# 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:**

| Drug | Dosage | Frequency |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**Over the Counter Drugs and Supplements:**

| Drug | Dosage | Frequency |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**Allergies to Medications:**

| Drug | Type of Reaction |
|---|---|
| | |
| | |
| | |
| | |
| | |

**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.**

| | | | |
|---|---|---|---|
| ☐ Allergies | ☐ Anxiety | ☐ Arthritis | ☐ Asthma |
| ☐ Blood Clots | ☐ Bronchitis | ☐ Cancer | ☐ COPD/Emphysema |
| ☐ Colon/Rectal Disorders | ☐ Depression | ☐ Diabetes | ☐ Easy Bleeding |
| ☐ Endocrine/Thyroid Disorders | ☐ Epilepsy/Seizures | ☐ Fibromyalgia | ☐ Glaucoma |
| ☐ Headaches | ☐ Heart Problems | ☐ Hepatitis | ☐ HIV/AIDS |
| ☐ High Blood Pressure | ☐ Kidney Disease | ☐ Liver Disease | ☐ Measles |
| ☐ MONO/EBV/CMV | ☐ Myocardial Infarction | ☐ Neurological Disorders | ☐ Obstructive Sleep Apnea |
| ☐ Osteoporosis | ☐ Other | ☐ Pneumonia | ☐ Rheumatic Fever |
| ☐ Skin Disorder | ☐ Stomach Ulcer | ☐ STD | ☐ 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:** It is the patient's responsibility to ensure that their Medicaid coverage is current and that our Practice is specifically accepted by their individual plan. Please bring your current Medicaid card with you to each visit or "proof of coverage." 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.

**No-Shows and Late Arrival Fee(s):** Our office charges for No Show/Missed Appointments, including late appointment check in. We understand that emergencies happen and we allow one (1) waiver (free pass) per patient, per year. Please observe the following:

- If you can't make your scheduled appointment, you must contact our office 24 business hours in advance to cancel/reschedule your visit.
- If you fail to cancel/show up for your appointment, you will be reminded of our no-show policy.
- If you fail to cancel/show-up a second (2nd) time, you will be charged a **$50 fee**.
    - Note: This fee is the responsibility of you, the patient, and we will not bill your insurance for this fee.
- Should you wish to schedule a third (3rd) appointment, you will be asked to make a payment **in full** that is non-refundable prior to your visit.
- If you are chronically late or miss more than three appointments, our office has the right to dismiss you from the practice. All fees must be paid before your next appointment is scheduled.

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.**

**For Office Use Only: A signature was not obtained because:**

_____

_____

_____