Patient Registration Form

PATIENT INFORMATION *(please print)*

First Name_____ Middle Initial _____ Last Name_____

Home Address _____

Zip Code _____ City _____ State _____

Billing Address (if different) _____

Work Address (if different) _____

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 _____

Employer _____ Employer Phone _____

Guardian Last Name (if applicable)_____ First _____ Initial _____

Emergency contact _____ Relationship_____ Phone _____

INSURANCE INFORMATION

Primary Insurance_____

Policy Holder Name _____ DOB _____ SS# _____

Address _____ City, State, Zip _____

Policy I.D. _____ Group # _____ Member # _____

Co-pay Amount _____ Policy Effective Dates: From: _____ To: _____

Patient Relation to Policy Holder: ❑ Self ❑ Spouse ❑ Child ❑ _____

Secondary Insurance _____

Policy Holder Name _____ DOB _____ SS# _____

Address _____ City, State, Zip _____

Policy I.D. _____ Group # _____ Member # _____

Policy Effective Dates: From: _____ To: _____

Patient Relation to Policy Holder: ❑ Self ❑ Spouse ❑ Child ❑ _____

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, then the patient is responsible for the bill, the interest, and collection and attorney fees.

AUTHORIZATION TO PAY BENEFITS TO PROVIDER:
I hereby authorize payment directly to the undersigned Provider for my charges.

AUTHORIZATION TO RELEASE INFORMATION:
I hereby authorize the undersigned Provider 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 of Minor): _____ Date: _____

FORM PTINFO-CTR

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Please list all of your prescription drugs and over the counter drugs.

Prescription Drugs *

Drug	Dosage	Frequency

Over the counter Drugs & Supplements *

Drug	Dosage	Frequency

Pharmacy Name & Phone Number _____

For insurance purposes, if Dr Ingram prescribes a nasal steroid or an antihistamine for you we need to know if you have tried the following.

Have you tried? Flonase _____ Nasonex _____ Allegra _____ Zyrtec _____ Claritin _____

Health History & Allergy Questionnaire

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

Name _____ ____ Male _____ Female _____

Address _____ City _____ State _____ Zip _____

Family Physician _____

Address _____ City _____ State _____ Zip _____

Referring Physician _____

Allergies to medicines _____

Medical Problems _____

_____

Surgeries _____

_____

Hospitalizations _____

_____

Serious Accidents _____

Current Medications _____

_____

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.

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 assistants, or his designees as necessary in his judgment.

I have been informed by William A. Ingram, MD, FAAOA that he believes in my case, the insurance may deny payment for some or all services. Some of these services include sublingual immunotherapy, B12 Injections, Myers Cocktail, IV Glutathione and IV Vitamin C. 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 _____

Witness: _____ Date: _____

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

_____ hereby
(Patient / Patient Representative)

Check one:

☐ Permits ☐ Revokes

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

Patient Name: _____

Patient Date of Birth: _____

☐ 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 HIPAA/PHI.

_____
Signature of Patient / Patient's representative

_____ _____
Printed Name of Patient / Patient's representative and relationship Date

---

FOR WILLIAM A. INGRAM MD, PC USE:
Received by: _____ *(Employee Initials)*
MR #: _____ *DATE:* _____

Payment Policy
William A. Ingram, MD, PC

Insurance:
Clinic staff will submit insurance claims according to the terms of the individual insurance company contracts.

All deductibles, co-pays, co-insurance, and payment for services rendered that are not covered by insurance are due at the time of service. We are required by our insurance contract to collect your co-pay.

Patient understands that he/she is financially responsible for all services. If insurance denies payment, patient agrees to be personally and fully responsible for payment.

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 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. Your co-pay is due at the time of service. If your co-pay is not paid at the time of service, your visit may be rescheduled.

Additional Health Insurance:
Clinic staff will file secondary insurance claims as a courtesy to you. If the insurance company does not pay within 45 days following the submission of your secondary claim, you are responsible for the remaining balance.

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, FAAOA without the referral, you will be responsible for the payment of the charges.

Self-Pay or No Insurance:
If you do not have insurance, you will be asked to pay for services at the time of your visit. You will receive a 10% discount for payment in full on the day of your visit.

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 1-888-516-4963 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 1-888-516-4963 to discuss payment options.

Unpaid Accounts:
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.

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

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f it is necessary to turn this service over to collection for non-payment after 90 days, then the patient is responsible for the bill, the interest, and collection and attorney fees.

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: A Signature was not obtained because:

_____

_____

_____