Ear, Nose and Throat, Ltd. / Dependant Patient Information Sheet

SECURITY PASSWORD:____________________ ENT ACCOUNT #:____________ DATE: __________
(Used to prevent possible identity theft)

PHARMACY / ADDRESS / PHONE:______________________________

NAME:____________________________ **DOB**:________ F ☐ / M ☐ S.S.N:____________
Last First MN **(Optional)**

RACE:________ **PRIMARY LANGUAGE**:____________ **ETHNICITY**:____________
(Use the information sheet on the clipboard for available choices RACE / PRIMARY LANGUAGE / ETHNICITY)

HOME PHONE:____________ WORK PHONE:______________ CELL:____________

_____ **preferred method of appointment reminder contact**: Home ☐ Cell ☐ Email ☐ Text ☐ EMAIL:________

____

ADDRESS:____________________________________ UNIT #:_____ ZIP:_____

_____

CITY:_______________________ STATE:_____

1) PARENT (Mother) / GUARDIAN

NAME:______________________

RELATIONSHIP:__________________

S.S.N:____________ DOB:________

ADDRESS:______________________

ZIP: ______CITY:_________ STATE:_____

EMPLOYER:____________________

HP:______ WP:_________CP:______

2) PARENT (Father) / GUARDIAN

NAME:______________________

RELATIONSHIP:____________________

S.S.N:____________ DOB: __________

ADDRESS:______________________

ZIP: ______CITY: _________ STATE: ____

EMPLOYER:____________________

HP:______ WP:_________CP:______

PERSON ACCOMPANYING CHILD – INFORMATION: (If <u>NOT</u> Child's Parent / Guardian)

NAME:____________________________________
Last **First** **Middle Initial**

RELATIONSHIP: ____________ S.S.N:__________ DOB:__________

HOME PHONE:__________ WORK PHONE:__________ CELL PHONE:__________

PRIMARY INSURANCE:________________________________

POLICYHOLDER'S NAME:____________________ SSN:__________

RELATIONSHIP:________________________ D.O.B:__________

POLICY NUMBER:__________________ GROUP NUMBER:____________

SECONDARY INSURANCE:______________________________

POLICYHOLDER'S NAME:____________________ SSN:__________

RELATIONSHIP:________________________ D.O.B:__________

POLICY NUMBER:__________________ GROUP NUMBER:____________

OTHER INSURANCE:__________________________________

RELATIONSHIP:________________________ D.O.B:__________

POLICYHOLDER'S NAME:____________________ SSN:__________

POLICY NUMBER:__________________ GROUP NUMBER:____________

REFERRING PHYSICIAN (The provider who sent you to us – we need a doctor's name not <u>where</u> you were seen)

REFERRING PHYSICIAN:____________________ OFFICE PHONE:____________

ADDRESS:____
Street City State Zip

FAMILY PHYSICIAN (The doctor you see regularly / write same if same as Referring)

FAMILY PHYSICIAN:____________________ OFFICE PHONE:____________

ADDRESS:____

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Street **City** **State** **Zip**

-- Over --

AUTHORIZATION FOR TREATMENT / ACCIDENTAL EXPOSURE / CONSENT FOR PHOTO / FINANCIAL POLICY & ASSIGNMENT OF BENEFITS / WAIVER FOR NO REFERRAL

1) – I hereby apply for treatment by the health care providers at Ear, Nose and Throat, Ltd. (ENT, Ltd.). Such treatments may include x-rays, hearing tests, and such other procedures as they deem necessary. I further understand that it is my responsibility to be familiar with the Notice of Privacy Practices (NPP) which spells out how my Protected Health Information may be used. This NPP is available for review and the Written Acknowledgement Form will be kept in your record.

2) – Additionally, if health care workers accidentally expose themselves to my body fluids, I agree to have my blood tested for any infectious disease that can be transmitted by exposure to blood and/or body fluids at Ear, Nose and Throat, Ltd.'s expense.

3) – I authorize ENT, Ltd. to take my picture for use in identifying me as the authorized person eligible to receive health care. It will not be used in any other form or function and will be kept secure in the Electronic Health Record.

By signing below you acknowledge reading and complying by the above statements.

Signature of Patient/Guarantor:____ **Date:**_______________

Printed Full Name:____

Witness:____ **Date:**_______________

4) –Financial Policy: I understand that my insurance policy is a contract between me and my insurance carrier and those co-payments and deductibles that have not been satisfied are the responsibility of the patient/guardian and **payment is expected at the time services are rendered**. For **Self Pay,** a standardized payment formula will be used for office visits and procedures conducted in the office. A minimum of **$150** is expected prior to seeing the doctor. A pre-established standard deduction would be applied by Ear, Nose and Throat, Ltd. to the office visit / procedure charge. For self-pay patients when surgery is required, a 50% down payment is expected at a minimum one week prior to the elective surgery date. The remainder of the payments will be expected within 30 days, unless other payment arrangements are made. In the event of default, I agree to pay the balance and all reasonable costs of collections, including agency and/or attorney fees, in the amount of **<u>at least</u> 15%** of the total amount due if turned over to collections. I acknowledge that this form is being signed in either Norfolk, VA, or Chesapeake, VA, and that services are being performed in either Norfolk, VA, or Chesapeake, VA and should a suit become necessary to collect on this account that court filings will be in either Norfolk, VA or Chesapeake, VA.

By signing below you acknowledge reading and complying by the above statement.

Signature of Patient/Guarantor:____ **Date:**_______________

Printed Full Name:____

Witness:____ **Date:**_______________

5) – If Applicable / Waiver for No Referral from Primary Care Physician: Your current insurance requires a referral from your Primary Care Physician before our physicians can see you and before we can submit a bill to your insurance company for reimbursement. Since you do not have a referral for this date of service, we require that you pay **$50** up front or establish payment terms with our Financial Consultants. If it is later determined that a referral was not necessary, or if you are able to provide Ear, Nose and Throat, Ltd. with a referral for the date of service **within 24 hours**, you will be reimbursed after the claim has been processed and the insurance company's Explanation of Benefits has shown the service to be eligible for payment.

I have elected to visit this specialist and to receive services **<u>without</u>** an insurance referral and/or authorization from my primary care physician for my HMO, PPO or POS insurance. However, with the understanding that if I abide by the above rules that I may be eligible for a refund.

I have requested services beyond those specified in my referral or services which are not covered benefits.

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By signing below you acknowledge reading and complying by the above statement.

Signature of Patient/Guarantor:____ **Date:**________
______

Printed Full Name:____

Witness:____ **Date:**________
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