

Dependent 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
Pharmacy: _____ Address: _____
Pharmacy Phone: _____ Access to pharmacy history? Yes No

Parent (Mother)/Guardian

Name: _____ DOB: _____ SSN: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Cell: _____

Parent (Father)/Guardian

Name: _____ DOB: _____ SSN: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Cell: _____

Person accompany child Information (if NOT child's parent guardian)

Name: _____
Relationship: _____ DOB: _____
Home Phone: _____ Work Phone: _____ Cell: _____

Insurance Information

Primary Insurance: _____ Policy #: _____
Group Number: _____ Policy Holder's Name: _____
Relationship: _____ DOB: _____ SSN: _____
Secondary Insurance: _____ Policy #: _____
Group Number: _____ Policy Holder's Name: _____
Relationship: _____ DOB: _____ SSN: _____
Other Insurance: _____ Policy #: _____
Group Number: _____ Policy Holder's Name: _____
Relationship: _____ DOB: _____ SSN: _____

Referring Physician

Name of Referring Physician: _____ Practice Name: _____
Office Phone: _____ Address: _____

Family Physician

Name of Family Physician: _____ Practice Name: _____
Office Phone: _____ Address: _____

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: You are responsible for any co-payments required by your insurance carrier at the time of service. If you are unable to pay your co-payment at the time of service, your appointment will be rescheduled. Please note you may receive a bill for additional charges for services rendered and any co-insurance or deductible per your insurance.

Potential Additional Costs: Certain tests/procedures may need to be performed that shall result in an additional charge billed to your insurance provider. Depending on your insurance contract, you may be billed additional fees for co-insurance, deductible and/or co-pay.* The amount can only be determined after submission to your insurance. The following procedures may appear as a surgical procedure on your insurance statement/Explanation of Benefits (EOB) from your insurance. Examples (most common but not limited to): Endoscopies, Microscope, Cerumen Removal and Hearing Tests.

Non-Covered Services: 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 will be rescheduled.

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, you will be considered self-pay. We will collect \$200.00 or \$250.00 with audiogram prior to being seen by a provider. There may be additional charges depending on the services actually provided for which you may receive a bill.

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 \$15.00 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 **757-623-0528**.

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: _____