

**EAR, NOSE AND THROAT, LTD.  
DEPENDENT INFORMATION SHEET**

ENT ACCOUNT #: \_\_\_\_\_ DATE: \_\_\_\_\_

NAME: \_\_\_\_\_ Preferred Name: \_\_\_\_\_  
Last First Middle Initial

DOB: \_\_\_\_\_ FEMALE  MALE  S.S.N.: \_\_\_\_\_ RACE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ UNIT. #: \_\_\_\_\_

ZIP: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

**PARENT / GUARDIAN INFORMATION:**

**MOTHER:** \_\_\_\_\_

S.S.N.: \_\_\_\_\_ DOB: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

ZIP: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_

WORK PHONE: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_

**FATHER:** \_\_\_\_\_

S.S.N.: \_\_\_\_\_ DOB: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

ZIP: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_

WORK PHONE: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_

**PERSON ACCOMPANYING CHILD – INFORMATION: (IF NOT CHILD’S PARENT / GUARDIAN)**

NAME: \_\_\_\_\_  
Last First Middle Initial

RELATIONSHIP: \_\_\_\_\_ S.S.N.: \_\_\_\_\_ DOB: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

**EMERGENCY NOTIFICATION:**

NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_  
First Last

HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

**PRIMARY INSURANCE:** \_\_\_\_\_

POLICYHOLDER’S NAME: \_\_\_\_\_ SSN: \_\_\_\_\_

POLICY NUMBER: \_\_\_\_\_ GROUP NUMBER: \_\_\_\_\_

**SECONDARY INSURANCE:** \_\_\_\_\_

POLICYHOLDER’S NAME: \_\_\_\_\_ SSN: \_\_\_\_\_

POLICY NUMBER: \_\_\_\_\_ GROUP NUMBER: \_\_\_\_\_

**OTHER INSURANCE:** \_\_\_\_\_

POLICYHOLDER’S NAME: \_\_\_\_\_ SSN: \_\_\_\_\_

POLICY NUMBER: \_\_\_\_\_ GROUP NUMBER: \_\_\_\_\_

**FAMILY PHYSICIAN (The doctor you see regularly)**

FAMILY PHYSICIAN: \_\_\_\_\_ OFFICE PHONE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
Street City State Zip

**REFERRING PHYSICIAN (The provider who sent you to us – we need a doctor’s name not where you were seen)**

REFERRING PHYSICIAN: \_\_\_\_\_ OFFICE PHONE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
Street City State Zip

**AUTHORIZATION FOR TREATMENT / ACCIDENTAL EXPOSURE /  
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. 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.

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.

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

Signature of Patient/Guarantor: \_\_\_\_\_

Date: \_\_\_\_\_

Printed Full Name: \_\_\_\_\_

Witness: \_\_\_\_\_

Date: \_\_\_\_\_

2) –**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 will 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 **at least 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: \_\_\_\_\_

**3) – 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 **without** an insurance referral and/or authorization from my primary care physician for my HMO, PPO or POS insurance. But 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.

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

Signature of Patient/Guarantor: \_\_\_\_\_

Date: \_\_\_\_\_

Printed Full Name: \_\_\_\_\_

Witness: \_\_\_\_\_

Date: \_\_\_\_\_