Adult Patient Information

Patient Name: ______________________ Patient ID: ____________________ Date: ____________
DOB: ______________________________ ☐ F/ ☐ M SSN (optional): ____________________
Address: ____ Unit #: __________ Zip: ____________
City: ______________________________ State: __________________ Email: ________________
Home Phone: ______________________ Work Phone: ____________ Cell: __________________
Preferred method of appointment reminder contact: ☐ Home ☐ Cell ☐ Email ☐ Text
Marital Status: ☐ M ☐ S ☐ W ☐ D
Pharmacy Phone: ________________________________ Access to pharmacy history? ☐ Yes ☐ No

Spouse Information:
Name: _______________________ DOB: _____________________ SSN: ____________________
Employer: ______________________________________ Work Phone: ______________________
Cell Phone: ____

Emergency Contact:
Name: _________________________________ Relationship: _____________________________
Home Phone: _______________ Work Phone: _______________ Cell Phone: _________________

Insurance Information:
Policy #: _______________________________ Primary Insurance: _________________________
Group Number: __________________ Policy Holder's Name: ______________________________
Secondary Insurance: ______________________ Policy #: ________________________________
Group Number: __________________ Policy Holder's Name: ______________________________
Other Insurance: _________________ Policy #: ____
Group Number: __________________ Policy Holder's Name: ______________________________

Referring Physician:
Name of Referring Physician: _______________________ Practice Name: ____________________
Office Phone: _______________________ Address: ____

Family Physician:
Name of Family Physician: _________________________ Practice Name: ____________________
Office Phone: _______________________ Address: ____

Injuries: (For workman's compensation, or injuries on the job, only. Your employer will have given you paperwork for us.)
Date/Time of Injury: ____ Work related? ☐ Yes ☐ No
Cause: ________________________________ Referred By: _____________________________
Workman's Comp. Carrier: ____

Authorization for Treatment

Treatment

You are responsible for making sure we have all up-to-date insurance information on file, including current insurance cards. Failure to provide this information in a timely manner may result in the charges being billed to you. We ask that you update and verify your record at each visit.

Notice of Privacy Practices

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. I understand that the NPP is available for review and the Written Acknowledgement Form (WAF) will be kept in my record.

Exposure to Bodily Fluids

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.

Photo for Use With Records

I authorize Ear, Nose and Throat, LTD to take my picture for use in identifying me as the authorized person eligible to receive health care. I understand that it will not be used in any other form or function and will be kept secure in my Electronic Health Record.

I have read the above financial policies of Ear, Nose and Throat, LTD and agree to be bound by its terms. I also understand that Ear, Nose and Throat, LTD has the right to amend these policies at any time.

Signature of Patient or Responsible Party: ______________________________ Date:____________

Printed Name of Patient or Responsible Party: ______________________________

Contact Phone Number of Responsible Party: ______________________________

Patient Responsibility Form

We at Ear, Nose and Throat, Ltd. are committed to providing quality care and service to all of our patients. Your understanding of our financial policies is important to our professional relationship. Please take a moment to read through this document to fully understand your responsibility as a patient and sign and date the bottom.

Insurance Information: You are responsible for making sure we have all up-to-date insurance information on file, including current insurance cards. Failure to provide this information in a timely manner may result in the charges being billed to you. We ask that you update and verify your record at each visit.

Health Plan Deductibles, Co-Payments and Co-Insurance: If you have not met your health plan's deductible on the date of service, we will collect an estimated amount before you are seen, which will go toward your deductible. Please note you may receive a bill for additional charges for services rendered. You are responsible for any co-payments and co-insurance required by your insurance carrier at the time of service. Payments received in excess of charges may be applied to subsequent services.

Non-Covered Services: We will do our best to verify coverage before you are seen, but it is ultimately your responsibility to ensure payment of your bill. Any services performed by our providers that are not covered by your insurance are your responsibility. It is your responsibility to know your benefits prior to being seen. Verification of benefits and insurance coverage is not a guarantee of payment.

Referrals: We will do our best to ensure we have a valid referral for services on file. However, if your insurance policy requires a referral, you are responsible for making sure there is a current and valid referral on file prior to being seen. If you do not have a referral for the date of service, you are required to pay $50 upfront 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 day 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.

Lost and Damaged Devices: Ear, Nose and Throat, Ltd. allows patients a 45-day trial of hearing devices prior to purchasing. In the event that a hearing device is lost or damaged during the trial period, you will be responsible for the full cost of the device.

Self-Pay: If you don't have health insurance, are on a plan we are not contracted with, or if we are unable to verify your coverage at the time of service, we will collect an estimated payment before you are seen by a provider. A minimum of $150 is expected prior to seeing the physician. There may be additional charges depending on the services actually provided for which you may receive a bill. For self-pay patients, when surgery is required, a 50 percent down payment is due one week prior to the elective surgery date. The remainder of the payment is due within 30 days unless other arrangements are made with Ear, Nose and Throat, Ltd.

Patient Responsibility Form

Returned Checks: We charge a $25.00 fee for any returned checks.

No-Show Policy: If you are unable to make your appointment, we ask that you cancel your appointment at least 24 hours before you are to be seen in our office. Failure to cancel an appointment in a timely manner will be considered a no-show appointment. Subsequent appointment requests must be secured with a $50 down payment. This down payment is applied to patient co-pay, deductible, co-insurance or visit after all claims have been processed with insurance, or forfeited upon no show. Credits shall be used to offset balances and/or refunded to the patient. Absolutely no same-day appointments.

Minors: For all services rendered to minor patients, the parent, guardian or responsible party who brings the patient to the appointment is responsible for all payments due at the time of service.

Delinquent Accounts: Additional fees, including collection fees, may be added to unpaid accounts. Your account may be sent to a collection agency if the balance is 60-days old and no formal payment arrangements are in place. A $10.00 fee will be added per account sent to collections. You acknowledge that this form is being signed, and services are being performed either in Norfolk, VA or Chesapeake, VA. Should a suit become necessary to collect on this account, that court filing will happen in either Norfolk, VA or Chesapeake, VA.

Contact: If you have any questions regarding your bill, please contact Ear, Nose and Throat, Ltd. at **757-623-0526.**

I have read the above financial policies of Ear, Nose and Throat, Ltd. and agree to be bound by its terms. I also understand that Ear, Nose and Throat, Ltd. has the right to amend these policies at any time.

Signature of Patient or Responsible Party: ______________________________ Date: ____________________

Printed Name of Patient: ______________________ Printed Name of Responsible Party: ____________________

Contact Phone Number of Responsible Party: ____