WILLIAM R. BOND, JR., M.D.,MBA, F.A.C.S.
106 Irving Street, N.W.
Suite 312
Washington, D.C. 20010

Registration
Date: _____

PATIENT INFORMATION

Name:_____Soc.Sec#_____

Address :_____Phone:(H)_____Cell_____

City: _____State: _____ Zip: _____

Sex: __M ___F Age:_____ Date of Birth: _____

Single: _____ Married: _____ Separated: _____ Widowed: _____ Divorced: _____

E-mail Address: _____

Pharmacy _____ Telephone #_____Fax# _____

Employer: _____

Address: _____City:_____ State:_____ Zip: _____

Phone: _____

Referring Physician: _____Phone: _____

Address: _____

INSURANCE INFORMATION

Insurance Company: _____PPO___HMO___

Subscriber ID#: _____Group#: _____

Secondary Insurance: _____PPO__HMO___

Subscriber ID#: _____Group#: _____

MEDICAL INFORMATION

Chief Complaint: _____

Is this complaint due to: Illness: _____ Injury: _____Date: _____

EMERGENCY INFORMATION

Emergency Contact: _____

Address: _____Phone: _____Cell Phone: _____

City: _____State: _____Zip: _____

WILLIAM R. BOND, JR., M.D.,MBA, F.A.C.S.
Otolaryngology (ENT) Head & Neck Surgery

Assignment and Release

I, the undersigned _____certify that I or the policy holder have insurance with the above named insurance Company, and that all insurance benefits as part of this service, whether is an office visit, surgery, or consultation will be assigned directly to Dr. William R. Bond, Jr.

Further, I understand that I am financially responsible for all charges, including those not paid for my insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature for all insurance submission.

Should there be any tests such as imaging services, lab tests, and/ or audiology exams, I understand that I am to call the office of William R Bond, Jr., M.D. to arrange a return office visit appointment to receive the test results.

_____ _____

Responsible Party Signature Date

WILLIAM R. BOND, JR., M.D.,MBA, F.A.C.S.

Otolaryngology (ENT) Head & Neck Surgery

PATIENT CONSENT FOR USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION

With my consent, William R Bond, Jr., M.D. LLC may use and disclose Protected Health Information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to William R. Bond, Jr., M.D.'s Notice of privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy practices prior to signing this consent. William R. Bond, Jr., M.D., LLC reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to William R. Bond, Jr., M.D. Privacy Officer at 106 Irving Street, N.W., Suite 312, Washington, D.C. 20010.

With my consent, William R. Bond, Jr., M.D., LLC may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out (Treatment, Payment, Healthcare Operations) TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, William R. Bond, Jr., M.D., LLC may mail to my home or other designated location any items that assist the practice in carrying out PHO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With my consent, William R. Bond, Jr., M.D., LLC, may e-mail to my home or other designated location any items that assist the practice in carrying out PHO, such as reminder cards and patient statements. I have the right to request that William R. Bond, Jr., M.D., LLC restrict how it uses or discloses my PHI to carry out Treatment, Payment, and Healthcare Operations (TPO). However, the practice is not required to agree to my requested restrictions.

By signing this form, I am consenting to William R. Bond, Jr., M.D., LLC's use and disclosure of my PHI to carry out TPO.
I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, William R. Bond, Jr., M.D., LLC may decline to provide treatment to me.

_____

Signature of Patient or Legal Guardian Date

106 Irving Street, N.W. Suite 312 Washington, D.C. 20010 202-726-7770