PATIENT INFORMATION FORM

Not filling out this form may delay or result in non-payment of insurance benefits leaving you responsible for services rendered

Last Name _____ First Name _____ MI_____

Maiden Name_____ Social Security # _____–_____–_____

DOB _____/_____/_____ Age _____ Ethnicity _____ Gender ☐Male ☐Female Marital Status ☐ S ☐ M ☐ W ☐ D

Street Address _____ Apt # _____

City _____ State _____ Zip _____

Primary phone (_____)_____ Secondary Phone (_____)_____

Email _____

Emergency Contact _____ Relationship _____ Phone (_____)_____

Referring Physician _____ Primary Care Physician _____

Required Information for Minor Patient (Under 18 yrs.)

Mother/Guardian's Name _____ Phone (_____)_____

Address (if different from above) _____

Father/Guardian's Name _____ Phone (_____)_____

Address (if different from above) _____

INSURANCE INFORMATION

Primary Insurance _____ID # _____Group #_____

Policy Holder's Name_____ DOB _____/_____/_____

Secondary Insurance _____ID # _____Group #_____

Policy Holder's Name_____ DOB _____/_____/_____

PHARMACY INFORMATION

Preferred Pharmacy _____ Address _____

Prescription/Drug Coverage _____ID # _____Group #_____

FINANCIAL AGREEMENT

1. As a courtesy to all our patients a claim with your insurance company will be filed on your behalf. Seeing an out-of-network provider may result in reduced or denied benefits. You are responsible for any bill or portion of a bill that is not paid by your insurance company. If we do not participate with your insurance, we do not accept any fee schedule reductions and you are responsible for the full amount of billed charges.
2. We are obligated by contract to collect co-payments (co-pays) at the time of service, so please bring your co-pay with you. You may be required to pay deductible and/or co-insurance at the time of service.
3. We require written approval/authorization by your employer and/ or worker's compensation carrier PRIOR to your initial visit. If your claim is denied, you will be responsible for payment in full.
4. Should your insurance company determine a charge to be non-covered, you are responsible for full payment of said charge.
5. Accounts 90 days outstanding will bear interest charges of 1% per month or 12% per annum.
6. Accounts turned over to a formal collection agency will be subject to a service charge of $25.00.
7. Returned checks will be subject to a $35 fee.
8. By signing below, you give your permission to ENTSA and its Affiliates or contractors to contact you for any purpose at the current or at any future numbers that are provided for your landline telephone, cellular telephone or any wireless device including the use of automated dialing equipment, prerecorded voice, or text messages (Standard telephone and text charges may apply).

AUTHORIZATION & RELEASE

I certify the information on this form is accurate and complete to the best of my knowledge. I accept responsibility for the medical charges incurred by the patient and agree to pay the bills at time of service unless other arrangements are made. I authorize my insurance claim to be paid directly to the clinic. I also understand I am responsible for all second opinion and pre-admission review requirements. I acknowledge that Ear, Nose & Throat Surgical Associates have provided me a copy of their Privacy Practices.

Signature: _____ Date: _____