James R. Carlson, M.D., M.B.A.
Thomas S. Kang, M.D.
Jonathan Lara, D.O.

Elizabeth A. Finch, Au.D., CCC-A
Amy M. Wheeler, Au.D., CCC-A
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Stephanie C. Carlson, R.N., CNOR

3172 N. Swan Rd.
Tucson, AZ 85712
(520) 795-8777
(520) 795-8787 Fax

1521 E. Tangerine Rd., Suite 225
Oro Valley, AZ 85755
(520) 797-8789
(520) 797-8787 Fax

PATIENT INFORMATION

NAME: LAST______________________________ FIRST____________________________ M.I._____

DATE OF BIRTH_________________ S.S.#_________________ MAIDEN NAME__________________

ADDRESS____

CITY____________________________________ STATE________________ ZIP CODE____________

HOME PHONE______________________________ CELL PHONE_____________________________

EMPLOYER________________________________ WORK PHONE_____________________________

PRIMARY CARE PHYSICIAN___________________REFERRED BY____________________________

Occupation:________________________________ E-MAIL ADDRESS__________________________

SECONDARY ADDRESS

____

PRIMARY INSURANCE HOLDER

NAME____ DATE OF BIRTH__________________

RELATIONSHIP TO PATIENT___________________________S.S.#_____________________________

ADDRESS____

CITY________________________ STATE______ ZIP CODE____________ Phone_________________

EMPLOYER______________________________ ADDRESS____________________________________

PRIMARY INSURANCE INFORMATION

INSURANCE COMPANY NAME____

SUBSCRIBER ID NUMBER____

GROUP NUMBER__________________ SUBSCRIBER'S NAME_________________________________

SECONDARY INSURANCE HOLDER

NAME____ DATE OF BIRTH__________________

RELATIONSHIP TO PATIENT___________________________S.S.#_____________________________

ADDRESS____

CITY____________________________________ STATE_________________ ZIP CODE____________

EMPLOYER______________________________ ADDRESS____________________________________

SECONDARY INSURANCE INFORMATION

INSURANCE COMPANY NAME____

SUBSCRIBER ID NUMBER____

GROUP NUMBER__________________ SUBSCRIBER'S NAME_________________________________

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EMERGENCY CONTACT

NAME OF LOCAL FRIEND OR RELATIVE____

ADDRESS____

CITY________________________________ STATE_________________ ZIP CODE___________

HOME PHONE___________________________ WORK PHONE___________________________

CONSENT FOR TREATMENT OF A MINOR

I HEREBY AUTHORIZE JAMES R. CARLSON, MD, THOMAS S. KANG, MD AND/OR JONATHAN LARA, DO TO TREAT (PATIENT'S NAME) ____

RELATIONSHIP TO PATIENT_____________ SIGNATURE______________________ DATE______

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I ____, acknowledge that I have received a copy of Carlson Ear Nose and Throat Associates' Notice of Privacy Practices. This notice describes how Dr. James Carlson, Dr. Jared Spencer, Dr. Thomas Kang, and/or Dr. Jonathan Lara, may use and disclose my protected health information, certain restrictions on
(Relationship to Patient)the use and disclosure of my healthcare information, and rights I may have regarding health information.

____ ________________________
Signature of Patient (or Personal Representative) Date

____

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By signing below, I give my consent for Carlson Ear Nose and Throat Associates to disclose my record for treatment, payment and healthcare operations. I understand that I may revoke this consent in writing at any time, except to the extent that this office has already taken action in reliance thereon. Additionally, this form allows me to identify restrictions on the disclosure of my records. These restrictions will affect the way health information can be used or disclosed to carry out treatment, payment, or healthcare operations. I understand that if Dr. Carlson, Dr. Kang and/or Dr. Lara do not agree with the specified restrictions and feels that appropriate care cannot be given with the specified restrictions, Dr. Carlson, Dr. Lara and/or Dr. Kang has the right to refuse treatment.

As part of my healthcare, I understand that oral communication is important and that if I do not specify individuals to whom my information may be released to, Carlson Ear Nose and Throat Associates will not disclose this information under any circumstance without a written authorization.

In my absence, Carlson Ear Nose and Throat Associates may discuss my medical condition with the following individuals:

______________________________ Name/Relationship to Patient

______________________________ Name/Relationship to Patient

______________________________ Name/Relationship to Patient

______________________________ Name/Relationship to Patient

☐ I agree that Carlson Ear Nose and Throat Associates may leave detailed messages regarding my medical condition at the following phone number(s)

____

☐ I do not wish to have messages left with individuals or answering machines.

☐ Additional restrictions for the use or disclosure of my health information:

____

____

☐ No restrictions are in place at the time of signing this consent.

______________________________ Patient's Printed Name

______________________________ Patient's Signature

______________________________ Date

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OUR CREDIT POLICY

Carlson Ear Nose and Throat Associates will charge a late payment on any part of the "Balance Forward" as shown on the monthly statements which remain unpaid 30 days or more after the first billing date. The ANNUAL PERCENTAGE RATE is approximately 10% per annum. You will be responsible for any collection fees incurred by Carlson Ear Nose & Throat Associates.

All payments shall be first applied to any late payment charge assessed on the account and then to the oldest charges unpaid, then to any current charges.

You are responsible for payment of your account balance regardless of your insurance coverage. We cannot accept responsibility for negotiating settlement with your insurance on a disputed claim. Notwithstanding insurance benefits that may have accrued, the late payment charges set out above shall be assessed against all accounts, even if the account will ultimately be paid wholly or partly by insurance benefits. **W**E DO NOT CURRENTLY ACCEPT **W**ORKERS COMPENSATION, **T**HIRD PARTY BILLING, OR **S**TATE FUNDED MEDICAL PLANS SUCH AS **AHCCCS, M**ERCY CARE, ETC.

FINANCIAL AGREEMENT AND VERIFICATION

The undersigned areas, whether he/she signs this form as a patient or an agent of the patient, that in consideration of the services to be rendered by Carlson Ear Nose and Throat Associates, he/she obligates himself/herself to pay the account in full within 30 days of the billing date, and with the regular rates and terms, which are subject to change without notice. In the event this account is referred for collection, the patient or patient's agent shall pay reasonable attorney's fees and collection expenses. We have the option to report your account status to any credit reporting agency such as a credit bureau. I have read and understand the information on this form and approve the annual percentage rate, the method of computing the late charges, and all other terms. I certify the information given is correct to the best of my knowledge.

Patient/Agent Signature: ____Date:__________________

INSURANCE RELEASE

I authorize Carlson Ear Nose and Throat Associates to release any medical information or other information to my insurance company in the course of my examination or treatment. I also request payment of government benefits to either myself or the party accepting assignment.

Patient/Agent Signature: ____Date:__________________

INSURANCE AGREEMENT

I authorize Carlson Ear Nose and Throat Associates to file insurance claims on my behalf for the services rendered and accept payments from my insurance carrier(s). I realize I am responsible for the full charges incurred on my account regardless of insurance coverage.

Patient/Agent Signature: ____Date:__________________