Ear Nose & Throat CENTER

WELCOME TO OUR OFFICE

Patient Information

Last Name _____ First Name _____ Middle Initial _____

Address _____ City _____ State____ Zip _____

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

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

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

Pharmacy Name: _____ Phone: (____) ____-_____

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 # (____) ____-_____

UPDATE ONLY ***(Initialing below indicates there has been no change to the above information.):***

DATE _____ **STAFF INITIALS** _____

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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. Our physicians **do not accept Public Aid/Medicaid as a secondary carrier.** Patient with Public Aid secondary is responsible for balance in full after primary insurance carrier processes claim.

5. 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 rebilling fee may be assessed.

6. **If an insurance company has not settled a claim within 60 days, the patient becomes responsible and is billed for the balance.**

7. Balances that have not been paid within three billing cycles are sent to a licensed collection agency.

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.