</b><br>_____<br>_____<br>_____ |
|--|