JANNING CENTER
EAR NOSE & THROAT

Welcome to our practice!

Thank you for choosing our office for your health care needs.

You may visit our website www.janningentcenter.com for additional information and directions to our Willmar office.

If you have any questions regarding your upcoming appointment, or any information included in this packet, please call our office at **(320) 231-3277**.

We look forward to serving your medical needs!

APPOINTMENT DETAILS

_____

Has an appointment in:

☐ **Willmar –** Janning ENT Center / 1801 19th Avenue SW

☐ **Glenwood** – Glenwood Medical Center / 10 4th Avenue SE *(ER entrance)*

☐ Mon. ☐ Tues. ☐ Wed. ☐ Thurs. ☐ Fri.

Date: _____ at_____

You are scheduled to see:

☐ Martin Janning, MD ☐ Jonathan Mellema, MD

☐ Kara De Groot, NP-C ☐ Beth Stevermer, PA-C

☐ *IF CHECKED, PLEASE SCHEDULE AUDIOGRAM PRIOR TO VISIT*

➡ **Arrive 20 minutes early to check-in/register** ⬅

Please call at least 24 hours in advance if unable to keep appointment. If appt is not confirmed you will be rescheduled.

Your appointment will be rescheduled if you are 10 minutes late.

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Willmar Office: (320) 231-3277
1801 19th Ave SW, Willmar, MN 56201
Fax: 320-214-5758 www.janningentcenter.com

Dear Patient:

Thank you for your interest in Janning ENT Center. We have compiled this registration packet to aid in expediting your check-in process. Please take a few minutes to complete the enclosed packet and bring it to your scheduled appointment, or if you prefer you may mail it back to our office at 1801 19th Avenue SW, Willmar, MN 56201. Please bring the following information with to your appointment:

1. This **COMPLETED** registration packet:
   a. It is very important that all sections be completed so we can properly file your insurance claims. ***Failure to provide this information may pre-empt us from filing your claim.***
   b. The guarantor is the person who is financially responsible for any balance that may remain on the account.
   c. The patient's ***current*** insurance card(s) and policyholder information (including Photo ID).

Please review the following information:

- ✓ **REFERRALS:** If your insurance policy requires a referral from a primary physician, it is the patient's responsibility to request this. Some insurance plans will not pay for services if a referral is not granted by your primary physician. If you are unsure whether your policy requires a referral, always contact the member services number on your insurance card. They can confirm if you need a referral or not. Failure to get a referral when needed will result in the patient being financially responsible for all charges not covered by insurance.

- ✓ **WORKER'S COMPENSATION CLAIMS:** Please bring a form from your employer stating the worker's compensation carrier, claim information, date of injury, and state of injury so that we may submit your claim appropriately.

- ✓ **AUTO ACCIDENT CLAIMS:** Please bring with you the claim number from your insurance carrier and address for claims to be submitted.

- ✓ Insurance co-pay (if applicable)—this will be labeled on the front or back of your card. Please note that Dr. Janning is a ***specialist.*** As such, the specialist co-pay will apply if your policy has multiple co-pay tiers listed.

- ✓ **SELF PAY: PAYMENT IN FULL IS REQUIRED AT TIME OF SERVICE.** Payments may be made to *"Janning ENT Center, LLC."* We accept cash, check, credit cards (Visa, Mastercard, Discover, American Express) and Care Credit.

REGISTRATION

PLEASE PRINT

PATIENT INFORMATION

LEGAL PATIENT NAME (LAST, FIRST, MIDDLE)				**ALIAS** (NICKNAME/MAIDEN NAME)	**SOCIAL SECURITY NUMBER**
DATE OF BIRTH	**AGE**	**GENDER** M ☐ F ☐	**LANGUAGE** (English, Spanish, Somali, Chinese, Hmong, French, German, Vietnamese, other (please specify))		**RACE** (Caucasian, Asian, African American, Native American, Hispanic, other (please specify))
MAILING ADDRESS			**CITY, STATE & ZIP CODE**		**MARTIAL STATUS** (Single, Married, Divorced, Widowed, etc.)
PRIMARY TELEPHONE NUMBER (HOME, CELL, WORK, OTHER)			**SECONDARY TELEPHONE NUMBER** (HOME, CELL, WORK, OTHER)		
EMAIL ADDRESS		**PRIMARY PHYSICIAN** (NAME/CLINIC)		**REFERRING PHYSICIAN** (NAME/CLINIC)	
EMPLOYER		**EMPLOYER ADDRESS**		**CITY, STATE & ZIP CODE**	
EMPLOYER TELEPHONE _____-_____-_____ **EXT:** _____		**OCCUPATION**			

RESPONSIBLE PARTY

RELATIONSHIP TO PATIENT	**GUARANTOR NAME**	**SOCIAL SECURITY NUMBER**	**DATE OF BIRTH**	**AGE**	**GENDER**
ADDRESS		**CITY, STATE**		**ZIP CODE**	
PRIMARY PHONE NUMBER (HOME, CELL, WORK, OTHER)		**SECONDARY PHONE NUMBER** (HOME, CELL, WORK, OTHER)		**EMPLOYER**	
EMPLOYER TELEPHONE NUMBER		**OCCUPATION**			

PRIMARY INSURANCE?	☐ **YES** ☐ **NO**	**Policy Name:**
SECONDARY INSURANCE?	☐ **YES** ☐ **NO**	**Policy Name:**

EMERGENCY CONTACT 1		**EMERGENCY CONTACT 2**	
NAME	**RELATIONSHIP TO PATIENT**	**NAME**	**RELATIONSHIP TO PATIENT**
PRIMARY PHONE NUMBER	**SECONDARY PHONE NUMBER**	**PRIMARY PHONE NUMBER**	**SECONDARY PHONE NUMBER**

I hereby grant authorization to **Janning ENT Center, LLC** 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 facility 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 facility for charges not covered by this authorization.**

SIGNATURE	**PRINTED NAME (PATIENT/LEGAL GUARDIAN)**	**DATE**

Thank you for your patronage!!

Consent for Purposes of Treatment, Payment, and Healthcare 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 dependent), obtain payment from me for healthcare 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 authorization 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: Heidi Graves

(Compliance Office)

1801 19th Avenue SW

Willmar, MN 56201-4946

Telephone: (320) 231-3277

Fax: (320) 214-5758

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PATIENT NAME: _____

FINANCIAL RESPONSIBILITY

Co-payments _____ (Initial**)**
All insurances that require a co-payment for your visit are due at the time of service. In some cases, multiple co-payment's may be required for your appointment. **If you chose to have this billed to you, a $5 service charge will be added**. Exceptions may include post operative visits for a determined period of time for some surgical procedures. However, 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 may be considered the same as surgery to the insurance company.

Diagnostic Procedure Consent _____ (Initial**)**
Your office visit may include a scope being placed into your nose or throat. This is considered a diagnostic procedure, which may 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.**

Insurance Coverage _____ (Initial**)**
I understand that my eligibility for coverage by _____ (insurance carrier) may not be verified at the time of my appointment, and I choose to receive medical services from Dr. Janning, Dr. Mellema, Kara De Groot, NP-C or Kasey Meyers, NP-C. I am aware that when the insurance is verified, there is a disclaimer that 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. I understand that I am responsible to provide all insurance coverage primary and secondary at the time of my visit.

Guarantee of Payment for Services & Assignment of Benefits _____ (Initial**)**
It is our office policy that you must pay for services 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. 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.

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. I understand that I am financially responsible for all charges whether or not paid by insurance. If collection is required, I understand and agree that I will be liable for all costs of collection, including but not limited to attorney's fees and court costs. I hereby authorize said assignee to release all information necessary to secure payment

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.

_____ _____

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

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PATIENT NAME: _____

24 HOUR/NO SHOW NOTICE FEE

We schedule our appointments so that each patient receives the right amount of time to be seen by our physicians and staff. That's why it is very important that you keep your scheduled appointment with us and arrive on time.

As a courtesy, and to help patients remember their scheduled appointments, Janning ENT Center sends text messages in advance of the appointment time.

If your schedule changes and you cannot keep your appointment, please contact us so we may reschedule you, and accommodate those patients who are waiting for an appointment. As a courtesy to our office as well as to those patients who are waiting to schedule with the physician, please give us at least 24 hours' notice.

If you do not cancel or reschedule your appointment with at least 24 hours' notice, you may be assessed a $25 "no-show" service charge to your account. This "no-show charge" is not reimbursable by your insurance company. You will be billed directly for it.

After two consecutive no-shows to your appointment, our practice may decide to terminate its relationship with you.

I understand the "no-show" policy of Janning ENT Center and agree to provide a credit card number, which will be charged $25 for any no-show of a scheduled appointment. I understand that I must cancel or reschedule any appointment at least 24 hours in advance to avoid a potential no-show charge to the credit card provided.

_____ _____

Patient or Guardian Signature Date