

**COLUMBUS OTOLARYNGOLOGY CLINIC**  
**NILA M. NOVOTNY, M.D.**  
**4508 38TH STREET, SUITE #152, COLUMBUS, NE 68601-1668**  
**(402) 563-4500 FAX (402) 563-3520**

ACCOUNT # \_\_\_\_\_

The information you provide to this office helps us to help you with important items such as: future appointments, insurance claim processing, payment on your account, etc. It could also be critical in the event of an emergency.

NAME OF PATIENT _____			
Street address _____	LAST NAME _____	FIRST NAME _____	MIDDLE INITIAL _____
Home phone _____	City _____	State _____	Zip _____
Employer _____	Work phone _____	Cell phone _____	
Names & ages of children at home _____	Occupation _____	Marital status (S, M, D, W) _____	
Social Security # _____ - _____ - _____	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Age _____	Race (Optional) _____
Email address _____			Birth date ____/____/____ Mo. Day Yr.
Preferred method of contacting you (Mark one) → <input type="checkbox"/> Home phone <input type="checkbox"/> Work phone <input type="checkbox"/> Cell Phone <input type="checkbox"/> Email <input type="checkbox"/> US Mail			
Referring Doctor _____		Family Doctor _____	
		Other Professional Involved _____	
PERSON FINANCIALLY RESPONSIBLE AND THEIR RELATIONSHIP TO THE PATIENT _____			

Spouse's Name _____			
Street address if different than patient's _____	City _____	State _____	Zip _____
Home phone _____	Work phone _____	Cell phone _____	
Employer _____	Occupation _____	Marital status (S, M, D, W) _____	
Names & ages of children at home _____			
Social Security # _____ - _____ - _____	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Age _____	Race (Optional) _____
Email address _____			Birth date ____/____/____ Mo. Day Yr.
Preferred method of contacting you (Mark one) → <input type="checkbox"/> Home phone <input type="checkbox"/> Work phone <input type="checkbox"/> Cell Phone <input type="checkbox"/> Email <input type="checkbox"/> US Mail			

Next of kin for emergency notification _____		
Relationship to patient _____	Phone # _____	Cell # _____

DO YOU HAVE MEDICAL INSURANCE? YES__ NO__ (If you have insurance cards, we will make a copy of them for you.)		
NAME & ADDRESS OF <b>PRIMARY</b> INSURER _____		
POLICY# _____	GROUP# _____	Is this a PPO or HMO plan? __YES__ __NO__
Do you have a co-pay for office visits? YES__ NO__	AMOUNT _____	
NAME & ADDRESS OF <b>SECONDARY</b> INSURER _____		
POLICY# _____	GROUP# _____	Is this a PPO or HMO plan? __YES__ __NO__
Do you have a co-pay for office visits? YES__ NO__	AMOUNT _____	

Services are rendered on a CASH BASIS ONLY unless previous arrangements are made.

I/We authorize payment of medical benefits directly to COLUMBUS OTOLARYNGOLOGY CLINIC/NILA M. NOVOTNY, M.D. I/We also agree that this authorization will be perpetual in nature and a copy of this assignment is as valid as the original. I/We further agree that should my insurance benefits be insufficient to cover the entire amount of charges, I/We will be responsible for the difference. I/We agree that payments will not be delayed or withheld because of any insurance coverage or the pendency of claims, and all proceeds of insurance are assigned to this Clinic where applicable, but without assuming responsibility for the collection thereof.

I/We agree that the above information is for the purpose of obtaining credit and is warranted to be true, I/We authorize the Clinic or its agent to make a credit investigation, including employment verification.

I/We agree that charges shown by statements are correct and reasonable unless protest within 30 days of original billing date. I/We agree that in the event legal action should be necessary to collect an unpaid balance due for services rendered to me or my family, I/We will pay reasonable attorney's fees or other such costs as the Court determines proper. I/We knowing that I/We have a condition(s) requiring examination, diagnosis, medical and/or surgical treatment, hereby consent to such treatment, including photographs, video taping, documentation and storage of medical records, in any form. I/We further acknowledge that no guarantees are made as to the results of such treatment. I/We consent to and authorize the release of medical information to my insurance provider and/or physician and/or other health care provider concerning my/our examination, diagnosis and treatment. You are entitled to a copy of this agreement should you request one.

(MEDICARE ONLY: I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF FOR ANY SERVICES FURNISHED ME BY COLUMBUS OTOLARYNGOLOGY CLINIC INCLUDING PHYSICIAN'S SERVICES. I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE TO THE HEALTH CARE FINANCIAL ADMINISTRATION AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR BENEFITS FOR RELATED SERVICES. WE ARE INFORMING YOU THAT SOME SERVICES MAY NOT BE PAYABLE BY MEDICARE IF THEY DEEM THEM TO BE NON-COVERED. YOU WILL BE RESPONSIBLE FOR PAYMENT OF NON-COVERED SERVICES. PLEASE REFER TO YOUR MEDICARE HANDBOOK FOR FURTHER DETAILS ABOUT NON-COVERED SERVICES.)

RESPONSIBLE PARTY SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_