Ear Nose & Throat CENTER

WELCOME TO OUR OFFICE

Patient Information

Last Name_____ First Name_____ Middle Initial _____

Address_____ City_____ State____ Zip _____

DOB___/___/_____ Marital Status: S M D W Gender: M F

Preferred Phone Number ***(Please Circle): Home or Cell***

May we leave a message with Health Information ***(Please circle): Yes or No***

Home (_____) - _____ Cell (_____) - _____ Work (_____) - _____

Emergency Contact Name and Phone Number: _____

Pharmacy Name:_____ Phone: (_____) - _____

Email Address _____

Authorization to Release Patient Health Information

I authorize the following people to have full access to any and all of my medical information with The Ear, Nose, and Throat Center:

_____

_____ This authorization expires _____

Signature _____ **Date** _____

Insurance Information

Primary Insurance Carrier _____ HMO PPO

Name of Insured_____ DOB_____/____/_____

Relationship to patient Self Spouse Parent

Secondary Insurance Carrier _____

Name of Insured_____ DOB_____/____/_____

Relationship to patient Self Spouse Parent

Information for persons in charge of payment for patients under the age of 18 years.

Last Name_____ First Name_____ Middle Initial _____

If different from patient:

Address_____ City_____ State_Zip__ DOB_

_____/____/_____ Gender: M F Phone # (____) - _____ Work # (____) - _____

The Ear, Nose & Throat Center
Financial Policy

The following is our policy concerning payment for professional services rendered. **Patients are responsible for deductibles, co-payments, and services not covered** by their insurance plan. Some plans require pre-authorization or referrals prior to service.

1. If we have a contract with your insurance company, we will send a claim form to them. **We are required to collect your co-payment at the time of service.** After we receive payment from your insurance company, we will bill you for any remaining balance.

2. If we do not have a contract with your insurance company, **you are required to remit full payment at the time of the office visit.** We will provide documentation for you to submit the charge(s) to your insurance company for reimbursement.

3. Our physicians accept Medicare assignment. **Medicare mandates that patients pay their calendar year deductible and 20% co-insurance.**

4. After we receive payment from your insurance company, you will be billed for any remaining balance. Statements are mailed monthly. **If payment is not received within 30 days, a late fee will be assessed.**

5. **If an insurance company has not settled a claim within 35 days, the patient becomes responsible and is billed for the balance.**

6. Balances that have not been paid within three billing cycles may be sent to a licensed collection agency. If your account is turned over to a collection agency, **you agree to pay an additional 30% of your balance to cover the collection agency fees imposed on Ear Nose & Throat Center.**

Please ask us if you have any questions about our financial policy or your insurance plan. The health insurance system is complex, but we want to help as much as possible.

I have read this policy and hereby authorize my insurance benefits to be paid directly to The Ear, Nose & Throat Center. I also authorize the release of medical information requested by my insurance carrier to facilitate payment for services rendered.

I realize that I am responsible to pay for services not covered by my insurance.

X _____ _____

Signature of Patient or Guardian

Please print name

Date _____

A photocopy of this assignment shall be considered as effective and valid as the original.

Revised 9/2020