WELCOME TO OUR PRACTICE

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Sumter, SC 29150
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David B. Lovice, MD
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Board Certified Otolaryngology – Head and Neck Surgery
Board Certified Facial Plastic and Reconstructive Surgery

We practice the art of medicine as a service to our patients. To that end, our mission is to provide comprehensive, contemporary care, continually striving to exceed the accepted medical standards. We are determined to do this in a pleasant environment with the utmost compassion, consideration and understanding for our patient's needs. We are specialists who treat disorders of the ears, nose, throat, and related structures of the head and neck and are most commonly called ENT's. We are trained in both medicine and surgery and can offer the most appropriate care for these disorders.

In addition to our physician services, we offer AUDIOLOGY services which include, hearing tests, hearing aids, balance testing and earplugs (for swimming and/or bathing). If you are interested in any of these services our staff members will be glad to provide you with information.

We also understand that paperwork and medical bills can be confusing, so we have compiled the following to help you understand our policies prior to receiving care. You should carefully read our appointment and insurance policies. If there is anything you do not understand, please feel free to have your questions answered by our staff.

There are several pages attached which must be completed by you and placed in your medical record. Please read these carefully and sign where necessary then bring them with you to your appointment. You will also need to bring your insurance card, a photo ID and any copay or referral form if required by your insurance company.

PREPARING FOR YOUR VISIT

Your time is valuable. Help us make your visit as efficient and beneficial as possible by preparing for your visit.

- Arrive early
- Make a list of your problems
- Bring a list of your medications, including dosages, reason for medication and prescribing doctor
- Bring your insurance card and a photo ID
- Be aware of your insurance coverage and co-payments for all services
- Make sure you understand your treatment plan before you leave our office
- Bring Social Security number for patient, even if patient is a child. This information is now required by most insurance companies

OFFICE HOURS

Our office is open Monday thru Thursday from 8:00 am until 5:00 pm. On Friday we are open from 8:00 am until 1:00 pm. A physician is available for **EMERGENCIES** twenty-four hours a day. Non-emergency calls and requests for medication refills after hours will be directed to the office during normal business hours. We request at least twenty-four hours notice for prescription refills before you are completely out of your medications. **The on call physician will not call in refills after hours**. Emergencies during normal office hours may be directed to the emergency room if they cannot be handled in the office. **At anytime if you are in a life-threatening situation, dial 911 or go to the nearest emergency room.**

The physicians are either with scheduled patients or in surgery during office hours and are managing hospitalized patients throughout the day. As such, the physician will be unlikely to speak to you directly if you call. A nurse or receptionist will speak to you and then convey your call to the physician in a timely fashion. If you insist on speaking to the physician directly, it may be twenty-four to forty-eight hours before your call is returned.

APPOINTMENTS

Arrive a few minutes early for your first appointment so any necessary paperwork can be completed and updated. If you are late for an appointment you may be asked to reschedule. This will insure you are given the appropriate time for your problem and will avoid penalizing the patient appointed after you. We strive to see you as close to your scheduled time as possible, so if more than twenty minutes has elapsed since your appointment time, please notify the receptionist. Unfortunately, emergencies occasionally arise and our physicians may have to work-in a patient, or may have to leave to see someone at the emergency room. We will notify you under these circumstances and give you the option of rescheduling and/or waiting to see the physician on a delayed basis.

If you are unable to keep your appointment, please give the office at least twenty-four hours notice so that other patients may be offered your time. If you fail to keep appointments without notifying our office in a timely manner, you may be charged or dismissed from the practice. If you have a cancellation fee charged to your account, you will not be rescheduled until your account has been paid.

PRIVACY POLICY

This office will not release patient information to anyone without the patient's consent (this includes family members). If we are treating your child and another family member or friend may bring the child to scheduled appointments, please complete the Designation of Care Providers form listing each individual with whom you will allow us to discuss their medical care. We must have written permission to see a child without their parent and/or legal guardian. An adult must accompany a child younger than 18 unless they are considered an adult under South Carolina Law.

INSURANCE POLICY

Be familiar with you insurance coverage and policies. Bring your insurance card with you so we can assist you with any questions regarding our services. Your health insurance is an agreement between you and your insurance company. It is your responsibility to know and understand the terms of your insurance contract. You are ultimately responsible for the payment of your bill regardless of the status of your insurance claim. We will, however, make every reasonable effort to submit appropriate claims on your behalf and to collect from your insurance company if it is one with which we have a contract. But please understand that failure of your company to pay promptly will result in you being asked to pay your balance in full.

If your plan requires referral from a primary care physician, please have this done before your office visit. We cannot see you without all required prior approvals from your primary doctor or insurance company.

There will be a $30.00 fee for all checks returned by your bank for non-sufficient funds.

If surgery is planned, you are responsible for 50% of your estimated co-payment at the time of scheduling. We will bill your insurance company after surgery. Any additional co-payment will be subsequently billed to you. In the event that surgery is cancelled, your co-payment will be fully refunded to you.

Insurance companies typically do not pay for cosmetic procedures. Because the surgery is elective in nature, and requires coordination of the anesthesia department and the hospital with our office, we ask that you take care of your financial obligation 14 days prior to surgery. In the event that surgery is cancelled, your prepayment will be refunded as specified in the patient information you will receive prior to scheduling.

If you have a balance on your account, you will receive regular statements every 30 days informing you of the status of your balance. If you neglect payment on your account, a monthly finance charge may be incurred. After 60 days, we will reserve the right to refer your account to a credit-reporting agency or to the Magistrate Court where you will be responsible for all collection and legal fees. Our billing staff is available at any time during regular business hours should you have any questions concerning your account.

CONTROLLED SUBSTANCES

Controlled substances (prescription pain medications, etc.) are not kept in our office. They may be prescribed for acute problems or short-term use, but are avoided in the treatment of chronic problems. These drugs are not prescribed or refilled after hours.

Sumter Ear, Nose, Throat & Facial Plastic Surgery
David Lovice, MD Paul A. Evangelisti, MD

Insurance Information

PATIENT NAME: _____ _____ _____
Last First MI

Please list below the names of each insurance company that we will file claims to for this medical treatment. **DO NOT LIST LIFE INSURANCE POLICIES OR DISABILITY POLICIES.** Please give us your insurance identification cards so that we can make copies to be placed in your medical record.

Primary Insurance Company

Name of Primary Insurance Company	Employer
Name of Policyholder	Birth Date
ID#	Social Security Number of Policy Holder
Relationship of Patient to Policyholder ( ) Self ( ) Spouse ( ) Child	

Secondary Insurance Company

Name of Primary Insurance Company	Employer
Name of Policyholder	Birth Date
ID#	Social Security Number of Policy Holder
Relationship of Patient to Policyholder ( ) Self ( ) Spouse ( ) Child	
If student insurance, please list name and address of school: Name of School _____ Address of School _____	

If Worker's Compensation **(TO BE COMPLETED BY OFFICE ONLY)**

Employer's Name	Insurance Company
Employer's Address	
Employer's Phone	
Person's Name Authorizing Treatment	Employer of Insurance Company

FILING INSURANCE CLAIMS IS A SERVICE PROVIDED WITHOUT CHARGE AND IN NO WAY RELIEVES YOU OF YOUR RESPONSIBILITY FOR YOUR BILL

See other side

BENEFITS RELEASE

I authorize payment of medical benefits to Sumter Ear, Nose Throat & FPS, LLC as indicated by the assignment on any and all claims filed. I also request payment of government benefits to the party who accepts assignment.

MEDICAL RECORDS RELEASE

I authorize the release of any medical information necessary to process any and all claims filed.

FINANCIAL RESPONSIBILITY RELEASE

I understand that I am responsible for all medical expenses regardless of insurance coverage and whether or not there is an accident for which I am not at fault. I understand that any copayment/ deductibles or other insurance contract provisions are my responsibility and that failure to adhere to my insurance policy will result in my personal responsibility for all charges incurred.

_____ _____

Patient or Responsible Party Signature Date

Payment is required at the time of service for all charges unless prior arrangements have been made. (Excluding those patients whose primary insurance is Medicare/Medicaid, a PPO/HMO or Worker's Compensation with which we participate – payment of co-pays and deductibles are expected.) As a courtesy to our patients, however, we will file for each date of service. Please present your insurance card(s) to the receptionist.

METHOD OF PAYMENT: ( ) Cash ( ) Check ( ) Visa/MC

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Demographic Information

PLEASE ANSWER ALL QUESTIONS

Patients Full Name: Last First MI					Was the Patient Injured? ( ) Yes ( ) No **DATE OF INJURY**_____
( ) Male ( ) Female	Age	Birth Date ___/___/____	Marital Status S M W D Sep	Race	If Yes, Will Treatment be under Worker's Compensation ( ) Yes ( ) No
Address: Street Apt./Suite City State					Zip Code
Patient's Employer			Spouse's Name and Employer		
Referred By		Family Physician		Patient's Social Security Number	
Responsible Party (If Child) Both Parent's Names		Mother: Father:			
If Child, Father's Employer			If Child, Mother's Employer		
Is There an Attorney Involved in this Treatment?			If Yes, Name:		

To respect your privacy please tell us which of the following numbers we should call to communicate with you regarding Appointment Reminders, Lab Results, etc. Only list the phone number, or numbers, you want us to call.

Home( ) _____ Work( )_____ Cell ( )_____
Other( )_____

CONSENT TO EVALUATE – TREATMENT

I hereby authorize Sumter Ear, Nose, Throat & Facial Plastic Surgery physicians to evaluate the patient named above and recommend diagnostic tests and treatment as may be deemed necessary or advisable. I am aware that the practice of medicine is not an exact science and acknowledge that no guarantees can be made as to the results of treatments or examinations.

RELEASE OF INFORMATION

I authorize the release of my evaluation to the referring physician and/or my family physician.

FINANCIAL RESPONSIBILITY

I understand that I am responsible for all medical expenses. **Please note that all procedures performed in our office may not be covered 100% under your health plan, such as nasal or laryngeal scopes, ear plugs and cresylate ear drops. You have the right to refuse any of these services, however, doing so may impair or prevent your treatment by our physicians**

I have read the above. I understand the above, and sign voluntarily. I certify that the information in this form is true and correct.

_____ _____
Patient or Responsible Party Signature Date

If we are filing your insurance, please complete the other side

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as a part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

- I request the following restrictions to the use or disclosure of my health information. ****PLEASE NOTE, ANY RESTRICTIONS MAY PREVENT US FROM PROVIDING MEDICAL SERVICES. PLEASE ASK BEFORE LISTING RESTRICTIONS*****

_____

_____

_____

_____

_____ _____

Signature of Patient or Legal Representative Witness

_____

Date

DESIGNATION OF CARE PROVIDERS FOR COMMUNICATION OF PROTECTED HEALTH INFORMATION

PATIENT NAME:_____

BIRTHDATE:_____ PHYSICIAN:_____

ADDRESS:_____

_____

PHONE NUMBER:(HOME)_____ (WORK)_____

I hereby request that my protected health information be communicated with others directly involved in my care. This designation of care providers will be kept as a permanent part of my medical record and will be copied as required in order to allow communication of my protected health information. I understand that my health care providers will use judgment in determining the minimum amount of information that must be shared in order to care for me.

DESIGNATION OF CARE PROVIDERS: (Specify name, relationship, agency, healthcare provider, etc. that will be allowed information as needed for your treatment)

Please list AT LEAST ONE friend or family member who might come with you to your appointment or who we might need to call if you have an emergency.
****For children-----please list at least one friend or family member (<u>other than mom or dad</u>) who might need to bring your child to an appointment if you cannot bring them.**
****<u>If they are not on this form</u>, they CANNOT bring your child to an appointment****

_____

_____

_____

_____

SIGNATURE:_____ DATE:_____

Original – Medical Record Copy – Patient

Sumter Ear, Nose, Throat & Facial Plastic Surgery, LLC

Patient Consent Form

Patient Name: _____

Date of Birth: _____

Patient Portal/Email Consent

This will give us permission to contact you by computer or on your cell phone.

□ **YES,** I hereby authorize Sumter ENT to use the email address I have provided as a means to communicate test results and other information to me through the patient portal.

E-mail:_____

□ **NO,** I do NOT wish to communicate through the patient portal and would prefer to be reached by phone for any future communication(s).

- □ **I do not have email address**
- □ **I do not wish to disclose email address**

X_____ _____

*** Signature of Patient or Legal Representative** **Date**

**** See other side ****

Authorization for Prescription History

I consent to allow the physicians of Sumter ENT and appropriate staff to access my prescriptions from external sources. (This would allow us to obtain your prescription information from a pharmacy, the hospital, your primary care doctor, etc. and allow us to send prescriptions to your pharmacy)

□ **Yes,** I give permission for the physicians of Sumter ENT and the appropriate staff to have access to my prescriptions from external sources.

Name of Your Pharmacy:_____

Name of Secondary Pharmacy:_____

(For patients who use Shaw AFB pharmacy, we need a secondary pharmacy)

□ **No,** I do not wish to give permission for anyone to have access to any of my prior prescription history from any external sources. (Checking this box will NOT allow us to prescribe any medication for you)

X_____ _____

***Signature of patient or legal guardian** **Date**

Patient Name DOB Today's Date

PLEASE LIST CURRENT MEDS

*****Including over the counter medication*****

Name of Medication	Dosage	How often taken

List meds you have taken for the problem for which you are referred to us.