



**Martin H. Janning, M.D.**  
Board Certified Otolaryngologist  
Head and Neck Surgeon

1801 19th Avenue SW ▪ Willmar, MN 56201-4946 ▪ Tel.: 320.231.3277 ▪ Fax: 320.214.5758  
www.janningentcenter.com

## Registration Packet Instructions

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Dear Patient:

Thank you for your interest in Janning ENT Center. We have compiled this registration packet to aid in expediting your appointment. Please take a few moments 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 19<sup>th</sup> Avenue SW, Willmar, MN 56201. Please be sure to bring the following information with to your appointment:

1. **this registration packet**
  - a. **It is very important that every section be completed so we may be able to successfully file your insurance claim(s). Failure to provide this information may pre-empt us from filing the claim(s).**
  - b. **If you do not agree to the terms in the “Financial Responsibility” or the Consent for Treatment” please notify our office before you appointment. Our office MUST have a signed copy of both of these forms in order to provide treatment for you and file insurance claims.**
  - c. **Guarantor = responsible party. Usually this person is the policyholder for the insurance. The guarantor is the person whom the statement will be addressed to if a non-insurance balance remains on the account.**
2. **If your insurance policy requires a referral from a primary physician, it is your responsibility to request this. Blue Plus recipients will be asked to sign a “Waiver for services” or be asked to reschedule their appointment if no referral has been received for a visit with us. Some insurance plans will not pay for services if a referral is not generated by the primary physician. If you are in doubt over whether your policy requires a referral, please contact the customer service number on the back of your insurance card. They will be able to confirm for you if you need a referral or not.**
3. **your current insurance card(s).**
4. **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 with apply if your policy has multiple co-pay values listed.**
5. **if self-pay, a \$50 down payment on the visit.**

Please contact our office at 320-231-3277 if you have any questions. Thank you again and we look forward to serving your medical needs.



**REGISTRATION** 06-06

**Please complete all information on this form**

PLEASE PRINT

**If this registration packet was mailed to you:  
Please complete these forms and bring them  
along with your insurance card(s) to your  
appointment. Thank you!**

<b>PATIENT</b>	LEGAL PATIENT NAME (LAST, FIRST, MIDDLE)			ALSO KNOWN AS (NICKNAME) / MAIDEN NAME			SOCIAL SECURITY NUMBER			
	DATE OF BIRTH	AGE	SEX <input type="checkbox"/> M <input type="checkbox"/> F	LANGUAGE <input type="checkbox"/> English <input type="checkbox"/> German <input type="checkbox"/> Spanish <input type="checkbox"/> Chinese <input type="checkbox"/> French <input type="checkbox"/> Other			MARITAL STATUS <input type="checkbox"/> Legally Separated <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Life Partner <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed			
	RACE <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian <input type="checkbox"/> Native American <input type="checkbox"/> African American <input type="checkbox"/> Hispanic <input type="checkbox"/> Other			ARE YOU A STUDENT? <input type="checkbox"/> Yes <input type="checkbox"/> No		STUDENT STATUS <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time		NAME OF ATTENDING SCHOOL		
	ADDRESS				CITY, STATE			ZIP CODE		
	TELEPHONE			PAGER / CELL PHONE			PRIMARY PHYSICIAN (First & Last Name)		REFERRING PHYSICIAN (First & Last Name)	
	EMPLOYER			EMPLOYER ADDRESS				CITY, STATE		ZIP CODE
	EMPLOYER TELEPHONE			EXTENSION	PATIENT'S EMAIL (Optional)			OCCUPATION		

<b>GUARANTOR</b>	RELATIONSHIP TO PATIENT		GUARANTOR NAME			SOCIAL SECURITY NUMBER			DATE OF BIRTH		AGE	SEX <input type="checkbox"/> M <input type="checkbox"/> F
	ADDRESS					CITY, STATE			ZIP CODE			
	TELEPHONE			PAGER / CELL PHONE			EMPLOYER					
	EMPLOYER TELEPHONE			OCCUPATION								

EMERGENCY CONTACT					NEXT OF KIN				
NAME			RELATIONSHIP TO PATIENT		NAME			RELATIONSHIP TO PATIENT	
TELEPHONE		EMPLOYMENT TELEPHONE	PAGER / CELL PHONE		TELEPHONE		EMPLOYMENT TELEPHONE	PAGER / CELL PHONE	
COMMENTS					COMMENTS				

PRIMARY INSURANCE				SECONDARY INSURANCE			
INSURANCE COMPANY NAME				INSURANCE COMPANY NAME			
ADDRESS				ADDRESS			
CITY, STATE		ZIP CODE		CITY, STATE		ZIP CODE	
TELEPHONE NUMBER		EFFECTIVE DATE		TELEPHONE NUMBER		EFFECTIVE DATE	
POLICY ID NUMBER		GROUP NUMBER		POLICY ID NUMBER		GROUP NUMBER	
PATIENT'S RELATIONSHIP TO SUBSCRIBER				PATIENT'S RELATIONSHIP TO SUBSCRIBER			
SUBSCRIBER'S NAME			DATE OF BIRTH	SUBSCRIBER'S NAME			DATE OF BIRTH
SUBSCRIBER'S EMPLOYER				SUBSCRIBER'S EMPLOYER			

I hereby grant authorization to **Martin H. Janning, MD** 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 physician 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 physician for charges not covered by this authorization.

SIGNATURE	PRINTED NAME (PATIENT/LEAGAL GUARDIAN)	DATE
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**How did you hear about our office?**

Physician Referral     Friend     Radio     Newspaper     Internet     Other \_\_\_\_\_

Thank you for your patronage!

# Consent for Purposes of Treatment, Payment, and Health-Care Operations

I consent to the use or disclosure of my "Protected Health Information" (PHI) by Janning ENT Center, LLC, 1801 19<sup>th</sup> Ave. 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 dependant), obtain payment from me for health-care 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.**

\_\_\_\_\_  
Signature of patient/guardian or authorized representative

\_\_\_\_\_  
Printed name of signed                      Relationship to patient

\_\_\_\_\_  
Printed name of patient if different from signed (ex: child)

\_\_\_\_\_  
Date

**Janning ENT Center, LLC  
Attn: Marik Jensen  
1801 19<sup>th</sup> Avenue SW  
Willmar, MN 56201  
320 231-3277  
320 214-5758 FAX**

**✓ BE CERTAIN TO READ AND SIGN/DATE BOTH SIDES OF THIS DOCUMENT!**

# Financial Policy

**Janning ENT Center, LLC, 1801 19<sup>th</sup> Avenue SW, Willmar, MN 56201  
320 231-3277 Phone, 320 214-5758 FAX**

**We are committed to providing you with the best possible care.** Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our Financial Policy or your responsibility.

**INSURANCE:** Insurance is a contract between you and your insurance company. We are **NOT** a party to this contract. We will file insurance claims to your Primary Insurance carrier if all necessary information is made available. You are responsible for filing to any Secondary Insurance carrier. We **WILL NOT** become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "usual and customary" charges, etc., other than supply factual information as necessary. You are responsible for the items above as well as any services considered "not medically necessary" by your insurance company.

**A payment is due at the time of service.** Your payment will be the lesser of 1) \$50 prepayment to cover the co-insurance portion of services rendered, or 2) the co-pay listed on your insurance card. (Note: The co-pay amount might be listed as \$0. There is no co-pay for Medicare.) If payment cannot be made at each visit, notify the billing department to make other arrangements. The remaining balance should be paid immediately upon notice from your insurance company.

**Patients without insurance (private pay):** Full payment is due at the time of service. If payment cannot be made at each visit, the billing department will assist you in making other payment arrangements.

**Financial charges:** You agree to remain personally responsible for any due but unpaid amounts and further agree to pay interest on such outstanding amounts after 30 days at an interest-rate at 1 ½ percent per month. In the event that collection action becomes necessary, you agree to reimburse **Janning ENT Center, LLC** for collection costs, including attorneys' fees and costs associated therewith.

**Workers' compensation:** All necessary information must be provided to file your claim. If your claim is denied by workers' compensation, you are responsible for payment in full.

**Liability and personal injury:** If you are a personal injury patient, our office will bill the appropriate insurance companies. If we are unable to obtain payment, the charges for the services rendered will be your responsibility. A \$50 prepayment is due at the time of each visit. If the insurance carrier makes a payment exceeding your balance, any credit for the prepayment you made will be refunded to you.

Our office **WILL NOT** become involved in disputes arising from personal injury or liability claims. All bills will be sent directly to you. It is your responsibility to forward them to your attorney if you wish. **Financial responsibility always rests upon the patient.**

**Minors:** The adult who signs as the "**Financially Responsible Party**" is responsible for payment of services rendered. Our office **WILL NOT** become involved in disputes between divorced parents.

**Authorization and assignment of benefits:** I authorize payment of medical benefits to **Janning ENT Center, LLC** for medical/professional services rendered. I further authorized release of any medical information necessary for billing, treatment, or health-care operations. I agree to pay, in current manner, any balance of said professional service charges over and above this insurance payment.

**Medicare patients:** I request that payment of authorized Medicare benefits be made either to me or on my behalf to **Janning ENT Center, LLC** for any services furnished by the physician/provider. I authorize any holder of medical information about me to release to The Centers for Medicare and Medicaid Services and its agents any information to determine these benefits or the benefits payable for related services.

Signature of Financially Responsible Party\_\_\_\_\_

Printed Name of Above\_\_\_\_\_

Date\_\_\_\_\_

FP-MHJ 08/28/2005

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**✓ BE CERTAIN TO READ AND SIGN/DATE BOTH SIDES OF THIS DOCUMENT!**

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